A Meeting of the NHS South Tees Clinical Commissioning Group

Governing Body

will take place on

Wednesday, 29 July 2015 at 2.00pm

at South Tees Business Centre, Enterprise Court, Middlesbrough TS6 6TL (A66)

AGENDA

<table>
<thead>
<tr>
<th>Time</th>
<th>Item No.</th>
<th>Item</th>
<th>Attached or Verbal</th>
<th>Presented by</th>
<th>Page No.</th>
</tr>
</thead>
<tbody>
<tr>
<td>14:00</td>
<td>1.1</td>
<td>Apologies for Absence</td>
<td>Verbal</td>
<td>Chair</td>
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<tr>
<td></td>
<td>1.2</td>
<td>Declarations of Interest</td>
<td>Attached</td>
<td>Chair</td>
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<td></td>
<td>1.3</td>
<td>Draft Minutes of previous meeting held on 27 May 2015</td>
<td>Attached</td>
<td>Chair</td>
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<tr>
<td></td>
<td>1.4</td>
<td>Matters Arising &amp; Action Log Action Log Appendix</td>
<td>Attached</td>
<td>Chair</td>
<td>25, 27</td>
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<td>1.4.1</td>
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<td></td>
<td>1.5</td>
<td>Chair &amp; Chief Officer’s Report</td>
<td>Attached</td>
<td>Chair/ Amanda Hume</td>
<td>29</td>
</tr>
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<td></td>
<td>1.6</td>
<td>Locality Reports:</td>
<td>Verbal</td>
<td>Dr Ali Tahmassebi</td>
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<td>• Middlesbrough</td>
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Section 2 – Items for Decision

|       | 2.1      | A Strategy to Support and Value Carers in Middlesbrough 2015-19      | Attached           | Amanda Hume / Julie Bailey    | 43       |
|       | 2.2      | Mental Health Strategy                                              | Attached           | Simon Gregory                 | 69       |
|       | 2.3      | Terms of Reference – Individual Funding Request Panels               | Attached           | Peter Race                    | 97       |
|       | 2.4      | Terms of Reference – Quality, Performance & Finance Committee        | Attached           | Jacqui Keane                  | 107      |

Section 3 – Items for Discussion

|       | 3.1      | Quality and Safeguarding Report                                      | Attached           | Jean Golightly                | 115      |
|       | 3.2      | Annual Safeguarding Report                                           | Attached           | Jean Golightly                | 123      |
|       | 3.3      | Finance Report                                                       | Attached           | Simon Gregory                 | 167      |
|       | 3.4      | QPF Committee Headlines                                              | Attached           | Simon Gregory                 | 177      |
|       | 3.5      | Tackling Health Inequalities across South Tees                        | Presentation       | Edward Kunonga / Paul Edmondson-Jones | -        |
|       | 3.6      | Urgent Care Strategy Development                                     | Attached           | Dr Nigel Rowell / Julie Stevens | 181      |
|       | 3.7      | 360° Stakeholder Survey Results                                       | Attached           | Dr Raj Khapra / Phillipa Poole | 187      |
|       | 3.8      | Assurance Framework                                                  | Attached           | Simon Gregory                 | 199      |
### Section 4 – Items for Information

<table>
<thead>
<tr>
<th></th>
<th>Update on Lead Provider Framework for Commissioning Support</th>
<th>Attached</th>
<th>Amanda Hume / Alex Sinclair</th>
<th>209</th>
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<tbody>
<tr>
<td>4.1</td>
<td>Report from Co-Commissioning Joint Committee</td>
<td>Attached</td>
<td>Simon Gregory Jacqui Keane</td>
<td>225</td>
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<tr>
<td>4.2</td>
<td>Chief Officer Review of Objectives and Performance 2014-15</td>
<td>Attached</td>
<td>Amanda Hume</td>
<td>229</td>
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### Section 5 – Confirmed Minutes

<table>
<thead>
<tr>
<th></th>
<th>Confirmed Minutes of:</th>
<th>Attached</th>
<th>Peter Race</th>
<th>Amanda Hume</th>
<th>241</th>
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<tbody>
<tr>
<td>5.1</td>
<td>Audit Committee held on 21 April 2015</td>
<td>Attached</td>
<td></td>
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<tr>
<td>5.1.1</td>
<td>Redcar &amp; Cleveland Health &amp; Wellbeing Board</td>
<td>Attached</td>
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<tr>
<td>5.1.2</td>
<td>held on 1 April 2015</td>
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### Questions from the Public – Members of the public may raise issues of general interest which relate to the Agenda

### Section 6 – Any Other Business

<table>
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<tr>
<th></th>
<th>The Annual General Meeting is scheduled to take place on Wednesday, 9 September 2015 at The Heart, Ridley Street, Redcar, TS10 1TD – time to be confirmed.</th>
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<tr>
<td>17.00</td>
<td>6.1</td>
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“Representatives of the press and other members of the public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted, publicity in which would be prejudicial to the public interest (Section 1(2) of the Public Bodies Admissions to Meetings Act 1960)”
<table>
<thead>
<tr>
<th>NAME</th>
<th>TITLE</th>
<th>NAME OF ORGANISATION AND NATURE OF ITS BUSINESS</th>
<th>POSITION HELD / NATURE OF INTEREST</th>
<th>PERSONAL INTEREST</th>
<th>DATE DECLARED</th>
<th>DATE UPDATED</th>
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</thead>
<tbody>
<tr>
<td>Dr Janet Walker</td>
<td>Chair</td>
<td>Eston Locality Lead</td>
<td>Partner : Dr Royal &amp; Partners Manor House Surgery, Normanby</td>
<td>Nil</td>
<td>06/12/2013</td>
<td>13.03.15</td>
</tr>
<tr>
<td>Mr David Brunskill</td>
<td>PPI Lay Member</td>
<td>Nil</td>
<td>Nil</td>
<td>31/10/2013</td>
<td>11.03.15</td>
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</tr>
<tr>
<td>Dr John Drury</td>
<td>Secondary Care Consultant</td>
<td>Nil</td>
<td>Wife undertakes voluntary work on the Oncology Unit at JCUH.</td>
<td>06/12/2013</td>
<td>14.04.15</td>
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</tr>
<tr>
<td>Mrs Jean Fruend</td>
<td>Executive Nurse</td>
<td>Hartlepool &amp; Stockton-on-Tees CCG</td>
<td>Executive Nurse (job share South Tees and Hartlepool &amp; Stockton-on-Tees CCG’s)</td>
<td>Nil</td>
<td>20/11/2013</td>
<td>25.02.15</td>
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<tr>
<td>Mr Simon Gregory</td>
<td>Chief Finance Officer</td>
<td>Nil</td>
<td>Partner works for Tees, Esk and Wear Valley NHS FT Finance Team</td>
<td>22/11/2013</td>
<td>25.03.15</td>
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<tr>
<td>Mrs Amanda Hume</td>
<td>Chief Officer</td>
<td>Nil</td>
<td>Nil</td>
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<td>26.02.15</td>
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<tr>
<td>Dr Rajesh K Khapra</td>
<td>Practice Representative, Back Pain Lead</td>
<td>Crossfell Medical Practice</td>
<td>Partner</td>
<td>31/10/2013</td>
<td>15.04.15</td>
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<tr>
<td>Dr Mike Milner</td>
<td>Urgent Care Lead, Governing Body Member</td>
<td>Northern Doctors, Out of Hours GP Service Huntcliff Surgery</td>
<td>Partner, Out of hours GP GP</td>
<td>Nil</td>
<td>04/12/2013</td>
<td>24.02.15</td>
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<tr>
<td>Dr Vaishali Nanda</td>
<td>Governing Body GP</td>
<td>The Discovery Practice</td>
<td>GP at The Discovery Practice</td>
<td>Husband owns Nanda Medical Services for private orthopaedic work</td>
<td>16/01/2014</td>
<td>09.04.15</td>
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Husband is a Consultant in orthopaedics at NTHFT | 02/04/2014
<table>
<thead>
<tr>
<th>Name</th>
<th>Role</th>
<th>Affiliation</th>
<th>Position</th>
<th>End Date</th>
<th>Start Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mr Peter Race</td>
<td>Lay Member, Governance</td>
<td>South Tees Trust</td>
<td>Governor (appointed by CCG)</td>
<td>04/11/2013</td>
<td>04/11/2013</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Brother John D Race MBE JP is an elected Governor with South Tees Trust.</td>
<td>12.04.15</td>
<td></td>
</tr>
<tr>
<td>Mr Nigel Rowell</td>
<td>Governing Body Member</td>
<td>Endeavour Practice Ltd</td>
<td>Director</td>
<td>27/11/2013</td>
<td>27/11/2013</td>
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<td>North of England Cardio</td>
<td>Primary Care Lead</td>
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<td>STAT JCUH Heart Failure Service</td>
<td>CPSI in Heart Failure</td>
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<td></td>
<td>Servier Laboratories Ltd</td>
<td>Live : Life Study Principal Investigator</td>
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<tr>
<td></td>
<td></td>
<td>Living Longer Lives Team</td>
<td>AF Clinical Champion</td>
<td>25.03.15</td>
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<tr>
<td>Dr Ali Tahmassebi</td>
<td>Governing Body Member</td>
<td>Bentley Medical Practice</td>
<td>Partner</td>
<td>05/11/2013</td>
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<td></td>
<td></td>
<td>Park Avenue Surgery</td>
<td>Partner</td>
<td>05/11/2013</td>
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<td></td>
<td></td>
<td>Slater's Bridge</td>
<td>Director</td>
<td>18/03/2014</td>
<td>18/03/2014</td>
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Minutes of the NHS South Tees Clinical Commissioning Group
Governing Body Meeting

Held on Wednesday, 27 May 2015 at 2.00pm
At The Resource Centre, Meath Street, Middlesbrough

Present:
Dr Janet Walker Chair - Governing Body GP Member
Mrs Amanda Hume Chief Officer
Mr Simon Gregory Chief Finance Officer
Dr John Drury Secondary Care Doctor
Dr Rajesh Khapra Governing Body GP Member
Dr Mike Milner Governing Body GP Member
Dr Vaishali Nanda Governing Body GP Member
Dr Nigel Rowell Governing Body GP Member
Mr Peter Race MBE Governing Body Lay Member
Mr David Brunskill Governing Body Lay Member
Ms Jean Golightly – Executive Nurse
(formerly Ms Jean Fruend)

In Attendance:
Mr Paul Edmundson-Jones Director of Public Health – Redcar & Cleveland Borough Council
Ms Sue Perkin Health Improvement Partnership Manager - Middlesbrough Council
Mr Craig Blair Associate Director – Commissioning, Delivery & Operations
Mrs Barbara Sword Company Secretary – North of England Commissioning Support (NECS)
Mrs Liane Cotterill Senior Governance Manager - NECS
Sandra Edwards Governance Officer - NECS – Minute Taker

Members of the Public:
Ian Hillery Senior Medical Rep/Territory Manager – Leo
Scott McGilligary Regional Account Director - Takhora
Kate Batley Territory Manager – Bayer
Raj Soren RSDM – Bayer
Carolyn Smith Pfizer
Joanne Curiston Account Manager - Pfizer

GB/26/15 Apologies for Absence

The Chair welcomed everyone to the meeting. Apologies were received from Richenda Broad (Middlesbrough Council), Ali Tahmassebi (GP Governing Body Member), Jacqui Keane (Corporate Governance Officer) and Edward Kunonga (Director of Public Health, Middlesbrough Council)

GB/27/15 Declarations of Interest

There were no interests declared in respect of items on the Agenda.

GB/28/15 Draft Minutes of Previous Meeting – 25 March 2015

The Minutes of the meeting held on 25 March 2015 were AGREED and APPROVED as a true and accurate record subject to the following amendment:
Minute ref GB/17/15 New Service Specifications for GP Practices 2015/2016 para 17.1.27 should read:

… at the end of April, being reported back to the Governing Body in May.

GB/29/15 Matters Arising and Action Log

29.1 Matters Arising

*Mental Health Care Crisis Concordat*
Mrs Hume advised that the Concordat had been signed by all partners. Project support was in place which would oversee delivery of the Action Plan.

29.2 Action Log

29.2.1 GB/01/15 – *Middlesbrough Fun Run* – The CCG’s sponsorship investment in the Fun Run was £3,000. The Fun Run would take place on 31 May 2015 with Dr Nanda presenting the prizes. It was agreed this action should be closed.

29.2.2 GB/02/15 – *Risk Management Strategy* – It was agreed to delegate the action to the Governance and Risk Committee which approves all policies. It was agreed this action should be closed.

29.2.3 GB/03/15 – *Prescribing Incentive Scheme* – The Scheme had been changed and taken to the Joint Co-commissioning Meeting in April for approval as the Quality Engagement Scheme. It was agreed this action should be closed.

29.2.4 GB/04/15 – *Quality, Performance & Finance Update* – Confirmation of the ambulance position had been taken to the Quality, Performance and Finance Committee in April 2015. It was agreed this action should be closed.

29.2.5 GB/06/15 – *Assurance Framework* – The issues had been discussed with Internal Audit and this action was now complete. It was agreed this action should be closed.

29.2.6 GB/07/15 – *SeQHIS Presentation* – Mrs Hume explained the purpose of SeQHIS (Securing Quality in Health Services) to members of the public. A Clinical Leaders’ Meeting had been held on 21 May 2015 through which additional work had been undertaken to develop the model of care. This will be further tested to enable the SeQHIS group to inform design of acute services across the area in future. It was agreed this action should be closed.

29.2.7 GB/08/15 – *Audit Committee* – This action had been completed and was now closed.

29.2.8 The Chair updated the Governing Body on the Practice Enhanced Treatment Services, explaining that this topic would be reported back to the Governing Body after being further discussed with the Joint Co-commissioning Group. Both schemes had been taken forward and were with the practices for their approval. These schemes would enhance patient care.

GB/30/15 Chair & Chief Officer’s Report

Mrs Hume presented the report highlighting key points.
30.1 **Practice Engagement**
Mrs Hume explained that practice visits continue. There had been a successful Practice Managers Engagement event, resulting in improving relationships.

30.2 **Clinical Council of Members**
The meeting held on 30 April 2015 had been well attended, and positive feedback had been received.

30.3 **Patient and Public Advisory Group (PPAG)**
The PPAG was developing and now had six Core Members. An induction would be held in June for these six Members with the first meeting in July.

30.4 **CCG Stakeholder Survey**
30.4.1 NHS England and Ipsos Mori had asked CCGs to undertake an annual 360° stakeholder survey to assess how relationships with stakeholders had developed and to inform the future development of the CCGs. The survey covered:
- Engagement and listening to views
- Acting on suggestions and working relationships
- Commissioning decisions
- Leadership
- Quality of services
- Plans and priorities and the wider contribution the CCG is making.

30.4.2 South Tees CCG had shown an improvement in most domains from the first survey as a CCG and had engaged well with partners, performing well in all areas relative to peers. The CCG were analysing the outcome for further areas of development and would report further to the Governing Body in July.

30.5 **Stonewall Benchmarking Tool**
The Stonewall Benchmarking Tool tracks progress on equality for lesbian, gay, bisexual patients and communities. Although the CCG came 35th the CCG was mindful that they were marked against larger organisations from Ambulance Trusts, Mental Health Trusts and Foundation Trusts. This continued to be a major focus with the CCG working with two Local Authorities, mental health provider and acute provider to implement areas of improvement recommended by Stonewall.

30.6 **Integration Programme Board (IPB)**
30.6.1 Members were updated on progress of the Integration Programme Board, now supported by Kathryn Warnock (Integration Programme Manager). A workshop run by Middlesbrough Council had been held the previous week at which an event-mapping exercise had been undertaken for a range of services provided by different partners with a view to design a single point of access. Discussions had been held on how each organisation could benefit and patient experience be improved.

30.6.2 A report about the scope of the project was due which would be taken to each member organisation. From a health perspective, a single point of access for GPs would allow GPs access to the right service first time.

30.6.3 Mr Blair gave an overview of the single point of access and how this could improve patient/public experience, cost and quality benefits. Mrs Hume commented that it was important to note the single access point would cover both health and social care and would take an asset-based approach, enabling improved access to services through greater awareness by front line professionals as to the resources available within the community. It was clarified
that the scoping on the single point of access project would be undertaken and approved through the Executive Committee and reported through to the Governing Body.

### 30.7 Mental Health Care Crisis Concordat
Integrated mental health working on a Tees-wide basis was well supported and gathering momentum. There was extensive work going on around the most vulnerable members of the population who use the services.

### 30.8 Middlesbrough Health and Wellbeing Board
David Budd had been appointed as the new Mayor for Middlesbrough and would become the Chair of the Health & Wellbeing Board.

### 30.9 Redcar & Cleveland Health and Wellbeing Board
Members noted that elections were to take place for the Leader of Redcar & Cleveland Council on 28 May 2015.

### 30.10 Designated Safeguarding Children’s Nurse
Alison Ferguson had been appointed as the Designated Safeguarding Children’s Nurse, giving increased safeguarding capacity for South Tees.

### 30.11 Governance
Following a recent positive external Governance Review and further internal review with Governing Body members developments were being taken forward. An additional lay member would be appointed to support the introduction of Co-Commissioning and succession planning. Dr Nigel Rowell had assumed a non-Executive Role on the Governing Body without portfolio from 1st May 2015.

### 30.12 Distribution of workload across the respective Committees would be reviewed, the outcome of which would be reported to the Governing Body, anticipated to be at the July meeting.

**The Governing Body NOTED the Chair and Chief Officer’s Report.**

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**GB/31/15 Locality Report**

### 31.1 Dr Nanda gave an overview. The three localities had co-ordinated agenda items ensuring there was consistency in the cascading of information. This was a positive step which was working as all practices received the same information within a similar timescale.

### 31.2 The Clinical Council of Members had met at the end of April. A key feature of this meeting, and also of the locality meetings, was the safeguarding, incident and risk management system (SIRMS) which is an incident reporting and management system available to practices. Practices were concerned they were feeding into the system but were receiving no feedback on trends, reports, etc. It was explained that some incidents were taken up with providers. SIRMS was not an immediate responsive system, some responses were longer term. The SIRMS profile needed to be raised to encourage practices to use the system. Serious incidents could be reported on SIRMS but there were also other ways of reporting such incidents.

### 31.3 NHS England had hosted a meeting of the Medical Assurance Group, the purpose of which was to keep oversight on the quality of primary care and would be looking at 12 indicators.
31.4 The judicious use of antibiotics had been discussed along with the importance of raising awareness. There are other aids for GPs regarding this: a phone application of the North East antibiotics guidelines and also a link to the Medicines Optimisation website with a range of patient information resources.

31.5 **Middlesbrough**

Dr Rowell reported that the Middlesbrough Locality Council had met on 14 May 2015 and had also covered SIRMS and antibiotic prescribing.

31.6 **Langbaurgh**

31.6.1 Dr Milner reported on the development of the STAR system – 7 day working in general practice. It was hoped to implement this in Redcar Hospital in June-July. Dr Milner acknowledged that being well ahead in delivering this goal was due to the excellent work undertaken by Dr Teik Goh.

31.6.2 The Prescribing Engagement Scheme had also been discussed, highlighting that the area was the highest antibiotic prescriber in the country and there was a need to drive this down through reduction in inappropriate prescribing.

31.6.3 The Garth Surgery was running a Wellbeing Project. The uptake had been reasonable but as there was extra capacity Dr Smith hoped to open this up to the whole of the Tees area.

31.7 **Eston**

Dr Walker reported that all three localities were working on a dementia collaborative. Practices had reported on the dementia difficulties they faced and debated how practices were proactive in diagnosing and recording appropriately the access to treatment required.

**The Governing Body NOTED the three Locality Reports.**

32.1 **Patient Stories**

**Stroke Early Supported Discharge Service**

32.1.1 The Chair explained that the Early Supported Discharge (ESD) scheme was part of the IMPrOVE programme and a new way to deliver the acute stroke service. James Cook University Hospital (JCUH) was providing a very good service but, perhaps, was not meeting ‘best practice’ as it was not located on one site. In other parts of the country, patients were being discharged early and supported at home. The ESD was now in place at Redcar Primary Hospital. Mrs Hume and Dr Walker had an instructive visit and the staff feedback was excellent. The staff acknowledged they had to work differently as all departments were on one site but working in the Unit had led to definite improvements for patients and was working well.

32.1.2 The Chair commented that one patient who used the ESD service was happy to use his story to illustrate how he had benefitted.

32.1.3 Michael Paranics was the first patient to take advantage of the new service. The retired ICI worker suffered a heart attack while on holiday in India in February. Following his return home and admission to the James Cook University Hospital in Middlesbrough he was also treated for a stroke which had affected his peripheral vision. A week later he was discharged and he is now receiving
rehabilitation therapy in the comfort of his own home thanks to the new stroke ESD scheme.

32.1.4 Michael was only too happy to be the first to take advantage of the service: “I’m proud to be a pioneer,” he said. “Everything is familiar here and we are not limited to walking 50 yards down a busy hospital corridor. Plus I feel more at home!”

32.1.5 The service is supported by Reablement Teams from the Middlesbrough and Redcar & Cleveland Local Authorities, psychology, community nursing services and the Stroke Association. The service which was expected to benefit up to 40% of patients admitted to hospital with a stroke, will complement the newly centralised in-patient rehabilitation service at Redcar Primary Care Hospital. From 1 April 2014 stroke services and Rehabilitation Teams were centralised at Redcar Primary Care Hospital, making it a centre of excellence for stroke rehabilitation with dedicated beds, specialist staff, excellent facilities and the added support of the ESD team.

32.2 Rapid Response Patient Feedback

32.2.1 The Chair explained that the rapid response was delivered by community staff to assess patients in their own home. Patients were monitored for 72 hours before either being discharged or placed under the care of their local Community Matron. Essentially the service exists to keep patients out of hospital or get them home sooner.

32.2.2 The Rapid Response Nursing and Therapies Scheme complements the social schemes in both Middlesbrough and Redcar & Cleveland. Feedback (about 20 per month) had been complimentary and exceptionally positive. It was unusual in a treatment survey that patients and carers commented that 100% of the time all four parameters were met (February). In March the figure was slightly lower. Patients and carers were extremely likely to recommend the service to others. The feedback provided evidence to promote the scheme to GPs which would enable them to realise the advantages of the hospital avoidance scheme.

32.3 Mrs Hume commented that it was important to bring lessons learned from patient experience when things have not gone so well. There was a need to explore this although it may be a challenge to obtain patient or family’s permission to share such experiences. Consideration would be given to this to enable a balance in Patient Stories reported going forward, including on services for younger people.

The Governing Body NOTED the information on Early Supportive Stroke Discharge and Rapid Response Patient Feedback.

GB/33/15 Patient and Public Involvement

33.1 Mr Brunskill gave an overview of engagement with the public since January 2015.

33.2 Primary Care Co-commissioning

An event had been held on 7 January 2015 regarding Primary Care Co-commissioning and a second event would be held on 17 June 2015. At the January meeting both GPs and the Executive Team approved Option 2 for Co-commissioning (80%).
Loftus Accord
A meeting of the Loftus Accord had been held on 21 January 2015 which a number of CCG representatives attended. The Loftus Accord comprises member groups and organisations within the parish of Loftus and focused on access to services for Loftus residents.

Patient and Public Advisory Group (PPAG)
A PPAG Information Session had been held on 31 March 2015 in Eston to inform local patients and the public of plans to develop core members of six critical friends linking with other organisations. There were 15 expressions of interest from people who wished to become more involved. Informal interviews were held on 21 April and six people have been chosen. The first PPAG meeting will be held on 10 June 2015. A full summary would be presented to the next appropriate Quality, Performance and Finance Committee.

41 Club
Mr Gregory and Mr Brunskill attended a meeting on 25 March 2015 where members were very supportive of the work of the CCG.

Mental Health Strategy Engagement Event
A well-attended meeting was held in Middlesbrough on 26 March 2015 for patients, service users, carers and partners to discuss and inform the CCG’s draft five-year mental health strategy.

Healthwatch
Healthwatch and the CCG hold regular meetings with relevant issues being presented to the Governing Body. The next Healthwatch meeting will be held on 16 June 2015.

Mental Health Strategy – Children and Young People Engagement
The Community group, Kidz Konnect, which engaged with children and young people on behalf of the CCG to inform the Mental Health Strategy had run family fun days with a health theme to garner feedback from young people in designing how their consultation work will be conducted. Mr Gregory pointed out that it was important to include Looked After Children. Ms Golightly advised that the Local Authority had undertaken a significant amount of work and suggested the CCG tapped into ‘Hearing a Child’s Voice’.

The Governing Body NOTED the Patient and Public Involvement Report.

GB/34/15 Strategic Aims / Corporate Objectives

Mrs Hume informed the Governing Body that work had been undertaken in Development Sessions to clarify the Governing Body’s priorities, build on previous work and take stock to ensure that priorities, corporate objectives and aims were sufficiently clear and focused. The CCG had been in existence for two years and there was a recognised need to keep processes live and responsive; ensuring the thread between the CCG mission and all specific work was strengthened. ‘Improving Health Together’ had been the mission statement of the CCG since its earliest formation and still stood as a central aim of the CCG. Members had been engaged in further development of the CCG’s Vision Statement and to refine and refresh the corporate aims. Members were invited to review the corporate aims, proposed corporate objectives and the proposed process for monitoring delivery as set out in the report to see whether further refinement was required.
34.2.1 **Vision Statement**
Mrs Hume explained that the Vision Statement was a result of much discussion which tried to capture the CCG’s raison d’être as succinctly as possible.

34.2.2 ‘Improving the quality of life for all in our community reducing preventable differences in people’s health, encouraging everyone to have greater responsibility for their own health, supported by accessible, high quality services that are designed around people and their needs.’

34.2.3 Mrs Hume asked for comments. The Vision was considered to reflect discussion to date, captured the corporate aims and was sufficiently ambitious allowing progress to be measured against it. It was considered that Partners would be able to empathise with the statement in working alongside the CCG.

**The Governing Body AGREED to ADOPT the Vision Statement.**

34.3. **Corporate Aims**
34.3.1 Mrs Hume explained that the CCG had attempted to consolidate the Corporate Aims to a reasonable number; concentrate on the main areas and focus on how progress could be measured against delivery. There was also a need to be aspirational and set direction.

34.3.2 **Corporate Aim 1** – To ensure the populations of Middlesbrough, Redcar and Cleveland are able to access healthcare services that are safe, effective, patient-centred and high quality both now and in the future.

34.3.3 It was suggested that ‘patient-centred’ might be ‘person-centred’ and following a short discussion it was agreed to change to ‘person-centred’.

34.3.4 **Corporate Aim 2** – To support and encourage people and those who are carers to take control of their own health and make informed choices about where and when to access healthcare.

34.3.5 Dr Milner noted the importance and simplicity in accessing urgent care and emphasised the role of Public Health in promoting the sensible use of antibiotics, and was keen there should be infrastructure to promote public education on a broader scale. Mrs Hume agreed that ‘patient education’ should be reflected in Objective 10.

34.3.6 Dr Drury suggested that the wording be amended to people and their carers.

34.3.7 **Corporate Aim 3** – To work with our populations and partners to reduce preventable differences in physical, mental and social wellbeing across Middlesbrough, Redcar and Cleveland.

34.3.8 Dr Rowell suggested that ‘optimal management’ could be added to objective 13, between ‘early’ and variable’ and look to partners to improve early detection. Dr Milner pointed out that a paper had been published in the Cardiology Journal reflecting that treating diabetes early was more important than how well patients were treated later on. Dr Milner added that ‘optimal management’ promoted through a programme of joint medical assurance across sectors would benefit patients.

34.3.9 Mr Edmundson-Jones noted that, in terms of Public Health, all of the aims demonstrate a link from the CCG to Local Authorities. Public Health could play a
role in public education. It was time to target those people who would not normally take an interest in their own health care to ensure they received the right message regarding their lifestyle and encourage them to follow their prescribed therapies.

34.3.10 Mr Edmundson-Jones pointed out that Objective 15 as it stood (To ensure equity of access to all commissioned services) would not fully address this Corporate Aim, suggesting it also needed to reflect derivation of benefit ‘Can offer equal access but aspire to equal ability to benefit’. The Chair suggested this objective be discussed further outside of the meeting.

34.3.11 **Corporate Aim 4 – To ensure the decisions we make are informed by best evidence alongside the needs and views of local people**

The Governing Body AGREED with this aim.

34.3.12 **Corporate Aim 5 – To ensure we get the best possible health benefit for every pound we spend.**

The Governing Body AGREED with this aim.

34.3.13 **Corporate Aim 6 – To explore and develop integration of the health and social care system to benefit the populations of Middlesbrough, Redcar and Cleveland.**

34.3.14 Discussion took place on the reference to specific populations following which it was agreed that the Aim be amended to refer to the population we serve thus enabling wider relevance to all communities served by the CCG within and beyond the boundaries of the two Local Authorities and also to the widest range of partners and other agencies.

34.3.15 Mrs Cotterill pointed out that Objective 24 was largely duplicated as Objective 28 in Corporate Aim 6 with a difference of only one word – To make the best use of information (management) and technology and business intelligence. Mr Gregory recommended that Objective 28 include reference to ‘technology and integration’.

34.3.16 Mrs Hume reminded the Governing Body they were being asked to:
- Consider the Corporate Aims and Objectives
- Agree to the principle of progressing these with the Workstreams
- Agree to take forward these amendments to the Workstreams.

34.4 **Summary of Amendments to Aims**

- 1 – person centred
- 2 – public education campaign
- 2 – people and carers
- 3 – optimal management - objective 13
- 3 – reword objective 15
- 6 – include ‘technology and integration’ into objective 28
- Focus on ‘communities’ rather than ‘Middlesbrough and Redcar & Cleveland’ – e.g. ‘the population we serve’.

**Action GB/09/15 – Mrs Hume**

The Governing Body AGREED the Vision, Corporate Aims and Objectives subject to the aforementioned amendments.

The Governing Body AGREED to the principle of progressing and taking
forward the amended Corporate Aims and Objectives through the Workstreams.

34.5 Responding to a query, the Chair replied that he refreshed Corporate Aims and Objectives would be taken to the PPAG and PPG for their feedback.

**Action GB/10/15 – Mr Brunskill**

34.6 **Strategy Update**
34.6.1 Mr Blair gave an overview of the CCG’s strategic intent.

34.6.2 In early 2014 the CCG Executive Team had agreed that in order to provide strategic direction to the clinically-led Workstreams and to ensure that commissioning activities and intent were focused on supporting the CCG to deliver its Clear and Credible Plan, work should commence on producing a suite of strategies. These strategies provided an overall plan of action designed to deliver the strategic vision. The expectation was that all strategies would be developed during 2014-15 with the subsequent development of implementation plans for progression in 2015-16 onwards.

34.6.3 These strategic documents fell in two main categories:
- Corporate strategies, being those that provide a framework for how the CCG operates
- Commissioning strategies being those that describe the strategic vision for the services which are commissioned.
- There was also a third category where the CCG was a key partner in developing external or system wide strategies

34.6.4 Mr Blair informed members of the present position: 20 strategies had been published or were in production, eight of which had been approved by the Governing Body over the past 18 months. The remaining strategies were either in the development stage or draft format.

34.6.5 Ms Perkin, noting the CCG’s Corporate Objectives and inter-relationship with Public Health, asked to be involved in the strategy developments. Mrs Hume added that the CCG were committed to developing strategies in a meaningful way with partners which by its nature took a little time and was an iterative process.

34.6.6 Dr Nanda emphasised the importance of increased awareness of JSNA and associated improvements required in response. Although there were challenges in taking this to the Workstreams all Workstreams needed to be aware of the bigger picture.

34.6.7 Mr Gregory pointed out that a Medicines Strategy was not currently referenced and should be considered for development.

34.6.8 The Chair thanked everyone for their comments, noting the need for the CCG to standardise the process, increasing its effectiveness and capturing the learning to date when so doing.

34.6.9 The Governing Body were recommended to agree:
- An Executive Clinical Lead for each Workstream
- The setting up of a Strategy Oversight Group
- The development of a standardised CCG process for strategies
The Governing Body AGREED the three recommendations of the Strategy Update.

**GB/35/15**  
**Presentation of Draft Annual Report and Accounts 2014-15**

35.1 Mr Gregory presented the Draft Annual Report and Accounts for 2014-15

35.2 He explained that the draft version of the Report (tabled at the meeting) would be submitted to NHS England by 29 May 2015 and the CCG would have a further week thereafter to refine the Report.

35.3 With regard to the Accounts, Mr Gregory explained that the final process evolved through the month and the final draft of the accounts had been presented to the Audit Committee prior to the Governing Body meeting.

35.4 Mr Gregory provided a detailed overview of the Draft Annual Report and Accounts and highlighted the requirements for each section. In addition, members considered and noted the responsibilities of the Governing Body, the Chief Officer and the Audit Committee in approving the Annual Report and Accounts.

35.5 In his presentation, Mr Gregory drew members’ attention to the successes and challenges experienced by the CCG during the year and confirmed that the Annual Report reflected a balanced and comprehensive summary. He also drew attention to the key risks that had been managed by the CCG throughout the year and confirmed that these had been presented to the Governing Body on a regular basis via the Assurance Framework.

35.6 With regard to the Remuneration Report, Mr Gregory advised this report gave details of the remuneration and pension rights of Governing Body members. The report also showed the ratio between the highest paid director and an employee who had the CCG’s median salary. For the CCG with only 18 staff that meant the median point was very low – a Band 2 salary. This ratio showed the highest paid director received five times the salary of a Band 2 employee. Having undertaken this exercise without GPs this brought the median point to Band 4. Comparatively, Sunderland CCG had 80-90 staff, with a median of Band 7. If South Tees CCG’s median had been a Band 7 the ratio would have been 2.8.

35.7 **Annual Accounts**

Mr Gregory was pleased to highlight that the CCG had met its financial targets:

- Having been required to make a surplus of at least 1%, the CCG had made a 2.1% surplus in 2014-15. This surplus would be held by NHS England and would be returned to the CCG in 2015/2016.
- The administration expenditure was £6,292,000, within the £6,792,000 administration resource /management cap. It was noted that the spend limit for 2015-16 was lower comprising a 10% management reduction.
- Despite the surplus, expenditure was up 2.8% compared with last year. Mr Gregory advised that money for the winter programme had been routed through the CCG.
- The item referring to ‘professional fees’ included payments to those GPs involved with Workstreams or other specialisms.
- The creditor position had increased slightly this year together with a reduction in the debtor position.
- The cash balance had been £80,000 which was within the £200,000
maximum allowed.
- 98.63% of invoices for non-NHS suppliers had been settled within the 30 day target period.

35.8
35.8.1 Review Process
Mr Gregory explained that NHS England receive a copy of the Report and Deloitte also give feedback on the draft to ensure that it was compliant with NHS England’s Annual Report guidance. He confirmed that the Report had been amended to address the requirement for additional information relating to addressing health inequalities, performance and sustainability.

35.8.2 Mr Gregory confirmed that the CCG had met all of its statutory duties.

35.8.3 Mr Gregory explained that the External Auditor’s Report would be received the following day in advance of the draft Annual Report and Accounts being submitted to NHS England on 29 May 2015. Following the external audit review two minor changes had been incorporated:
- Refinement to the Public Sector Payment reference
- Inclusion of referenced to Dr Drury’s interest in Tees, Esk and Wear Valleys NHS Foundation Trust as a Governor operating on behalf of the CCG, within the Related Party section
- Name changes (Ms J Fruend to Ms J Golightly)

35.8.4 Mr Race (Chair of Audit Committee) advised the Governing Body that one of the duties of the Audit Committee was to report to the Governing Body on the Final Accounts. He emphasised that the CCG had a very good year for 2014-15 and everyone should be congratulated.

35.8.5 The Audit Committee had thoroughly reviewed the accounts on four occasions since the initial draft in April 2015. An Audit Committee had been held prior to the Governing Body to enable the Final Accounts to be recommended for approval. Mr Race explained that Deloitte do not sign their report until they have seen the CCG’s signed accounts. Deloitte had given verbal assurance that they were happy with the accounts and that the CCG had met all of its duties together with delivering a surplus.

35.8.6 The Audit Committee recommended to the Governing Body that they should accept the accounts.

35.8.7 Mr Race congratulated the whole Team, particularly Finance, in providing clarity to the Audit Committee. Mr Gregory also thanked and congratulated NECS colleagues for their sustained effort in producing the Accounts.

35.8.9 Dr Rowell noted there were 24 GPs involved in the CCG, an extraordinarily high figure, which reflected how well the GP membership was involved in the CCG.

35.8.10 Mrs Hume thanked Mr Race for his comments, endorsing his comments about the Finance Team. Mrs Hume added that producing the report and accounts was a substantial undertaking and also expressed particular thanks to Julie Bailey and Mark Burdon.

35.10 Disclosure to Auditors
35.10.1 Mr Gregory advised that all members of the Governing Body were required to confirm the ‘Disclosure to Auditors’. In Dr Tahmassebi’s absence he had sent a confirmation e-mail thus fulfilling his obligation.
Having declared that she had seen Dr Tahmassebi’s e-mail, the Chair read out the following disclosure:

**35.10.2 Each individual who is a member of the Governing Body at the time the Members’ Report was approved, confirms:**

- So far as the Member is aware, that there is no relevant audit information of which the Clinical Commissioning Group’s external auditor is unaware; and
- That the Member has taken all the steps that they ought to have taken as a Member in order to make them self-aware of any relevant audit information and to establish that the Clinical Commissioning Group’s auditor is aware of that information.

The Governing Body AFFIRMED the disclosure.


**GB/36/15 Standards of Business Conduct and Declarations of Interest Policy**

36.1 Mr Gregory advised that this was an update to the previous policy, in response to statutory guidance for CCGs; Managing Conflicts of Interest (18 December 2014), ahead of its natural review date.

36.2 Section 2.5 set out the statutory guidance which had, in the main, impacted on Declarations of Interest which commenced at Section 7. In particular, 7.6 covered commissioning of primary medical service under joint or delegated arrangements.

36.3 New forms had been included within the appendices as per the statutory guidance.

36.4 Mrs Hume commented that this gave further assurance to the Governing Body and provided further safeguards to manage conflicts of interest. There were a number of scenarios where conflicts of interest could possibly arise, eg co-commissioning of services.

The Governing Body APPROVED the updated Standards of Business Conduct and Declarations of Interest Policy and RECOGNISED the changes therein.

**GB/37/15 System Resilience Group Report – Recommendations on Use of Resilience Funding**

37.1 Mr Blair informed the Governing Body that in 2014-15 System Resilience Groups (SRGs) had been tasked with providing the forum to co-ordinate capacity planning and operational delivery across all stakeholders in the health and social care system. To support this, SRGs were allocated national ‘winter resilience monies’ in support of schemes that would reduce and mitigate the impact of increased levels of surge and demand during winter 2014-15. The ST CCG SRG was allocated £2,098,774 to support this.

37.2 The ST CCG SRG had implemented a process whereby all stakeholders were invited to submit funding proposals for schemes that would support surge management. The process implemented considered the potential impact and
priority level for each scheme underpinned by key performance and costing information. Schemes within the following organisations had originally been supported in 2014-2015:

- South Tees NHS Foundation Trust
- Redcar & Cleveland Local Authority
- Middlesbrough Local Authority
- Middlesbrough Public Health
- North East Ambulance Service
- Tees, Esk and Wear Valley NHS Foundation Trust (TEWV)
- South Tees CCG

37.3 NHS England had suggested that SRGs should consider the following areas when developing schemes and proposals to combat winter surge:

- Reduce A&E attendance
- Achieve the A&E 4-hour target (95%)
- Reduce non-elective admissions
- Reduce Walk-in and Minor Injury Unit attendance
- Reduce Delayed Transfers of Care

37.4 At the end of March 2015 a total of 28 schemes had been implemented throughout the winter period, all supported by systems resilience monies. As an outcome the system managed reasonably well compared to others. The SRG was required to review all 28 schemes to decide which would continue in 2015-16.

37.5 The SRG undertook the evaluation process and were recommending nine schemes to take forward in the forthcoming year, based on their effectiveness:

- Winter Communications Campaign
- Flu Communication Campaign
- Seasonal Ailment Scheme
- A&E Screening Team
- Emergency Nurse Practitioner expansion
- Surgical Decision-Maker at front of house
- Medicines Optimisation
- Extra Capacity for Delirium Patient Assessments
- Medical Decision-Maker at front of house

37.6 The total anticipated costs were approximately £2.74m with £1m allocated from the Better Care Fund with the remainder to be identified from within CCG baseline allocations.

37.7 Dr Nanda asked whether the nine schemes were taking place solely during the winter or throughout the year. Mr Blair confirmed they were run throughout the year in an attempt to build a response to the surge, including a summer surge.

37.8 Dr Nanda pointed out that working in primary care, confusion arose as to the timings of some of the schemes, with the seasonal ailment scheme, in particular, raising expectation. She suggested it would be helpful for this scheme to run all year. Mr Blair queried whether the confusion arose around communication as to when the schemes ended. Dr Nanda agreed this was so, explaining that patient behaviour changed to accommodate this and it would be helpful to run this scheme throughout the summer.

37.9 Dr Khapra suggested renaming the ‘Seasonal Ailment Scheme’ to the ‘Minor Ailment Scheme’ as currently there was confusion about when the ‘seasonality’
began and ended. As a ‘Minor Ailment Scheme’ it could be run at any time.

37.10 The Chair pointed out that the Medicines Optimisation service were looking at how this could be carried forward between periods of surge to gain the best benefit. All CCGs within the Northern CCG Forum were collaborating on a Winter campaign and this would dovetail with the SRG initiative to be a programme throughout the year.

37.11 Mr Gregory pointed out that SRG money for mental health was mainly invested with TEWV, noting that the CCG had to increase the mental health spend by 1.7% and also to maintain winter mental health projects.

37.12 The Governing Body was asked to support the following recommendations:

- Support the continuation of recommended SRG schemes
- Support the use of identified resources to enable delivery of these schemes
- Provide a mandate to the Quality, Performance and Finance Committee in affording oversight to the SRG for delivery of the schemes and to monitor financial spend against the agreed envelope.

The Governing Body AGREED to all three recommendations in the System Resilience Group Report.

GB/38/15 Quality and Safeguarding Report

38.1 Ms Golightly highlighted the key points.

38.2 South Tees FT Serious Incidents

Serious incidents were decreasing. Grade 3 and 4 pressure ulcers remained the most common category but these had reduced to less than 25% of the 2013-14 total. However there was an increase in serious falls which was being closely monitored. This is being discussed with the Trust with root cause analyses results expected soon.

38.3 Mortality Rates

South Tees Hospitals Foundation Trust (STHFT) was a negative outlier for the Hospital Standardised Mortality Rate (HSMR). The Trust was undertaking review of the reasons including the impact of coding of specialist palliative care cases.

38.4 HCAI

STFHT continued to be challenged in this area. The MRSA target for last year was 0 but there were 4 cases attributed to HCAI. However, this was a reduction on the previous year of 5.

38.5 Clostridium Difficile

38.5.1 C.Diff remained an issue. The Trust had exceeded the trajectory for last year, 76 cases against 49, despite this being during a period of increased focus, scrutiny and inspection around HCAI related practices. The CCG has been supportive in many different guises, particularly in reviewing antibiotic prescribing and in commencing benchmarking of the position with other CCGs to examine lessons learned from elsewhere.

38.5.2 Discussion took place around the need for further escalation around this issue to combat this.
38.6 **Care Quality Commission (CQC)**

STHFT was inspected in December 2014. The report had been expected in April but this had now been rescheduled to be presented at a Quality Summit in June 2015 to which Monitor, Healthwatch, Local Authority colleagues, NHSE and CCGs will be invited.

38.7 **National Staff Survey**

38.7.1 STHFT achieved a response rate of 35% which was down on the response rate of 53% in 2013. Mrs Hume acknowledged this response rate was low and we would be picking this up with the Trust through the CQRG process. TEWV were in the top response rate and ST in the lowest response rate.

38.7.2 STHFT’s workforce figures showed a decline in performance and were under discussion with the FT, including looking at how the figures may be presented in a different way.

38.8 **North East Ambulance Service FT**

38.8.1 NEAS had significant challenges to face but the picture had improved in relation to the Action Plan.

38.8.2 A six-month update had been provided covering the issues taken to the NEASFT Extraordinary Quality Surveillance Group (QSG) including:

- Performance against nationally mandated metrics
- Governance Review
- Next steps for the Trust

38.8.3 It was recognised that engagement of the workforce would have an impact upon quality outcomes. The NEAS Trust was very engaged with commissioners and receptive to different ways of working to ensure patients received the service they required when it was needed.

38.9 **Tees, Esk & Wear Valley FT**

38.9.1 As a health provider, TEWV had a recent CQC inspection, with the high level feedback reported as positive. TEWV had been marked as ‘Good’ overall and ‘Outstanding’ for Leadership. The Director of Nursing would be retiring this year and the CCG wished her well and looked forward to working with the new postholder.

38.9.2 A particular areas of focus would be Adult and Children’s Safeguarding, where mandatory training was at levels the CCG was not comfortable with; the position remained under review by the CCG.

38.9.3 TEWV was also working with the CCG on workforce metrics to enable greater granularity in relation to professions, localities and specialties.

38.9.4 TEWV had also taken part in the National staff survey with a response rate of 57% compared with a rate of 60% in 2013. The 57% was in the highest 20% of mental health/learning disability trusts in England and showed that TEWV was a consistently good performer.

38.10 Ms Perkin commented that both Trusts (STNHSFT and TEWV) had signed up to the Health Promoting Hospitals programme where Public Health worked with health teams, with a Public Health member of staff supporting the Trust within the HR Department. Ms Perkin would be keen to look at where Public Health could contribute towards targets, for example in relation to education on C.Diff. Ms Golightly noted that work was also being undertaken with Public Health.
England around C.Diff. She thanked Ms Perkin for her offered help and would meet with her outside of the meeting to take this forward.

The Governing Body NOTED the Quality and Safeguarding Report.

GB/39/15 Finance Report

39.1 Mr Gregory summarised the position at the year end March 2015.

39.2 Although a surplus had been delivered there had been a QIPP shortfall which was disappointing. However, there had been a 3.9% reduction in admissions – the highest reduction in the North East and one of the highest in the country. This was attributed to a combination of the Primary Care Scheme and Rapid Response which had picked up in the last two months, being commensurate with reduction in admissions.

39.3 The CCG had no official data but the emergency admissions trend had reduced for the last half year. The Trust had recognised this as a real change; however due to change of case mix the cost of spells had increased.

39.4 In terms of benchmarking, comparing ST CCG elective procedures with those of similar sized CCGs, Mr Gregory explained that ST CCG spends more than the national average. This was due to a combination of specialised services - bariatric surgery (which was very expensive) and endoscopy (higher than the national average). Skin surgery was an outlier.

39.5 In terms of outpatient data the CCG was an outlier in a number of specialties including Dermatology, Orthopaedics and Gynaecological procedures are higher than the national average. James Cook University Hospital had indicated that more procedures should be undertaken in primary care. ENT was also a slight outlier.

39.6 Mr Gregory pointed out that the benchmarking for medicine prescribing costs had been undertaken for the first time. Everywhere in the North East and Cumbria was higher than the national average, with South Tees being the second highest with a per capita cost of c. £45, which was c. £4 greater than the regional average and £7.60 higher than the national average.

39.7 Dr Milner queried whether the variance on paediatric medicine spend was for acute. Mr Gregory confirmed it was for elective activity.

39.8 Further benchmarking details would be brought to the next Governing Body Meeting.

Action GB/11/15 – Mr Gregory

39.9 The Chair asked for more comparison of costs with local peers. Mr Gregory responded that this was being worked on and that by the end of July it was anticipated that the peer group benchmarked position would be reviewed which would be reported to the Governing Body in July. The Chair suggesting capturing some of these issues in Commissioning Intentions, ie: MSK, Dermatology, Paediatrics.

Action GB/12/15 – Mr Gregory

39.10 Mr Gregory provided an update on the Annual Finance and Activity plan for 2015-16. The CCG had been asked to review activity plans in line with an NHS
England request for ensuring commissioners standardise their activity plans. A specific issue for the CCG was that ambulatory care activity should be shown in plans as on-elective activity, however this does not change how it is recorded and monitored for the FT contract.

39.11 Mr Blair stated that the CCG had been asked to choose two metrics for the Quality Premium, for which cancer staging data and readmissions had been selected. An update, with the rationale behind their selection, would be presented to the Quality, Performance and Finance Committee.

Action GB/13/15 – Mr Gregory

The Governing Body NOTED the Finance Report

39.12 Contract Positions
Mr Gregory pointed out this was a summary of the contracts for 2015-16. Two contracts were still unsigned. Both contracts are subject to region wide negotiations being led by other CCGs, both were now subject to local dispute resolution processes.

The Governing Body NOTED the current Contract Positions.

GB/40/15 QPF Committee Headlines

40.1 The Governing Body studied the QPF Infographic which gave the end-of-year position in March 2015.

40.2 Mrs Hume advised that the detail was dealt with by the QPF Committee. The infographic was helpful in presenting the headlines to the Governing Body. However, she felt there would be benefit in additional text on areas of risk and concern, and associated actions.

40.3 The Chair suggested presenting the headlines with key issues and actions to be taken, together with timescales.

Action GB/14/15 – Mr Gregory / Mr Burdon

The Governing Body NOTED the QPF Committee Headlines.

GB/42/15 Assurance Framework

Mr Gregory advised that this had been covered in the Annual Report in presenting the risk position.

GB/42/15 Confirmed Minutes

42.1 Audit Committee – 4 February 2015
The confirmed Minutes of the Audit Committee held on 4 February 2015 were NOTED.

42.2 Governance & Risk Committee – 11 February 2015
The confirmed Minutes of the Governance & Risk Committee held on 11 February 2015 were NOTED with the Governing Body ACKNOWLEDGING that the refreshed Business Continuity Plan had been approved by the Committee.
42.3  
_Middlesbrough Health & Wellbeing Board – 6 February 2015_
The confirmed Minutes of Middlesbrough Health & Wellbeing Board held on 6 February 2015 were NOTED.

42.4  
_Redcar & Cleveland Health & Wellbeing Board – 7 January 2015_
The confirmed Minutes of Redcar & Cleveland Health & Wellbeing Board held on 7 January 2015 were NOTED.

The Governing Body NOTED the aforementioned Minutes.

**GB/43/15 Any Other Business**

There was no other business to discuss.

**GB/44/15 Public Questions**

The Chair asked whether any members of the public had questions for the Governing Body.

There were no questions raised by Members of the Public.

**GB/45/15 Date, Time and Venue of the Next Meeting**

The next meeting was scheduled for **Wednesday 29 July 2015 at 2.00pm** at Redcar & Cleveland College, Corporation Road, Redcar

The meeting closed at 5.00pm

Signed:  
Dr Janet Walker  
Chair of the Governing Body

Date: ______________________
<table>
<thead>
<tr>
<th>Action Number</th>
<th>Date of Meeting</th>
<th>Subject</th>
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<tbody>
<tr>
<td>GB/09/15</td>
<td>27.05.15</td>
<td>Corporate Aims</td>
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<td>Mrs Hume</td>
<td>10.07.15</td>
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<td>Closed</td>
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<td>A further detailed set of per capta benchmarks to be brought to next Governing Body Meeting</td>
<td>Mr Gregory</td>
<td>10.07.15</td>
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</tr>
<tr>
<td>GB/13/15</td>
<td>27.05.15</td>
<td>Finance Report</td>
<td>Two metrics (cancer staging data and readmissions) to be presented to QPF in June</td>
<td>Mr Gregory</td>
<td>10.07.15</td>
<td>These two metrics were presented to the June QPF Committee Meeting</td>
<td>17/07/2015</td>
<td>Closed</td>
</tr>
<tr>
<td>GB/14/15</td>
<td>27.05.15</td>
<td>QPF Infographic</td>
<td>To include text on areas of risk concern - key issues, actions to be taken, timescale, etc</td>
<td>Mr Gregory / Mr Burdon</td>
<td>10.07.15</td>
<td>A fuller narrative is now attached to the QPF infographic.</td>
<td>17/07/2015</td>
<td>Closed</td>
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</table>
### Vision Statement

"Improving the quality of life for all in our community reducing preventable differences in people’s health, encouraging everyone to have greater responsibility for their own health, supported by accessible, high quality services that are designed around people and their needs."

<table>
<thead>
<tr>
<th>Aim reference</th>
<th>Aim</th>
<th>Objective Reference</th>
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<tbody>
<tr>
<td>Aim-001</td>
<td>To ensure the populations we serve are able to access healthcare services that are safe, effective, person centred and high quality both now and in the future</td>
<td>Obj-001</td>
<td>To ensure care is delivered in the right place at the right time to deliver the best quality outcome, ensuring people recover from ill health or injury</td>
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<td></td>
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<td>Obj-002</td>
<td>To continuously improve the quality of life for all people and those who care for them, including patient groups with specific needs</td>
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<td></td>
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<td>Obj-003</td>
<td>To improve the quality, access and responsiveness of primary medical services</td>
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<td>Obj-004</td>
<td>To fulfil our statutory obligation to commission services specified in the Health and Social Care Act</td>
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<td>Obj-005</td>
<td>To ensure safeguarding of adults and children</td>
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<td>Obj-006</td>
<td>To protect people from avoidable harm</td>
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<td>Obj-007</td>
<td>To ensure more people have a positive experience of care and support</td>
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<tr>
<td>Aim-002</td>
<td>To support and encourage people and their carers to take control of their own health and make informed choices about where and when to access healthcare</td>
<td>Obj-008</td>
<td>To simplify and ensure timely access to services</td>
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<td>Obj-009</td>
<td>To involve people in decisions about healthcare</td>
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<td>Obj-010</td>
<td>To ensure appropriate Patient Education</td>
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<td>Obj-011</td>
<td>To promote self care and awareness of signs and symptoms of ill health and to promote and support safe and independent living</td>
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<td></td>
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<td>Obj-012</td>
<td>To enable patients and carers to make choices through empowerment and commissioning an appropriate range of services</td>
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<tr>
<td>Aim-003</td>
<td>To work with our populations and partners to reduce preventable differences in physical, mental and social wellbeing across the populations we serve</td>
<td>Obj-013</td>
<td>To improve early detection and reduce variability in outcomes in cardiovascular disease, cancer, diabetes, smoking related disease and alcohol related disease</td>
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<td>Obj-014</td>
<td>To support progression of the health and wellbeing strategies</td>
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<td>Obj-015</td>
<td>To promote equity of access to all commissioned services</td>
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<td>Aim Reference</td>
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<td>Objective Reference</td>
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<tr>
<td>Aim-004</td>
<td>To ensure the decisions we make are informed by best evidence alongside the needs and views of local people</td>
<td>Obj-016</td>
<td>To promote innovation, research and the application of NICE guidance to continuously improve the quality, effectiveness and efficiency of services</td>
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<td>Obj-017</td>
<td>To ensure our health professionals and member practices are involved in planning care and provide a sound evidence base for service change</td>
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<td>Obj-018</td>
<td>To ensure ongoing involvement and engagement with the public</td>
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<td>Obj-019</td>
<td>To continuously improve the way the CCG involve people from protected groups, including children, and those who would not normally share their views</td>
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<td>Obj-020</td>
<td>To increase involvement and raise profile of carers, including young carers</td>
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<tr>
<td>Aim-005</td>
<td>To ensure we get the best possible health benefit for every pound we spend</td>
<td>Obj-021</td>
<td>To promote best value, effective appropriate use of medicines</td>
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<td>Obj-022</td>
<td>To appropriately manage and monitor our provider contracts, activity and demand</td>
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<td>Obj-023</td>
<td>To appropriately manage the CCG</td>
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<td>Obj-024</td>
<td>To encourage innovation and productivity in providers</td>
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<td>Obj-025</td>
<td>To ensure effective CCG governance processes and compliance with law and guidance</td>
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<td>Obj-026</td>
<td>To ensure the organisation promotes and makes incremental improvements in sustainability</td>
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<tr>
<td>Aim-006</td>
<td>To explore and develop integration of the health and social care system to benefit the populations we serve</td>
<td>Obj-027</td>
<td>To make the best use of information management and technology and business intelligence</td>
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<td>Obj-028</td>
<td>To promote and adopt innovative ways of working to improve the experience of our populations</td>
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<td>Obj-029</td>
<td>To develop workforce plans to support a sustainable health and social care system</td>
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<td>Obj-030</td>
<td>To ensure effective monitoring and management of activity and demand</td>
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<td>Obj-031</td>
<td>To ensure Health and Social care services are ‘joined up’ and seamless to service users</td>
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NHS South Tees Clinical Commissioning Group

Governing Body

Agenda Item: 1.5

Wednesday 29 July 2015

<table>
<thead>
<tr>
<th>Purpose of Paper</th>
<th>For Information</th>
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<tbody>
<tr>
<td>Title</td>
<td>Report of the Chair and Chief Officer</td>
</tr>
<tr>
<td>Responsible</td>
<td>Dr Janet Walker, CCG Chair and Mrs Amanda Hume, Chief Officer</td>
</tr>
<tr>
<td>Author of the Report</td>
<td>Mrs Jacqui Keane, Corporate Governance and Risk Officer</td>
</tr>
<tr>
<td>Recommendation(s)</td>
<td>The Governing Body is asked to note the content and receive the Report.</td>
</tr>
<tr>
<td>Summary</td>
<td>The report provides the Governing Body with a short summary of business since the Governing Body meeting in May 2015.</td>
</tr>
<tr>
<td>Financial Implications</td>
<td>There are no financial implications relating to this report.</td>
</tr>
<tr>
<td>Legal/Regulatory Implications</td>
<td>There are no legal or regulatory implications relating directly to this report.</td>
</tr>
<tr>
<td>Assurance Framework/Risk Register Implications</td>
<td>There are no Risk Register or Assurance Framework implications relating directly to this report.</td>
</tr>
<tr>
<td>Details of relationship to the NHS Constitution</td>
<td>A number of areas highlighted in the report reflect the CCG’s compliance with the principles of the NHS Constitution, eg. partnership working, engagement and continuing to work to improve the quality of services.</td>
</tr>
<tr>
<td>Details of Patient and Public Involvement and/or Implications</td>
<td>Although the content of this report was not subject to patient and public involvement, it outlines some of the areas the CCG is pursuing to enhance involvement and engagement with patients, stakeholders and member practices.</td>
</tr>
<tr>
<td>Has an Equality Analysis been completed?</td>
<td>Not applicable to this report</td>
</tr>
<tr>
<td>Attachments</td>
<td>Report of the Chair and Chief Officer – July 2015</td>
</tr>
<tr>
<td>Please detail any Committees or Forums at which this paper has previously been tabled</td>
<td>None.</td>
</tr>
</tbody>
</table>
1. Introduction

This report provides a short summary of some of the business undertaken since the Governing Body meeting in May 2015. The Governing Body is asked to receive the report, note the update and consider the issues highlighted.

2. Partnership working

The north east is recognised as an area with specific health and social care challenges and high levels of health inequalities. The best way for us to tackle this and work to improve our population’s health is by working together with other agencies; the following gives a flavour of some of the areas we are pursuing:

a. Clinical Council of Members

The CCG comprises all 46 GP practices in South Tees and regular meetings are held with representatives of those Practices to ensure there is an opportunity to collectively discuss key areas of mutual interest and/or concern. The Clinical Council of Members (CCOM) meetings are in addition to our regular programme of meetings with individual Practices.

At the most recent CCOM meeting on 9 July 2015, we discussed: urgent care schemes and the draft Urgent Care Strategy Case for Change; commissioning intentions and the draft Primary Care Strategy. Dr Teik Goh presented an update on the South Tees Access and Response (STAR) scheme which received funding from the Prime Ministers Challenge Fund and Dr Rashpal Singh gave a presentation on the Innovation Scouts. Updates were provided from colleagues at South Tees Hospitals Foundation Trust on the rapid response services and the CCG’s Executive Nurse, Jean Golightly, gave an update on Safeguarding including details of the training programme “In The Wrong Hands” Child Sexual Exploitation (CSE) campaign. The CCOM also formally received the CCG’s Annual Report and Accounts.

b. Integration Programme Board

As previously reported, the CCG works closely with other agencies including Local Authorities and provider Trusts to progress the schemes identified as part of the Better Care Fund. This Integration Programme Board (IPB) is key to ensuring that the health and social care system, with input from other public services, works together to ensure joined-up services are provided for the public. At the June meeting discussions focussed on agreeing a forward work programme which would include priority workstreams of: establishing a single point of access; improve urgent care across the whole system; strengthening primary care; improving the way we work with, and support, nursing and care homes; improving services for people with diabetes; reviewing and enhancing the support that carers receive; establishing a rehabilitation strategy and ensuring that young people under 5 get the best start in life.
This is a challenging programme of work that needs to be managed effectively in order to produce the desired results of improving care for our population. To help with this, a BCF monitoring group has been established to manage the day to day implementation of these projects.

c. Care Homes

As part of the Better Care Fund, the CCG is working with other agencies with an aim to improve the health of Care Home residents, help prevent accidents and illness, manage emerging health problems in a timely way and develop the overall resilience of the Care Home Sector in managing health needs. This aims to improve the quality of care of residents and reduce unplanned and unnecessary admissions. To ensure a multi-agency approach, work is ongoing with secondary care looking at hospital admissions as well as working with GP Practices to understand their views.

d. Annual Cancer Event

The CCG Chair and Chief Officer attended the Trust's cancer event in June. The Trust are developing their cancer strategy and it is important that the CCG stays connected with this crucial piece of work. The event highlighted the opportunities for greater alignment across the healthcare system, including the need for greater focus on prevention and early diagnosis. The event gave the opportunity for some cancer patients to describe their personal stories and to also hear how these had impacted on clinical practice.

e. MacMillan Integration of Cancer Care Project

The CCG is supporting the Macmillan Integration of Cancer Care Project which has been developed to, amongst other things, review existing services and patient pathways in order to provide standardised integrated pathways for patients with cancer from diagnosis and throughout their cancer journey. The scope of the project covers: lung cancer, brain and central nervous system cancer and lymphoma as well as palliative care and the development of the workforce.

f. Specialised Commissioning

There are some areas of healthcare that the CCG does not directly commission because of the specialised nature of the services (including: neurosciences, cardiac surgery, radiotherapy, chemotherapy, renal dialysis, specialist inpatient eating disorders and neonatal intensive care). Such services are commissioned by NHS England. However, as the commissioning landscape changes we are keen to explore opportunities for greater collaboration and, therefore, the Chief Finance Officer and Chief Officer attended a networking meeting to gain further insight into the priorities and processes for NHS England’s specialised commissioning teams.

g. Joint working in Redcar & Cleveland

Agreement has been reached with Redcar & Cleveland Local Authority to work together on continuing healthcare and community/GP hubs with services working together. This will build upon the social prescribing approach piloted in Redcar and Cleveland.
h. **360 Stakeholder Survey**

We were pleased with the results of the 2015 national survey which asked our stakeholders for feedback on a number of key issues. Overall feedback was very positive; 93% of respondents rated the working relationship with the CCG as either very good or fairly good and 80% were very or fairly satisfied with how the CCG had engaged with them over the preceding 12 months. Indeed, the rating for the CCG had improved from the previous year in every area. More detailed information is provided in the report as part of the agenda.

i. **Health Education North East Partnership Council**

Representing all the CCGs in the North East, the Chief Officer attended a meeting of the Health Education North East Partnership Council. Health Education North East is part of the national leadership organisation responsible for ensuring that new education, training, and workforce development drives the highest quality public health and patient outcomes. The role of CCGs is important in influencing workforce planning and workforce requirements for the future health economy based on service need.

j. **Northern Treatment Advisory Group**

The CCG is a member of the Northern Treatment Advisory Group (NTAG) which brings together clinical expertise, patients and commissioning representatives, to make recommendations on the commissioning of treatments within the NHS North East and Cumbria. NTAG is a collaborative arrangement established by the Northern CCG forum to recommend approval, or rejection, of treatments presented to it for consideration. A copy of the first Annual Report is attached.

3. **Public involvement and engagement**

As a CCG we are committed to involving the public in our work so that we can further understand the needs of our population and, thus, inform and influence our decision making. The following summarises some of the involvement activity undertaken over the last two months and also highlights some ongoing or imminent opportunities for the public to tell us their views:

a. **Developing an urgent care strategy for South Tees**

In response to increasing pressure on the health care system, in 2013 the Government announced a comprehensive review of the NHS urgent and emergency care system in England.

The overall objective of the review was to consider how to improve services for patients, right across the spectrum of urgent and emergency care, and to identify potential solutions. In South Tees, we are doing exactly that and we would like to hear from the public, to help influence the development of our urgent care strategy.

We are welcoming views from the public, particularly those that have accessed health services at a local walk in centre, a minor injuries unit, the GP out of hours service, telephoned the NHS 111 service, or used A&E at James Cook University Hospital.

We are gathering views from 13 July to 10 August 2015 through a variety of methods and people are urged to have their views heard by:
Completing the online survey at http://www.southteesccg.nhs.uk/urgent-care/
- Requesting a paper copy of the survey by contacting the communications and engagement team on 01642 745401.
- Attending one of the drop in events (please contact 01642 745401):
  
  - Wednesday 22 July 2015, 4.30pm-6.30pm, Skelton Civic Hall, Coniston Road, TS12 2HP;
  - Friday 24 July 2015, 11am-2pm at Breckon Hill Community Centre, Breckon Hill Road, Middlesbrough, TS4 2DS;
  - Thursday 30 July 2015, 11am-3pm, in partnership with Redcar MIND on the 3rd floor of the Redcar Beacon on the seafront in Redcar;
  - Wednesday 5 August 2015, 1.30pm-3.30pm, Know Your Money – 73 Corporation Rd, Middlesbrough, TS1 1LY.

b. **Healthwatch**

We value the relationship we have with Healthwatch and the crucial role they have in representing the public. We are continuing to update them on our work to develop the urgent care strategy and our upcoming review of the Life Store. In addition, we are delighted that they have agreed, on our behalf, to independently seek the experience of patients now receiving care through the early supported discharge service for stroke which came into effect in April this year. The feedback from this work will inform our ongoing implementation of the IMProVE programme.

c. **Making the Life Store work for the public**

In line with the CCG’s duty to review all of its commissioned services, we are currently in the process of undertaking a review of the Life Store service. The service provides a health signposting service, offers intervention such as weight management and some sexual health services as well as hosting a small number of services delivered by other health service providers such as Foundation Trusts, eg Improving Access to Psychological Therapies (IAPT) and smoking cessation. The CCG has been aware for some time that the service, though commissioned for the entire South Tees population is rarely accessed by residents from Redcar and Cleveland. Whilst some outreach has been undertaken in Redcar and Cleveland to address this, there are limitations with regards to staffing resources. The review will explore how the service could be delivered in the future to serve the whole population and tackle the health inequalities challenges we face.

To do this effectively, we need to hear the views of the public, current users, partners and stakeholders and we will soon be starting an engagement exercise so we are encouraging people to look out on the CCG website, in local GP Practices or at the Life Store itself so you can join in with this important discussion and get your views heard.

d. **Patient and Public Advisory Group (PPAG)**

We were delighted to involve our patients and public at our first PPAG on 10th July. This will be a key forum for the CCG as we strive for greater public involvement in CCG business. Our aim is to ensure that we make the best use of the PPAG members’ experiences as we look to develop our services and we will call on them
as our critical friend. The next meeting will be held in October and will focus on Urgent Care.

e. **Annual General Meeting**

We will be holding our 2nd Annual General Meeting on Wednesday 9 September at The Heart, Ridley Street, Redcar and would encourage our stakeholders and members of the public to come along. In additional to hearing about the work of the CCG over the previous year we will also be giving a forward view of our upcoming plans. There will also be a Health and Wellbeing Fair with the opportunity for members of the public to talk to experts from a variety of health backgrounds as well as information on healthy lifestyle choices.

f. **Twitter**

We know that it isn't always possible for people to come along to meetings to get involved in what we do and that sometimes public invitations to events can easily be missed. We are keen, therefore, to use other communications methods, including social media. The CCG’s twitter site is another way of hearing about events and finding out about the work done by ourselves and some of our partners and we would encourage members of the public to follow us on twitter using at @SouthTeesCCG. We are proud that we now have over 1,000 Twitter followers.

4. **Our involvement in the broad spectrum of healthcare**

a. **Care Leavers Health Equality Project**

The CCG is one of 10 across the country taking part in a national project to understand how CCGs can better commission the health needs of children, young people and adults who have been in the care of the local authority. South Tees is the only CCG in the North East taking part. The Care Leavers’ Association has been funded by the Department of Health to support CCGs with this work and ultimately develop a good practice toolkit for commissioning that can be used by all CCGs. We have good support from our partners who are keen to work with us on addressing this important area of health inequality.

b. **Children and Young People’s Mental Health developments**

A child, adolescent mental health services (CAMHS) crisis and liaison service is now operational Tees-wide. The service is based at West Lane Hospital in Middlesbrough and also works across several other sites, including into The James Cook University Hospital, assessing and treating as early as possible. The CCG is receiving regular project updates on the team’s development.

In a separate development, NHS England is introducing Access and Waiting Time Standards for CAMHS community eating disorders services from 1st April 2016. The standard will be 1 week from referral to treatment for urgent cases and a maximum of 4 weeks for routine cases. There are a range of therapies outlined in NICE guidance and the service commissioned by the CCG does meet the required standards, however, we will be receiving additional funding in order to improve services that support crisis or self-harm services.
c. **Mental Health Crisis Care Concordat Group**

Representatives from the Police, Mental Health and Acute, NEAS, Local Authorities and the voluntary sector, are continuing to work together to learn from the experiences of service users across the range of services so that a standard process can be replicated across different cohorts of service users, with the aim of having a common understanding and care plan for vulnerable people at risk of crisis, and to better inform our commissioning decisions.

d. **Rehabilitation Strategy – ‘No Place Like Home’**

On 18 June a successful event was held to consider different ways of looking at rehabilitation, reablement and recovery so that we are able to ensure that there is a range of services that support people in primary and secondary care enabling them to live as independently as possible. There was a real sense of shared purpose and agreement around the need to work collaboratively to deliver a South Tees wide strategy and to have ‘home’ as the default position.

e. **Safeguarding children**

We were delighted to welcome Alison Ferguson to the CCG’s team of dedicated staff. Alison started with the CCG on 1 July in her role as Designated Nurse for Safeguarding and brings with her a wealth of experience and huge dedication.

f. **Bright Idea wins award**

Dr Rashpal Singh’s community pulmonary embolism pathway was runner up at the Bright Ideas in Health Awards run by the Allied Health Science Network and NHS Innovations North. He won £1,000 to invest in the further development of the idea. We will be highlighting this to our member practices demonstrating how important even simple ideas can be and that they can be supported and developed by the CCG.

5. **Striving for continuous improvement**

a. **Board to Board with South Tees FT to focus on reducing C.difficile**

Members of the CCG’s Governing Body and South Tees Hospitals Foundation Trust’s Board met on 15 July to focus on the plans to reduce incidences of C.difficile.

The CCG has been in regular formal discussions with the Trust over a number of months to seek assurance on the actions in place to reduce the level of infections within the Trust’s hospitals. The Board to Board meeting was the culmination of these meetings and is a formal part of the CCG’s escalation process.

The aims of the meeting were three-fold: firstly, for the CCG to be assured of the actions being taken by the Trust and the levels of monitoring, involvement and ownership by the Trust’s Board; secondly, for the CCG and the Trust to explore ways of working together across primary and secondary care to reduce community acquired infections which includes work with GP practices to review antibiotic prescribing and providing more information to patients about the appropriate use of
antibiotics. Finally, the CCG is required by Monitor to approve the Trust’s Action Plan – joint discussions will continue around this and the Action Plan will include the work being done in primary care as well as giving clearer indications of expected outcomes and progress.

b. Care Quality Commission visit – Children’s Safeguarding & Looked After Children

The CCG’s arrangements, including our commissioned services, relating to children’s safeguarding and looked after children were inspected by the CQC during June. Informal feedback was largely positive and highlighted many areas of good practice which reflects how hard the CCG has worked to keep a focus on this key agenda despite challenges around capacity, staff moves and not yet having recruited a GP lead. The main issues highlighted for improvement were around midwifery record keeping and actions are underway to address this.

c. Care Quality Commission Quality Summit at South Tees Hospitals Foundation Trust

The Chief Officer and Executive Nurse attended the Quality Summit at the Trust in early June where the Trust received an overall rating of ‘requires improvement.’ Whilst the overall rating was disappointing, there were a number of areas of good practice highlighted. The Trust is the main provider of the CCG’s commissioned services and, as such, we will be closely managing and monitoring this situation through our internal mechanisms so that we can support the Trust in addressing the areas highlighted for improvement.

d. Internal governance arrangements

As reported at previous meetings of the Governing Body, we have been doing a great deal of work revisiting our governance arrangements to further strengthen the arrangements currently in place. In conjunction with all members of the Governing Body, we have agreed to:

- advertise for an additional lay member to particularly support the Primary Care Co-Commissioning agenda and to provide some succession planning for the Audit Chair.
- Change the Chairmanship of our Governance & Risk Committee and Quality, Performance & Finance Committee so that these are chaired by a Lay Member and the Secondary Care Doctor respectively.
- Appoint a new Caldicott Guardian. With effect from 1 October 2015 this will be Dr Raj Khapra; thus allowing the existing Caldicott Guardian to focus on other key issues.
- Governing Body GP, Dr Nigel Rowell will become an Executive GP, in that he will not lead a particular portfolio of work and will, therefore, be able to provide greater depth of scrutiny to the work of the Governing Body and committees.

Five of the six current Governing Body GPs reach the end of their term of office in October 2015. The Local Medical Committee has written to all GPs across South Tees to seek nominations to become members of the Governing Body; should any nominations be received then a full election process will take place. If no additional nominations are received, then the existing Governing Body GPs will be reappointed to their roles.
e. **Local recognition for the CCG**

The North of England Commissioning Support Unit held the first Commissioning Awards Ceremony in June. We were delighted to receive two winner awards and 2 runner up awards. Our Chief Finance Officer, Simon Gregory, won the award for financial efficiency and Julie Stevens, Commissioning and Delivery Manager, won the CCG outstanding contribution award. We were finalists for IMProVE which was shortlisted for the region wide working award and Dr Rashpal Singh was shortlisted for the innovations award.

5. **Supporting the local community**

a. We were pleased to once again sponsor the Middlesbrough Fun Run and 5k. This is a wonderful family event which encourages healthy living and exercise.

b. We were delighted to sponsor the health and Wellbeing Award category of the Redcar & Cleveland Voluntary Development Agency Volunteer Awards programme. This year, the award was given to Carers Together for their volunteer team which is doing fantastic work on a voluntary basis to support local carers. The range of organisations and individuals supporting their local community was impressive; reminding us of the valuable contribution of the voluntary sector to health and wellbeing within our population.

Dr Janet Walker  Amanda Hume  
CCG  Chief Officer
Northern Treatment Advisory Group: 1st Annual Report, April 2015

Chairman’s foreword

I am very pleased to report on the successful establishment of NTAG as an authoritative part of the treatment appraisal and decision-making landscape within the Region over the last 14 months.

During the period following the ending of NETAG in 2013 the region had no expert body to advise on the adoption of new treatment pathways and to help ensure a consistent approach to the adoption of new treatments for patients in the North East and Cumbria. The Northern CCG Form recommended the establishment of NTAG to address this deficiency.

I would like to thank my NTAG colleagues for their hard work and commitment to establishing the group and their continuing enthusiasm for what is often a very complex and difficult agenda. I would also like to record special thanks to Will Horsley the former professional secretary of NETAG and Jeanette Stephenson the Head of Medicine Optimisation at NECS for their invaluable assistance in establishing NTAG.

Dr Ian Davidson,
Director of Quality and Safety
NHS North Durham Clinical Commissioning Group

Background

The Northern (NHS) Treatment Advisory Group (NTAG) was formed in February 2014. NTAG continues the work of the former North East Treatment Advisory Group (NETAG) and it brings together clinical expertise, patients and commissioning representatives, to make recommendations on the commissioning of treatments within NHS North East and Cumbria. NTAG is a collaborative arrangement established by the Northern CCG forum to recommend approval, or rejection, of treatments presented to it for consideration. Recommendations are based upon proven clinical outcomes, value for money and affordability.

Remit of the group

The remit of NTAG has been updated to reflect the changes in NHS commissioning structures. NTAG has a remit to consider CCG commissioned treatments only, this includes non-pharmaceutical treatments such as medical devices, and interventional or surgical procedures. NTAG will not consider specialist treatments that are commissioned by NHS England or treatments for an indication which NICE has already evaluated or for which publication of a NICE technology appraisal is imminent (i.e. within six months of the next scheduled NTAG meeting).

Membership

Representation has been drawn from throughout NHS North East & Cumbria, both geographically and strategically (i.e. primary and specialist care, providers and commissioners), and the group is also seeking patient representation. This provides the group with a wide range of experience and expertise, ensuring fair and comprehensive treatment appraisals. Membership is based broadly on the membership of the old NETAG meetings. A re-review of membership is currently taking place as the group has now been running for over a year. Professional secretarial support to the group is provided by the Regional Drug and Therapeutics Centre (Newcastle) who also help facilitate the work plan and produce the appraisal reports alongside public health colleagues. The support and engagement of key organisations in nominating their representatives is acknowledged, as is the time that existing members have committed to NTAG, often in addition to their existing workload.

Processes

It was recognised early on that re-establishing the functional processes of NTAG was an important task. Drawing on their considerable experience the group provided guidance in shaping these processes. It was agreed that meetings would continue to be quarterly as previously this had worked well. In addition the following process documents were approved:

- NTAG Terms of reference
- What Treatments will NTAG consider?
- NTAG Ethical Framework
- NTAG Appeals Process
- Declaration of Interests Policy

All of the above documentation can be accessed from the NTAG website.
Website
www.ntag.nhs.uk

The development of a website was seen as an early priority for the group and the website was launched in September after the 2nd NTAG meeting. The website now serves as the principal point of information for all NTAG communications. A user friendly interface has been developed and the added feature of a news feed allows healthcare professionals to keep up to date with new recommendations issued.

Work plan

The majority of appraisals have been conducted following a referral or request to the group with a minority identified prospectively through horizon scanning processes. An early request for comments on the proposed work plan from local APC’s also prevented any potential duplication of workload. The current work plan is available on the website and is updated following each meeting should any changes be made. The group also continues to receive requests to re-review old NETAG recommendations that are now out of date.

Appraisal and Recommendations

In the 14 months since NTAG was re-formed the group has issued eleven new recommendations and associated appraisals; of these eight were not recommended and three were recommended for use.

- Nalmefene (Selincro®) in the management of alcohol dependence. (not recommended but superseded by NICE TA)
- Sequential pharmacological therapies in the management of macular oedema secondary to retinal vein occlusion (RVO) (recommended)
- Dapoxetine (Priligy®) for Premature Ejaculation. (not recommended)
- Rivaroxaban (Xarelto®) for acute coronary syndromes. (not recommended)
- High Dose Vitamin and Mineral supplements for the prevention of progression of AMD. (not recommended)
- Sativex® for the treatment of non-MS pain. (not recommended)
- Biologic drugs for treatment-refractory moderate to severely active ulcerative colitis in younger patients (to avoid colectomy). (not recommended but superseded by NICE TA)
- Aripiprazole (Abilify Maintena®) long acting injection for schizophrenia (recommended)
- Lurasidone (Latuda®) for the treatment of schizophrenia in adults. (not recommended)
- Rituximab for the treatment of Immune (Idiopathic) Thrombocytopenic Purpura (recommended)
- Airsonett® laminar flow device for treatment of uncontrolled asthma (not recommended)

The group has also issued four updated recommendations and appraisal documents following a change in clinical evidence available; of these three did not change from previously and one drug (paliperidone) is now recommended when previously it was not recommended:

- Ulipristal (Ellaone®) for post-coital (up to 120 hours) contraception. (recommended post 72 hrs)
- Bevacizumab (Avastin®) for age-related macular degeneration (recommended)
- Verteporfin (Visudyne®) with photo-dynamic therapy for chronic central serous chorioretinopathy (not recommended)
- Paliperidone depot injection (Xeplion®) for schizophrenia (recommended)

All of the above recommendations and their associated appraisal documents can be accessed via the NTAG website.

Other projects

NTAG was also involved in the evaluation of a budget impact model proposed by a pharmaceutical company. This was referred to NTAG by the North of England Commissioning Support Unit on behalf of CCGs as it was felt that NTAG was best placed to review this kind of economic data.

Further information

This is the first annual report for NTAG and covers the period of 25th February 2014 to 9th April 2015.

The NTAG website serves as the primary source of information for NTAG. However further details can be provided by the professional secretary:

Contact:
Bhavana Reddy,
Head of Prescribing Support,
RDTC
Tel: 0191 213 7855
Email: bhavana@nhs.net
### Attendance 2014/2015

<table>
<thead>
<tr>
<th>Representing</th>
<th>Position</th>
<th>Feb-14</th>
<th>Jun-14</th>
<th>Sep-14</th>
<th>Nov-14</th>
<th>Apr-15</th>
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<tbody>
<tr>
<td>N Durham CCG - GP</td>
<td>Lead/Deputy</td>
<td>Y</td>
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<tr>
<td>Sunderland CCG - GP</td>
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<tr>
<td>Middlesbrough/Hartlepool &amp; Stockton CCG - GP</td>
<td>Lead/Deputy</td>
<td>Y (both)</td>
<td>Y</td>
<td>Y</td>
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<tr>
<td>CCG Meds Management</td>
<td>Lead/Deputy</td>
<td>Y</td>
<td>Y</td>
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<tr>
<td>CCG Finance and commisioning</td>
<td>Lead/Deputy</td>
<td>Y</td>
<td>Y</td>
<td>Y (both)</td>
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<tr>
<td>CCG Chief Officer</td>
<td>Lead/Deputy</td>
<td>Y</td>
<td>Y</td>
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### Provider Hospital Trust representatives

<table>
<thead>
<tr>
<th>Trust Description</th>
<th>Position</th>
<th>Feb-14</th>
<th>Jun-14</th>
<th>Sep-14</th>
<th>Nov-14</th>
<th>Apr-15</th>
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<tbody>
<tr>
<td>Mental Health Trusts</td>
<td>Lead/Deputy</td>
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<td>Y</td>
<td>Y</td>
<td>N</td>
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<tr>
<td>City Hospitals Sunderland</td>
<td>Lead/Deputy</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
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<tr>
<td>South Tees</td>
<td>Lead</td>
<td>Y</td>
<td>Y</td>
<td>N</td>
<td>Y</td>
<td>N</td>
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<tr>
<td>Newcastle hospitals</td>
<td>Lead</td>
<td>N</td>
<td>Y</td>
<td>Y</td>
<td>N</td>
<td>Y</td>
</tr>
<tr>
<td>Northumbria and N Cumbria</td>
<td>Lead/Deputy</td>
<td>Y</td>
<td>Y</td>
<td>N</td>
<td>N</td>
<td>N</td>
</tr>
<tr>
<td>District General - Gateshead or CD&amp;D FT</td>
<td>Lead/Deputy</td>
<td>Y</td>
<td>Y</td>
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<td>N</td>
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<tr>
<td>Public Health (non voting)</td>
<td>Lead/Deputy</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
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<tr>
<td>Secretary (non voting)</td>
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<td>Y</td>
<td>Y</td>
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<tr>
<td>Patient rep</td>
<td></td>
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<td>Vacancy</td>
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<tr>
<td>Purpose of Paper</td>
<td>For Decision</td>
<td></td>
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</tr>
<tr>
<td>Title</td>
<td>A Strategy to Support and Value Carers in Middlesbrough 2015-2019</td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Responsible</td>
<td>Amanda Hume, Chief Officer</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Author of the Report</td>
<td>Julie Bailey, Partnership and Innovations Manager</td>
<td></td>
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</tr>
<tr>
<td>Recommendation(s)</td>
<td>The Governing Body is asked to approve the Strategy.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Summary</td>
<td>There are around 5.4 million unpaid carers in England, with the financial benefits from carers being estimated at £119 billion per year. This Strategy aims to better empower and support carers in Middlesbrough to manage their own health and wellbeing in order to continue caring, as well support choice, control and independence in their caring role and beyond caring.</td>
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<tr>
<td>Financial Implications</td>
<td>Additional funding is not sought as part of the Strategy. However it is recognised we will commission services differently in the future which may have financial implications and will be considered at the time.</td>
<td></td>
<td></td>
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<tr>
<td>Legal/Regulatory Implications</td>
<td>The Strategy supports implementation of the Care Act.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Assurance Framework/Risk Register Implications</td>
<td>There are no risks associated with approval of this strategy. Supporting the strategy will contribute to the delivery of the CCG’s corporate aims specifically Aim 2: To support and encourage people and their carers to take control of their own health and make informed choices about where and when to access healthcare.</td>
<td></td>
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<tr>
<td>Details of relationship to the NHS Constitution</td>
<td>Principle 5: The NHS works across organisational boundaries and in Partnership with other organisations in the interest of patients, local communities and the wider population.</td>
<td></td>
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</tr>
<tr>
<td>Details of Patient and Public Involvement and/or Implications</td>
<td>Representatives from frontline organisations advocating for, supporting and working alongside carers have been involved in a series of engagement events to determine the strategy’s priority areas.</td>
<td></td>
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<tr>
<td>Has an Equality Analysis been completed?</td>
<td>Yes. No adverse impact has been identified.</td>
<td></td>
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</tr>
</tbody>
</table>
| Attachments      | 1. Cover Paper  
2. A Strategy to Support and Value Carers in Middlesbrough 2015-2019 |
| Please detail any Committees or Forums at which this paper has previously been tabled | Senior Management Team  
Executive Group  
In addition, the Strategy will be reviewed by Local Authority committees. |
Purpose of the report

To seek the Governing Body's approval for the Strategy to Support and Value Carers in Middlesbrough 2015 - 2019.

Background

The development of partnership working over a number of years led officers locally from Middlesbrough Council, Middlesbrough Voluntary Development Agency (MVDA) and NHS South Tees Clinical Commissioning Group (STCCG) to agree that they could improve and embed partnership work within commissioning. A new strategic planning process was designed and agreed, and work was undertaken to develop a carers’ strategic plan by using this process.

Carers strategic planning process

The strategic planning process was implemented from summer 2014 onwards and was facilitated by Middlesbrough Council, MVDA and STCCG. This process established the development of the new strategy and aligned it to the four stage commissioning process (understanding need, planning, securing improved outcomes and monitoring and review).

The process included a series of discussions with those involved in planning, developing and delivering carers services in Middlesbrough. These discussions focused on establishing the future for carers in Middlesbrough, identifying what is available and in place to support carers now and agreeing on how to move from the current to the future position. Additional priorities, themes and issues to address support to carers in Middlesbrough were also considered:

- Analysis of current and emerging national and local policy
- Analysis of a wide range of intelligence, building on data and information gathered at various levels
- A review of information and results from a range of engagement and consultation activities with local carers
- Consideration of good practice from other local authority areas
- Identifying themes from discussions within local partnerships and forums.

This process has resulted in the identification of finalised strategic outcomes described at section 6 in the Strategy.

Carers

Specifically the planning process took into account the new person and family centred duties outlined in the Care Act 2014 which contains a new, broader definition of what it means to be a carer and includes the provision of practical and emotional support for carers.
It is the intention that the outcomes in the strategy will apply to the majority of, if not all, groups of carers in Middlesbrough. It is, however, recognised that the way support is provided will be different for each carers group – for example, the way in which improved emotional wellbeing outcomes to support young carers will be different to the approach to support older carers. Further work is required to determine how all relevant stakeholders in Middlesbrough will support the implementation of the strategy. This will include consideration of the different ways the outcomes need to be implemented to ensure that they improve the wellbeing of the different groups of carers in Middlesbrough. The outcomes in the strategy will be achieved by a combination of commissioning through local public bodies and exploring opportunities with other sectors such as the voluntary and community sector.

GOVERNANCE
Governance arrangements will be primarily through two levels:

i. Through the Health and Wellbeing Board – as the existing strategic partnership structure that brings together key stakeholders in Middlesbrough, this strategy will be aligned to the priorities for the Board in improving health and wellbeing outcomes for the local population.

ii. A carers partnership for Middlesbrough – oversight and implementation of this strategy will be the responsibility of a multi-agency carers partnership for Middlesbrough.

In addition, the priorities and outcomes detailed in this strategy will be aligned to those for carers in Redcar & Cleveland to provide a joined up approach where possible across the South Tees area.

MONITORING AND REVIEW
An appropriate framework of robust performance indicators will be developed to ensure that the outcomes are achieved. This framework will be designed and agreed with all local stakeholders. Appropriate data and information to support the measurement of the performance indicators will also be decided and agreed upon. Both the data and information and the methods of collection will be standardised wherever possible across organisational and sector boundaries. Accountability will be through monitoring the performance indicators on an annual basis and reporting through appropriate organisational and sector arrangements, but ultimately the Health and Wellbeing Board.

It is also anticipated that the outcomes will be incorporated into all partner organisations monitoring and performance systems. Partners in the voluntary and community sector, local NHS and local authority, carers and carers representatives will be enabled to contribute to the overall performance monitoring of the strategy, where appropriate. The use of regular feedback from carers and carers’ organisations to evaluate progress will also be a priority.

ACROSS SOUTH TEES
Provision and support for carers is provided on a locality and sub-regional level. In order to build on the partnership working it is important to consider joining up work across the
South Tees area. Local strategies relating to health and wellbeing exist and cover both Middlesbrough and Redcar and Cleveland and on a South Tees basis. There are clearly similarities and overlaps and also crucial differences in these strategic approaches to delivering on priority issues. In terms of quality of support given to local carers and ability to react to needs it is important that work being carried out on a South Tees basis is joined up wherever possible.

Initial discussions have taken place with representatives from South Tees CCG, Redcar and Cleveland Voluntary Development Agency, Middlesbrough Council and Middlesbrough Voluntary Development Agency to consider the formalities of joining up the work on carers on a South Tees basis. This work will continue.

Report on behalf of Middlesbrough Local Authority, Middlesbrough Voluntary Development Agency and NHS South Tees CCG.
16 July 2017
A strategy to support and value carers in Middlesbrough

2015 - 2019
<table>
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<th>Contents</th>
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<td>2. Local context</td>
<td>4</td>
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<td>3. Strategic planning process</td>
<td>5</td>
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<td>4. Groups of carers</td>
<td>6</td>
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<td>5. Governance</td>
<td>7</td>
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<tr>
<td>6. Outcomes</td>
<td>8</td>
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<tr>
<td>7. Monitoring and performance measures</td>
<td>21</td>
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</table>
1. Introduction

Progress has been made over recent years to improve the lives of carers, through specific initiatives to increase the numbers of carer’s breaks, improve crisis response services, as well as more general but equally important areas of work such as providing easily accessible information and advice. This outcome focused strategy reflects the need for continued collaborative efforts to continue to support carers in Middlesbrough.

An ambitious strategic planning process was implemented from summer 2014 onwards and facilitated by Middlesbrough Council, Middlesbrough Voluntary Development Agency (MVDA) and NHS South Tees Clinical Commissioning Group (STCCG). The aim of this planning process was to identify and agree the key strategic outcomes for carers in Middlesbrough over the next four years (2015 – 2019). This process established the development of the new strategy and aligned it to the four stage commissioning process (understanding need, planning, purchase and supply and monitoring and review).

Commissioners and frontline services were engaged with so that a range of information sources arising from carer engagement and consultation activities could be used to inform and identify the priorities. In practice this took the form of two conversations with these organisations. A combined roadmap for change was developed from these conversations and this roadmap compared with intelligence derived from a wide-range of data and information (e.g. local JSNA information), national and local policies and directives and discussions at partnership meetings and specific review meetings.

Specifically the planning process took into account the new person and family centred duties outlined in the Care Act 2014 which contains a new, broader definition of what it means to be a carer and includes the provision of practical and emotional support for carers.

It has been recognised by the NHS that carers are a huge asset, with an estimated 5.4 million people in England providing unpaid care for a partner, friend or family member. This support has an estimated economic value of £119 billion per year.

The population is changing; people are living longer, the numbers of people with a long-term illness and disability are increasing. At the same time the national austerity

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1 The Care Act 2014 defines a carer as “an adult who provides or intends to provide care for another adult (“adult needing care”)” – Clause 10 (3)

2 It is widely recognised by stakeholders in Middlesbrough that there are significantly more carers than the national estimates and therefore identifying and supporting hidden carers, where appropriate, will be of local importance.
has led to a reduction of services available from both the statutory and voluntary sectors. The number of carers is therefore rising. The focus of this strategy and work over the next four years is on improving the long-term health and wellbeing of carers to support and enable them to continue in their caring role with no undue adverse impact on their own lives.

This strategy adopts the Government vision for carers as stated by the Carers at the heart of 21st-century families and communities (2008):

*Carers will be universally recognised and valued as being fundamental to strong families and stable communities. Support will be tailored to meet individuals’ needs, enabling carers to maintain a balance between their caring responsibilities and a life outside caring, while enabling the person they support to be a full and equal citizen.*

The joint vision for carers in Middlesbrough is contained within this strategy. This recognises and values carers and their significant contribution which they make and strengthens and renews the collective commitment to support carers and to promote their health and wellbeing.

2. **Local context**

Supporting carers in Middlesbrough to develop and maintain their own health and wellbeing whilst caring for others is a priority within this strategy. This will not only support and empower carers to lead healthy and fulfilling lives, but will also benefit the local health and social care economy too.

In Middlesbrough the health of the population fairs worse than the average population when compared nationally. Middlesbrough also has a population that is living longer than the generation before them and has high levels of chronic health conditions and people experiencing mental distress which can increase demand for local health and social care services which are already under significant pressure. Furthermore, when specialist care is needed most people would prefer to be treated and recover at home when safe and appropriate to do so rather than spend time in hospital. The implementation of this strategy is to move greater care into community settings to support carers.

Carers, alongside health and care professionals, will be instrumental in supporting people at home and in the local community and are crucial to the local and national vision of bringing care closer to home.

3. **The Strategic Planning Process**

Led and facilitated by Middlesbrough Council, MVDA and NHS South Tees CCG, a strategic commissioning approach was adopted to develop this new carers strategy.
It focused on understanding need and agreeing local priorities that would improve outcomes for carers in Middlesbrough. The process included a series of discussions with those involved in planning, developing and delivering carers services in Middlesbrough on the assumption that these stakeholders – the majority providing frontline services – were in an ideal position to identify the issues facing carers. Each conversation resulted in a road map for change, which was developed through answering three questions: what is the future vision for carers in Middlesbrough, what is it like for carers at the moment, and what needs to be done to do to move from the current state to the future state? Each of the road maps for changed was than amalgamated to produce a final set of priorities (outcomes) (see page 9).

Building on the series of conversations detailed above the following was also undertaken to identify additional priorities, themes and issues to address the support carers in Middlesbrough:

- Analysis of current and emerging national and local policy
- Analysis of a wide range of intelligence, building on data and information gathered by a range of organisations
- A review of information and results from a range of engagement and consultation activities with local carers
- Consideration of good practice from other local authority areas
- Identifying themes from discussions within local partnerships and forums.

Throughout the process, the emerging priorities for this strategy were constantly reviewed and refined with the intention of ensuring all outcomes were constantly strengthened to make a difference to carers in Middlesbrough.

This process has resulted in the identification of finalised strategic outcomes described at section 6.

4. Groups of carers

It is the intention that the outcomes outlined in section 6 will apply to the majority of, if not all, groups of carers in Middlesbrough. It has to be recognised that there is no typical carer. Carers are individuals who may not see themselves as carers, but see themselves above all as a parent, child, wife, husband, partner, friend or neighbour. Carers’ circumstances vary enormously, as can the type of support they give.

There are many different groups of carers who can broadly be categorised by those who they care for. This cannot be an exact delineation as there will be considerable overlaps between the groups -

- Parent carers – caring for children who have particular needs e.g. physical, sensory or learning disability
• Mental health carers – caring for people who have mental health problems
• Learning disability carers – caring for people with learning disabilities
• Kinship carers - carers who are raising children who cannot live with their parents
• Alcohol and substance misuse carers – carers who support people who misuse alcohol and other substances

There are also groups of carers who are defined by their own situation or attribute-

• Older carers – carers who are older themselves and are predominantly caring for an aged partner or family member
• Young carers (including young adult carers) – children and young people who are carers either for a parent, a sibling or a family member
• BME carers – carers who are from a black and minority ethnic background
• Working carers – carers who are working and/or in training either full or part time

Also added to these categories carers can be:

• Full-time carer – caring full time
• Part-time carer – caring part-time perhaps with employment
• Respite carer – short-term caring to give the person or carer a break
• Hidden carers – individual carers who have not identified themselves as carers either to themselves or support providers

It is recognised in this strategy that the way support is provided will be different for each group of carers – for example, the way in which improved emotional wellbeing outcomes to support young carers will be different to the approach to support older carers. Work needs to be undertaken around how all relevant stakeholders in Middlesbrough will support the implementation of the strategy. This will include consideration of the different ways the outcomes need to be implemented to ensure that they improve the wellbeing of the different groups of carers in Middlesbrough. The outcomes in the strategy will be achieved by a combination of commissioning through local public bodies and exploring the potential to bring additional investment to the area (primarily by the voluntary sector).

5. Governance

It is recognised that ensuring and maintaining appropriate governance arrangements is key to the delivery of this strategy in improving outcomes to make a difference to carers in Middlesbrough.

Governance arrangements will be primarily through two levels:

i. Through the Health and Wellbeing Board
As the existing partnership structure that brings together key stakeholders in Middlesbrough, this strategy will be aligned to the priorities for the Board in improving health and wellbeing outcomes for the local population. The strategy will report to and provide assurance to the Board through the appropriate delivery partnership on an annual basis as a minimum.

Any issues that arise during the reporting period will be escalated through the Health and Wellbeing partnership arrangements, the request for which could be triggered from a number of perspectives.

ii. A carers partnership for Middlesbrough

Oversight and implementation of this strategy will be the responsibility of a multi-agency carers partnership for Middlesbrough. The membership of the Partnership will reflect the range of stakeholders that support carers and will have the appropriate skills, knowledge and understanding to work collaboratively to deliver on ambitious, but achievable priorities. Membership will include commissioners, providers and carers. This group will be supported by officers to discharge their duties.

In addition, the priorities and outcomes detailed in this strategy will be aligned to those for carers in Redcar & Cleveland to provide a joined up approach where possible across the South Tees area.

6. Outcomes

The strategic planning process adopted as described above means that the high-level strategic outcomes for carers are identified and described. These outcomes have been continuously refined throughout the process and there is confidence that these will address the most appropriate priorities for Middlesbrough.

A total of twelve (12) outcomes have been identified and form the road map for change, underpinned by four key assumptions.

The following pages list the strategic outcomes with further detail as to why they have been identified as priorities and how the success will be measured.

Assumptions:

i. Collaborative working leads to better policy and practice
ii. Organisations working in partnership can maximise and lever more resources to support carers
iii. Partners need to embrace change, think creatively and plan for the long-term
iv. There is a need to focus the collective efforts of all stakeholders to provide more preventative and early intervention support

<table>
<thead>
<tr>
<th><strong>Outcome 1</strong></th>
<th><strong>Carers have improved health and wellbeing</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>The needs of carers go beyond the person they are caring for and unfortunately caring can have a negative impact on their health and wellbeing. Carers often neglect their own health and wellbeing and in order for them to continue caring for as long as they wish to and/or is possible it is important that appropriate provision of services and support is available to carers themselves. Besides the physical health of a carer there is a need to support their mental health. Improving carers psychological wellbeing, their knowledge of mental ill-health (and management techniques) and their access to mental health services are just as important as keeping carers physically well.</td>
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<table>
<thead>
<tr>
<th><strong>Why has this been included as a priority?</strong></th>
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<tbody>
<tr>
<td>The health and wellbeing of carers is not only important to the carer themselves and the person(s) they are caring for, but it is also important for organisations that support carers – namely the local authority, health organisations and voluntary and community organisations to ensure carers are able to function in their role. The introduction of the Care Act 2014 re-enforces this by introducing the duty of Local Authorities to promote the health and wellbeing of carers.</td>
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<thead>
<tr>
<th><strong>How will the impact be known?</strong></th>
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<tbody>
<tr>
<td>• Increase in Carers Allowance with the Department for Work and Pensions</td>
</tr>
<tr>
<td>• Reduction in the use of emergency bed days</td>
</tr>
<tr>
<td>• Reduction in crisis episodes and emergency support services given to carers</td>
</tr>
<tr>
<td>• Percentage increase in people reporting their sense of wellbeing has improved and support services have had a positive impact (including through the Personal Social Services annual survey)</td>
</tr>
<tr>
<td>• Public Health to promote health and wellbeing of carers</td>
</tr>
<tr>
<td>• GP and other health appointments times to be structured around the needs of carers (first appointments of the day)</td>
</tr>
<tr>
<td>• Reduction in GP and other health appointments for mental ill-health</td>
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<tr>
<td>• Health and wellbeing provision, including psychological and other mental health indicators, in carer assessments as well as carers needs in the support plan for the person cared for</td>
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<tr>
<td>• Provision of training and/or support for carers in coping strategies/stress management e.g. manual handling training</td>
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**Outcome 2**  
**Carers feel supported and valued**

Carers contribute significantly to the local economy and wider community by meeting caring needs. Carers need to be recognised and valued as this is fundamental to their self-esteem; maintaining strong families and also maintaining stable communities. Carers need to feel that they are contributing to society and receive recognition for what they do. They need to be supported, have their needs considered and importantly the support available to carers needs to be of high quality.

**Why has this been included as a priority?**

Carers say that caring can be very rewarding – providing relatives with the best care possible. This role and actual support provided by carers is difficult to quantify in monetary terms and is therefore often overlooked. It is however important for carers to feel that their support is recognised, valued and supported. Carers need to be seen as a person and valued outside of their caring role.

**How will the impact be known?**

- Carers are involved in the care planning and review process
- Carers views gathered about their experiences of all services
- Carers views are used to inform and influence commissioning priorities
- Carers are recognised as an expert care partner by health and social care staff
- Carers are better informed about the transition from children to adult services and subsequent services
- Carers rights information is produced and promoted
- The pressures of caring is more widely recognised
- Carers needs are treated on an equal level to the needs of those they are caring for
- Carers have opportunities outside of their caring role
- Good quality services are available to carers
- Positive roles of caring are promoted/publicised
### Outcome 3

**There is a reduction in those carers that experience financial hardship**

Taking on caring responsibilities may mean, for example, long-term financial hardship as a loss of income from paid work is exacerbated by higher household and travel costs. This strain on the carer and their families can have far reaching consequences and thus the importance to reduce this situation is a priority.

### Why has this been included as a priority?

Reducing financial hardship and the systemic issues which contribute to financial disadvantage can only benefit the carer, the cared for person and the wider family and community.

### How will the impact be known?

- Reduction in numbers of carers accessing emergency support e.g. food banks, emergency funds etc.
- Increase in take up of Carers Allowance and other benefits
- Increase in numbers of carers able to remain in employment
- Increased recognition of hidden costs for carers
- Increased lobbying for the reform of benefit infrastructure
- Workforce development to embed carers issues into human resource (HR) practices
- Career planning and return to work at the end of the caring role built into HR practices
- Increase in long-term financial planning advice for carers
- Increase in range of discounts for carers e.g. in utilities
**Outcome 4**
Greater empowerment of carers to support themselves in their caring role

Carers need to be able to manage their role as a carer and to be able to make choices for themselves. The definition of “empowerment” is often confused, but carers want and need to be put at the forefront of defining their own needs and how outcomes will be achieved. Carers are the most knowledgeable about their own situation and their input is crucial. This involves having autonomy, control and involvement in decision-making and having access to information to optimise their own health and quality of life.

**Why has this been included as a priority?**

Carers need to be at the forefront of support and service provision and their needs more easily defined and supported. This will allow them to take responsibility for defining the right service/support. This should enable support services to be more efficient and effective.

**How will the impact be known?**

- Increase in access to independent advocacy
- Increase in uptake of self-management and peer support programmes
- Increase in uptake of Carer Personal Budgets
- Increase in uptake of direct budgets
- Increase in policy/procedure co-production with carers
- Greater involvement of carers in planning, commissioning and evaluation of services
- Greater carer independence
- Increased ability of carers to navigate systems and care pathways e.g. drawing on external support when required to ensure needs of the cared for person
- Increase in information given to carers about healthy living
- Increased opportunities to have a life away from the caring role
- Increase in carers having access to general information
- Improved self-reports of carer wellbeing
- Greater number of carers being appropriately supported to undertake basic medical management with support e.g. through new technology and recognising signs of deterioration
Outcome 5
Increased opportunities for carers to participate in training, education, volunteering and employment

The benefits of carers accessing training, education and employment (paid or unpaid) are well documented and include better income, pension rights, career prospects and social networks and a decrease in the negative impact of the carer role. Employment, education and training can be beneficial to carers’ emotional and physical wellbeing, boosting self-esteem, providing stability and reducing the risk of social exclusion. For parent carers, work is important in maintaining a personal balance and in participating in normal life.

Why has this been included as a priority?
Research shows that carers are more likely to lack confidence and self-esteem. This, in addition to their lack of availability, is likely to disadvantage them in taking up education, training, employment or volunteering activities. For those carers that have been out of the workplace for some time, they may need to build skills and confidence before considering work. There is also a need to provide additional support where necessary, e.g. to young carers.

How will the impact be known?

- Increase in identification of carers training, education, volunteering and employment needs
- Increase in number of carers accessing training, education, volunteering and employment opportunities
- Increase in peer support and volunteers
- Increase in access to transport and travel
- Numbers of carers remaining in employment is increased
- Reduced numbers of young adult carers who are not in education, employment or training
- Increase in access for young carers to university
- Increase in good-quality, flexible approach to support and information for carers to fulfil their training, education, employment and volunteering needs
- Awareness of carers and their needs is increased in providers of local education, training and volunteer opportunities and with local employers
- The Carers Charter includes access to training, education, volunteering and employment opportunities
**Outcome 6**  
There is an increased understanding and appreciation of the role of carers within the Middlesbrough community

Local communities do not necessarily have a knowledge or appreciation of what carers do and their understanding may be based on personal knowledge or policies within their organisations. There may be a basic understanding of the practical help carers perform, but the wider value to communities of carer’s willingness to spend significant resources (time, money, love) and large parts of their own life attending to the needs of others is often missed. Middlesbrough would benefit from being a carer friendly town – promoting carers and increasing awareness and understanding of their roles and contributing to the different carer groups.

**Why has this been included as a priority?**

By increasing the understanding of what carers do and acknowledging their value to local communities will benefit carers to have more opportunities. Local organisations may be more willing to consider carers as volunteers and employers more willing to retain staff that are carers with caring responsibilities or consider flexible working.

**How will the impact be known?**

- Increase in the number of registered carers
- Increase in number of carers registered with local services (e.g. GP, Adult social Care etc)
- Organisations share information (with permission) on contacts with carers to increase the carers counted
- Increase in number of PSS Annual Surveys completed
- A public awareness raising campaign run to improve knowledge and understanding of carers issues
- A programme of workforce development across organisations to embed structures to support carers
- Increase in positive messages
- Tackle inequalities and improve the experiences of marginalised groups in accessing support
**Outcome 7**

**More carers have their needs met**

Carers should receive the right help and support at a convenient time to ensure that they can continue their role. The focus should be on the range of carers needs to be met by different organisations, groups and sectors.

**Why has this been included as a priority?**

When carers have their needs met as far as possible, this enables them to continue in their role and will ultimately support the people they care for and provide an invaluable service to their communities. This follows the Triangle of Care principles\(^3\). Having their needs met will increase their health and wellbeing and prolong their own independence as well as the person(s) they are caring for.

**How will the impact be known?**

- Increase in support services taken up by working age carers
- Percentage increase in carers receiving a personal budget
- Increase in number of carer assessments
- Carers needs integral in care planning process
- Reduction in absenteeism in schools (young carers)
- Increase in the number of young carers accessing training and/or high education
- Number of stakeholders signed up to the Carers Charter
- Greater involvement of carers in planning, commissioning and evaluating services
- Number of carers accessing training, education, employment and volunteering opportunities
- Whole person approach (person centre care within their community) established linked to life beyond caring role
- Cross-reference with the Carers Charter
- Linkages to workforce development
- Link to Middlesbrough as a carer friendly community

\(^3\) The Triangle of Care, Carers Included: A Guide to Best Practice in Mental Health Care in England
**Outcome 8**  
**Increased range of information, advice and advocacy that is high quality, appropriate and accessible**

Accurate, accessible and appropriate information, advice and advocacy are essential for good decision-making. It underpins all aspects of carer’s health and wellbeing. It is important that information, advice and advocacy are prioritised by services and is an intrinsic part of ongoing provision to support local people to ensure they get the right services at the right time. It should be available to all carers and tailored to their individual needs and also reflecting the changes in the nature of the caring role.

**Why has this been included as a priority?**

The provision of appropriate information, advice and advocacy enables carers to design services that work well for them. This does not only cover those traditionally associated with social care, but it covers a whole range of social and community activities, and applies whether people are eligible for services or are paying for their own services.

**How will the impact be known?**

- Increased numbers of carers accessing support and other services
- Increased numbers of directed self-referrals to advice and advocacy services
- Increase in numbers of carers assessments completed
- Carers assessments developed and reviewed with carers to agree a holistic assessment framework
- Reported increase from agencies to greater understanding of carers needs/role and awareness of role of other agencies
- Greater numbers of carers sharing their experience/feedback on a range of quality information, advice and advocacy
- Greater number of carers being appropriately supported to undertake basic medical management with support e.g. through new technology and recognising signs of deterioration
### Outcome 9

**Middlesbrough has an improved infrastructure of support for carers, which includes a range of high quality flexible services that enables choice**

Individual carers and groups of carers will need different kinds of practical and emotional support. This means that there needs to be a cross-section of support services available and provided by different organisations to a high quality standard. These organisations and groups should not work in isolation, but will need to refer and signpost to each other. An infrastructure with appropriate mechanisms for involvement of carers needs to be in place.

### Why has this been included as a priority?

An overarching infrastructure to support carers groups or services providing organisations is important so that carers have appropriate services, can influence what services are provided and gaps in provision are filled. There is also a need to recognise the individual needs of carers and also the changing nature of a caring role.

### How will the impact be known?

- Maintained or increase in the number of community carer groups
- Increased peer support groups
- Support continued for management of carers involvement forum
- Increase in reporting in satisfaction rates
- Carers involvement in the design of services
- Decrease in time from identification of need to assessing services
- Flexibility integral to all commissioned services for carers to recognise changes in caring role
**Outcome 10**

**Improved health and social care pathways that identify and recognise the caring role and support choice throughout the care and the caring experience**

Pathways to different health and social care services can be travelled along (and back) by users of services. These services should be constantly improved for the user, but should also consider the carer as well. Carers can enter a pathway for services at different places dependent upon their own needs and those of the person they are caring for. They can enter from different sectors (health, local authority and the VCS) and can be referred to different pathways of support. It is important that professionals and staff in these pathways recognise that an individual is a carer, and ensures they obtain the right support throughout the pathway.

**Why has this been included as a priority?**

Carers need to be identified at an appropriate stage and as early as possible. This will allow carers to obtain the right support and have their needs met.

**How will the impact be known?**

- Increased satisfaction feedback from carers
- Maintained or increase in number of community carer groups
- Increased peer support groups
- Decrease in waiting times to access services reported by providers
- More services populating/contributing to a central database of services with up-to-date information
- Increase in numbers of carers identified
- Increase in numbers of carers assessments undertaken
- Increase in number of carers identified immediately when a user enters a pathway
- Greater communication and information sharing between organisations
- New pathways designed, existing pathways reviewed or decommissioned using co-production and multi-agency involvement
- Staff supporting carers to report increased satisfaction with the provision provided to them
**Outcome 11**

**Improve understanding of the needs of carers that enables early identification to promote support at the right time**

The needs of carers are often hidden behind the person being cared for. Carer’s needs are also often complex and difficult to understand with carers not recognising they have needs. It is therefore important to have procedures and mechanism to help identify carers and their needs as early as possible to ensure that the appropriate support given at different stages. This will enable carers to have their needs met consistently and at the right time.

**Why has this been included as a priority?**

It is crucial to identify carer’s needs and understand them so that support and services are provided appropriately and efficiently and effectively. Identification of carers needs as soon as possible will ensure that the carer continues in their role for as long as possible with the right support and services.

**How will the impact be known?**

- Increase in uptake of carers information and services
- Increase in number of carers registered (including with GPs)
- Increase in number of carers assessments completed
- Increase in groups working for and with carers
- Improved data on needs of carers
- Increase in satisfaction rates
- Increase in staff self-reporting as carers
- Reducing the delay between identification of need and access to services
- Improved flexibility in workforce practices to ensure carers continue to be employed
- Increased understanding of role of a carer by Middlesbrough employers (link to Carers Charter)
**Outcome 12**

Increased collaboration between carers, providers and commissioners to shape strategic and service planning to continuously plan for the future through the effective use of resources

Carers are experts on both their needs and those of the person(s) they are caring for and will therefore have useful information, views and experience which service providers and commissioners of services can utilise. It is important that carers and the person cared for are not only consulted by providers and commissioners, but are fully engaged in the commissioning cycle and service planning process. Carers need to be supported to be involved. Providers and commissioners need to work together with carers to ensure that the appropriate services are commissioned and delivered within existing resources. This includes information sharing with providers encouraged to share information.

**Why has this been included as a priority?**

To ensure that the resources in Middlesbrough are collectively and efficiently utilised.

**How will the impact be known?**

- Greater opportunities to bring carers, providers and commissioners together
- Minimum of an annual review of this strategy and plans which fall from it
- Greater number of carers involved in planning, commissioning and evaluation of services
- Updated Topic Section of the Middlesbrough Joint Strategic Needs Assessment (JSNA).

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**7. Monitoring and performance measurement**

It is important that measurement takes place of what progress is being made against the twelve outcomes during the life of the strategy and what difference (impact) it is
making. To do this an appropriate framework of robust performance indicators will be
developed to ensure that the outcomes are achieved. This framework will be
designed and agreed with all local stakeholders. Appropriate data and information
to support the measurement of the performance indicators will also be decided and
agreed upon. Both the data and information and the methods of collection will be
standardised wherever possible across organisational and sector boundaries.
Accountability will be through monitoring the performance indicators on an annual
basis and reporting through appropriate organisational and sector arrangements, but
ultimately the Health and Wellbeing Board.

A separate traffic light system to indicate the overall performance of the strategy will
also be developed and used and produced on a regular basis. This will provide
commissioners, providers and carers an indication of the impact that the strategy is
making in a readily accessible format:

**Red** – Progress towards individual outcomes is not progressing with urgent work
required

**Amber** – Progress towards individual outcomes is progressing, but improvements
are required

**Green** – Progress towards individual outcomes is progressing satisfactorily

The specific outcomes of the strategy will be incorporated into all partner
organisations monitoring and performance systems. Partners in the voluntary and
community sector, local NHS and local authority, carers and carers representatives
will be enabled to contribute to the overall performance monitoring of the strategy,
where appropriate. The use of regular feedback from carers and carers' organisations to evaluate progress will also be a priority. It is proposed that the
Action for Carers Forum\(^4\) will provide governance for the delivery of the strategy;
ensuring carers views regarding performance are routinely captured.

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\(^4\) Refer to section 5 Governance.
**Purpose of Paper**  |  **For Decision**  
---|---
**Title**  |  Draft Mental Health Strategy  
**Responsible**  |  Simon Gregory, Chief Finance Officer  
**Author of the Report**  |  Mark Burdon, Commissioning Manager (MH)  
**Recommendation(s)**  |  The Governing Body is asked to approve the Strategy.  
**Summary**  |  This is a South Tees CCG Strategy for Mental Health, both for children/young people and adults/older people. The key outcomes sought are to improve mental health outcomes in line with national strategy guidance and to bring commissioning of mental health services into parity with physical and health services.  
**Financial Implications**  |  None  
**Legal/Regulatory Implications**  |  None  
**Assurance Framework/Risk Register Implications**  |  None  
**Details of relationship to the NHS Constitution**  |  Principle 5: The NHS works across organisational boundaries and in Partnership with other organisations in the interest of patients, local communities and the wider population.  
**Details of Patient and Public Involvement and/or Implications**  |  The draft has been made public online and circulated to partners. Two public events held, one in North Ormesby and one in Redcar. Separate consultation held via a young people's charity.  
**Has an Equality Analysis been completed?**  |  The Strategy includes a list of disadvantaged groups for the CCG to be aware of when commissioning MH Services.  
**Attachments**  |  
**Please detail any Committees or Forums at which this paper has previously been tabled**  |  Executive Meeting  

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**NHS South Tees Clinical Commissioning Group**

**Governing Body**

**Agenda Item: 2.2**

**Wednesday 29 July 2015**
Executive Summary

1. Introduction

Emotional wellbeing and good mental health contributes to every aspect of a person’s life regardless of age. It is important in helping to strengthen families, improve educational attainment, promote social inclusion, tackle anti-social and offending behaviour, expand opportunities and improve general health and wellbeing.

Our strategy focuses on mental health care delivered locally in primary care, in the community, and in adult and older people's inpatient facilities. Separate strategies are being developed within the CCG and with partners for Learning Disabilities and Dementia services.

2. Vision

Our vision for mental health and emotional wellbeing in South Tees is that we will improve mental health together by improving outcomes in line with the National Mental Health Strategy and by implementing parity of esteem in commissioning. This means giving equivalent levels of attention and scrutiny to services dealing with mental health as those that deal with physical health.

3. National and local context

Our strategy is influenced by the national context: the outcomes we are looking to improve are defined in the National Mental Health Strategy ‘No Health without Mental Health’, while the means we will use to improve those outcomes are influenced by documents such as ‘Future in Mind’, the NHS England ‘Five Year Forward View’, and ‘Closing The Gap’.

We have also analysed comparative data on the determinants of mental health, prevalence, and outcomes. This data shows that while there are areas of comparative strength (such as the performance of Early Intervention in Psychosis teams and waiting times for psychological therapies), in general our area has significant negative factors that result in poorer mental health for the population. These include high levels of admissions for self-harm among young people, high rates of looked after children, high rates of teenage pregnancy, high male suicide rates and high levels of antidepressant prescribing.

We asked local GPs using a survey to tell us what their priorities were for improving mental health services. Several of them told us the importance of recognising the social factors that affect mental health, such as housing, unemployment, family issues and finances. They also mentioned the need for good access to treatments other than drugs for common mental health problems. A third priority for GPs was to improve how mental health services communicate back to them about their patients’ treatment. We have taken these on board and included them in our list of key principles for commissioning mental health services.
We also held events and ran a survey for members of the public, service users, carers and partner organisations to tell us what their priorities are. Some of the top priorities highlighted by these means of communication were:

- Rapid access to assessment and treatment
- Supporting and including carers and families
- Services for children and young people

**Key principles for commissioning mental health services**

These can be summarized in four areas: access to the right services at the right time, services that consider the whole person, services that empower people to act, and evidence-based commissioning.

**Access to the right services at the right time**

- Commission services to enable early detection and intervention
- Commission to enable access and reduce waiting times
- Commission to ensure access to vulnerable groups and tackle health inequalities
- Commission to support prevention and health promotion and less use of high cost crisis and inpatient care

**Services that consider the whole person**

- Commission for the whole person, integrating physical health and mental health pathways
- Commission ensure safe and smooth transitions across services
- Commission to support and involve families and carers
- Commission jointly across boundaries including those between health and social care, primary and secondary care, mental health and physical health services and those dealing with substance misuse and mental illness

**Services that empower people to act**

- Commission to enable personalisation and choice
- Commission services that empower people to become resilient in the face of challenges including family breakdown, isolation and deprivation
- Commission for recovery focussed services and evidence-based approaches, including non-pharmaceutical interventions

**Evidence-based commissioning**

- Commission for meaningful involvement and collaboration in service improvement with people who use services
- Commission intelligently using good outcome measures, local and national metrics

4. **CCG Mental Health Strategy for 2015-2020**
By 2020, we want to improve the mental health of children and young people in the South Tees area in the following ways:

Firstly, by implementing priorities linked to the ongoing Tees-wide CAMHS Transformation programme:

- ensuring high quality of care through the implementation of the newly developed evidence based service specification for the CAMHS service and associated pathways
- reducing the rate of admissions of children and young people who self-harm and use alcohol, increase the access to community based talking services
- improving transition arrangements between CAMHS and adult mental health services to ensure that there is no risk of untreated illness at this critical time
- ensuring that local people get the best possible start in life, including mental health support for expectant and new mothers
- ensuring that children with complex needs, including mental health issues are given full and equal access whilst being assessed under the new Children’s Act responsibilities and, where appropriate, are able to take advantages of opportunities offered by personal health budgets including those children in special schools
- developing a pathway for children with sensory process disorder
- developing resilience in young carers
- developing a robust collaboration process for children, young people and their families to influence the commissioning and review of commissioned services
- working towards holistic care for children and young people across physical and mental health
- ensuring compliance with the waiting time and access standards for mental health services, as well as supporting the national priorities to enhance Early Intervention in Psychosis services, and to develop talking therapies for children and young people at tier two.

We will commission with reference to the principles laid out in the Tees-wide children and young people’s mental health strategy.

We have also identified several priorities from local intelligence and engagement:

- Preventing high-cost interventions in emergency and crisis services for mental health-related issues through prevention and early intervention
- The high number of children on child protection due to family dysfunction and high numbers of parents in drug or alcohol treatment indicate a priority for access to coordinated adult mental health services and substance misuse services and social care services where children are present.
- Young people vulnerable to developing mental health problems need to be identified and supported to access services. This is especially urgent for young people leaving care, young people in the criminal justice system, children in the care system and children who have been abused.
- There are a high number of young people living with a learning disability within the population who will need good access to integrated services.
We want to improve mental health together for adults and older people. The priorities we have identified in order to do this are:

- To increase access and early intervention
- To improve access to Psychological Therapies
- To ensure parity of esteem between physical health and mental health
- To improve Perinatal Services
- To encourage providers to adopt a Recovery approach
- Ensuring that people with mental health conditions known to secondary mental health services have their physical health needs actively addressed.
- Developing psychiatric liaison services to ensure people with long term conditions and people who access acute care have their mental health needs identified and addressed.
- Addressing the challenge of responding holistically for people with mental health and alcohol or substance misuse issues
- Ensuring quality and effectiveness in the core secondary mental health community and inpatient services
- To develop and implement a robust collaboration process to involve service users and carers in each stage of the commissioning cycle
- To develop stronger mental health commissioning capacity and knowledge within the CCG infrastructure
- To develop a Joint Local Implementation Plan for National Mental Health Strategy
- To support the Armed Forces covenant

Local joint commissioning priorities
To achieve our priorities, we will work collaboratively with our commissioning colleagues in public health, local authority, police and the third sector to ensure the mental health needs of people in the Middlesbrough and Redcar and Cleveland areas are identified and met:

- Developing a crisis care pathway, so that everyone experiencing crisis can access the most appropriate service in a timely and dignified way
- Developing services that work with maternity and primary care teams
- Child protection and safeguarding
- Changing systems to build resilience into young people in South Tees, allowing them to ‘overcome’ from adversity
- Support for vulnerable people across criminal justice system, care leavers, families living with domestic violence and emotional abuse, families where English is not spoken well.
- Helping people with mental illnesses recover in terms of employment, housing and social integration
Equality and Diversity

We need to be mindful of equality and diversity when commissioning mental health services. There are marginalised groups in our communities that are at a higher risk of developing mental health problems, including people who are:

- young first-time mothers;
- living with long-term conditions
- living with disabilities, including learning disabilities;
- people who have experienced abuse or bullying;
- victims of crime;
- living as migrants;
- from minority backgrounds;
- from the Lesbian, Gay, Bisexual, and Transgender communities;
- in the justice system;
- looked after young people and people leaving care as adults;
- living with sight or hearing impairment;
- older and living alone or in isolation.

Our vision, improving health together, covers all members of our communities and we will take care to ensure that we understand the needs of people who are vulnerable to mental health problems and ensure equitable, non-discriminatory access to appropriate services.
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1. Introduction

Welcome to NHS South Tees Clinical Commissioning Group’s Mental Health Strategy. This strategy sets out our long term mental health vision for improving the emotional and mental health and wellbeing of people of all ages who live in Middlesbrough and Redcar and Cleveland.

As a local GP, I frequently meet with people struggling with their mental health and see the impact this has on their whole life, including their physical health. This strategy outlines our determination to improve services so that our local communities can be confident that services are available to support them when they need it the most.

We recognise that this strategy cannot be delivered in isolation and are committed to working with partners in local government, NHS provider organisations, voluntary and community sector organisations and others. We also recognise the importance of talking and listening to service users and their carers, and will work closer with them.

We are determined to achieve the NHS Mandate for ‘Parity of Esteem’ (equally valuing mental health with physical health and vice versa) – both in the way that we commission services and in the way those services operate.

Dr Angel Carrasco

Clinical Lead for Mental Health

South Tees CCG
1.1 Importance of this strategy

Emotional wellbeing and good mental health contributes to every aspect of a person’s life regardless of age. It is important in helping to strengthen families, improve educational attainment, promote social inclusion, tackle anti-social and offending behaviour, expand opportunities and improve general health and wellbeing.

1.1.1 Children and Young People

For children and young people, tackling mental health earlier not only reduces distress for the individual and their family but will also lead to reduced demand on higher cost mental health, education, social care and other services:

- Half of all lifetime cases of diagnosable mental illness begin by age 14, and three-quarters of lifetime mental illness arise by mid-twenties.¹
- Yet 60 to 70% of children and adolescents who experience clinically significant mental health problems have not been offered evidence based interventions at the earliest opportunity.²
- In the UK, mental illness during childhood and adolescence results in costs of £11,030 to £59,130 per person per year.³

There is now a wealth of evidence to show that interventions to improve emotional wellbeing and promote good mental health across the population, particularly with children and young people, will result in the following benefits for individuals, communities and populations⁴:

- reduced mental illness and suicide
- improved physical health and life expectancy
- better educational achievement and attendance at school
- reduced health risk behaviour such as smoking, alcohol and drug use
- improved employment rates and productivity
- reduced antisocial behaviour and criminality
- higher levels of social interaction and participation

1.1.2 Adults and older people

Mental illness is a major issue, and one that touches on all aspects of life. Around one in four adults experience at least one mental disorder, and mental illness costs society around £105.2bn a year⁵. Mental illness – or, alternatively, poor mental health – can impact negatively on people’s ability to work, their family life, their free time, and even their ability to cope with physical health problems.

- More than 350 million people suffer from depression worldwide⁶. Suicide is the leading cause of death for men between 20 and 34 in England and Wales, representing 24% of all deaths in 2013. The North-East region has the highest suicide rate in England.⁷
- Anxiety disorders account for the 6th highest Years of life lived with disability (YLD) in the years living with a disability in both high and middle-income countries.⁸
• Only 27% of working age adults in England with a mental illness are in employment, compared to 70% for the population as a whole.\textsuperscript{ix}
• Adults aged 18-73 with serious mental illness have a mortality rate three times higher than the general population.\textsuperscript{x}
• Evidence shows that where people have a physical long-term condition, diagnosis of mental health problems is more difficult.\textsuperscript{xi}
• About 40% of carers are thought to be at risk of depression or stress because of their caring role.\textsuperscript{xii}
• It is estimated that at least 50,000 young people are carers for a parent with a mental health problem.\textsuperscript{xiii}
• Social isolation and loneliness can contribute to mental health problems, including rarer conditions such as schizophrenia.\textsuperscript{xiv}

The importance of good mental health, early intervention for those living with mental health distress, and support for those who have longer-term needs and their careers and families, is clear. We are determined to commission appropriate services, which will meet the mental health and well-being needs of everyone in our communities and ensure that they are effective, safe and that the people using them and delivering them will be properly supported.

This strategy describes our vision, our commissioning intentions, the commissioning values, principles and drivers that have shaped our intentions and finally the work stream structure, which will enable us, work towards achieving our vision; enabling all people living in the South Tees area to have mental health services of which they can be proud.

1.2 Scope of this Strategy

The CCG has a specific role in commissioning health services that will help achieve our vision. Essentially, we commission health services to support people get early help when they become unwell, support people to recover and get their lives back on track, or help them to stay well in spite of their symptoms, and support people quickly when they become acutely distressed. It does not relate directly to Learning Disabilities or Dementia services, although there are clearly important links with these areas – strategies are being developed within the CCG for Learning Disabilities and Dementia services.

The diagram below illustrates a “stepped model” of need, and service delivery. Fewer people will need to access the more specialised services at the higher tiers, but those who do have more complex problems and need more intensive support. The italic text in brackets shows who leads the commissioning of each type of service.
The CCG is responsible for commissioning some mental health services at each tier of provision except for universal Tier One services. However, the diagram does not show the entire picture, as people with mental health needs will also access physical health services and may have social care needs commissioned for by local authorities. As such, in order to achieve our desired outcomes for improving mental health, joint working and commissioning is required. Details of our priorities that relate to joint working or which fall mostly in the scope of a partner organisation are found on pages 16-17 of this strategy.

As such, the resources needed to achieve all 6 of the mental health outcomes do not sit within the CCG’s commissioning remit. The CCG is committed to working alongside our Local Authority colleagues and Health and Wellbeing Boards and neighbouring CCG colleagues. We need to ensure all our commissioning strategies complement each other and coordinate services and resources across the whole mental health landscape: from tackling wider determinants, to improving factors which put mental health at risk, to contracting services which enable access and recovery to supporting community development which protects and maintains mental health. The priorities identified in this strategy that sit outside CCG commissioning responsibility will be recommended for inclusion in to Local Authority, and to the Area Teams for their health and wellbeing and public health strategies.

We will also contribute to joint strategies with our local authorities and co-ordinate with Health and Wellbeing Boards.

<table>
<thead>
<tr>
<th>Tier Four</th>
<th>Adult and older people inpatient (CCG)</th>
<th>CAMHS and specialist inpatient (NHS England)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tier Three</td>
<td>Adult and older people community services (CCG)</td>
<td>Specialist CAMHS community services (CCG)</td>
</tr>
<tr>
<td>Tier Two</td>
<td>Primary Care/ GP services (NHS England*)</td>
<td>Targeted CAMHS community teams, IAPT (CCG)</td>
</tr>
<tr>
<td>Tier One</td>
<td>Universal services (Public Health)</td>
<td>Public Health and Wellbeing (Public Health)</td>
</tr>
</tbody>
</table>

*: South Tees CCG co-commissions some primary care services with NHS England
2. Vision

Our overarching vision is to improve health together across South Tees. The Clear and Credible Plan (2012-17) says that this means we want to reduce health inequalities, reduce variable access to health care, continuously improve wellbeing and drive up the quality of services we commission.

Our vision for mental health and emotional wellbeing in South Tees is that we will improve mental health together by improving outcomes in line with the National Mental Health Strategy and by implementing parity of esteem in commissioning. All of these priorities fit with the outcomes contained within the National Mental Health Strategy and its companion paper, Closing the Gap: 25 essential priorities for mental health commissioning\textsuperscript{\textcopyright}. The outcomes we want to improve are:

- More people will have good mental health: More people of all ages and backgrounds will have better wellbeing and good mental health. Fewer people will develop mental health problems – by starting well, developing well, working well, aging well
- More people with mental health problems will recover: More people who develop mental health problems will have a good quality of life
- More people with mental health problems will have good physical health: Fewer people with mental health problems will die prematurely, and more people with physical ill health will have better mental health.
- More people will have a positive experience of care and support: Care and support, wherever it takes place, should offer access to timely, evidence-based interventions and approaches that give people the greatest choice and control over their own lives, in the least restrictive environment, and should ensure that people’s human rights are protected.
- Fewer people will suffer avoidable harm: People receiving care and support should have confidence that the services they use are of the highest quality and at least as safe as any other public service.
- Fewer people will experience stigma and discrimination: Public understanding of mental health will improve and, as a result, negative attitudes and behaviours to people with mental health problems will decrease.

We are committed to establishing parity of esteem between physical and mental health. As a commissioner of secondary and community care services, our role in bringing about parity of esteem is twofold: firstly, to commission comprehensive services that will fulfil the mental health needs of our population with the same high quality and access as we expect from physical health services, and secondly, to ensure the levels of support, scrutiny, planning and analysis given to mental health by the organisation are equitable given the equal value we place on mental and physical health.

We acknowledge the need to improve health together by working closely with our communities, member practices, local authorities, provider organisations and the voluntary sector to achieve the aims set out above.
3. National and local context

3.1 Summary of sources

Our strategy is influenced by the national and local context. These influences can be split down to four categories: Patient experience factors, policy, local information and best practice.

The following table is a partial list of the policy drivers, key factors to consider, best practice principles, and aspects of local intelligence that inform the development of this strategy.

<table>
<thead>
<tr>
<th>Patient experience factors</th>
<th>Policy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transitions across and within services</td>
<td>“No health without mental health” national strategy</td>
</tr>
<tr>
<td>Out of area placements/ young people admissions to acute inpatient services</td>
<td>“Closing the gap: 25 priorities for Mental Health commissioning”</td>
</tr>
<tr>
<td>High under-75 mortality amongst people living with a mental health problem</td>
<td>Future In Mind</td>
</tr>
<tr>
<td>High Suicide rate amongst males</td>
<td>Mental Health Crisis Care Concordat</td>
</tr>
<tr>
<td>Mental health problems in top four conditions for years living with a disability</td>
<td>Waiting time and access targets</td>
</tr>
<tr>
<td>Crisis care and places of safety</td>
<td>Maternal and child / perinatal mental health</td>
</tr>
<tr>
<td>Carer experience increased mental health need</td>
<td>NHS Five Year Forward View – integrated commissioning</td>
</tr>
<tr>
<td>Access to primary care /community based services</td>
<td>Mental health currencies and payment</td>
</tr>
<tr>
<td>Recovery focussed services</td>
<td>NHS mandate: Parity of esteem</td>
</tr>
<tr>
<td>Undetected Mental health of people living with long term conditions</td>
<td>Equality Duty 2010: Ensuring access effective design and delivery of services to groups who are vulnerable and seldom heard</td>
</tr>
<tr>
<td></td>
<td>Health and Social Care Act 2010: Personal health budgets, increasing choice of provision, duty to involve patients and carers</td>
</tr>
<tr>
<td></td>
<td>Mental Health Act and Mental Capacity Act</td>
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<td></td>
<td>Transforming Care (Winterbourne)</td>
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</table>

<table>
<thead>
<tr>
<th>Best practice</th>
<th>Local information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Commissioning for outcomes</td>
<td>Local authority strategies for Carers and Mental Health strategies</td>
</tr>
<tr>
<td>Value-based commissioning</td>
<td>Health and Wellbeing Board strategies</td>
</tr>
<tr>
<td>NICE clinical guidelines and quality statements</td>
<td>Mental health LIT strategies</td>
</tr>
<tr>
<td>Rebalancing the investment from inpatient to early accessible community care</td>
<td>Public health strategies</td>
</tr>
<tr>
<td>Improve data quality and outcomes to support intelligent commissioning</td>
<td>CCG strategies</td>
</tr>
<tr>
<td>Integrated joint commissioning</td>
<td>Tees-wide Children and Young People’s Mental Health Strategy</td>
</tr>
<tr>
<td>Mental health currencies / payment by outcomes</td>
<td>South Tees CCG’s Clear and Credible Plan</td>
</tr>
<tr>
<td>Choice, personalisation, health budgets and personal budgets</td>
<td>Public health outcome profiles data</td>
</tr>
<tr>
<td>Early intervention and recovery focus</td>
<td>Information from public engagement</td>
</tr>
<tr>
<td>Reducing health inequalities</td>
<td>Joint Strategic Needs Assessment</td>
</tr>
<tr>
<td>Meaningful patient and public involvement</td>
<td></td>
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<tr>
<td>IAPT</td>
<td></td>
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<tr>
<td>Liaison Psychiatry</td>
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</table>
3.2 Mental health outcomes for children, young people adults and older people: a local picture

Whilst it is important to implement national policy and best practice, we need to understand how national policy relates to South Tees CCG. Data from the Public Health Outcomes Profiles were used to benchmark outcomes for Middlesbrough and Redcar and Cleveland against other local authority areas nationally. The text boxes in the below diagram and its equivalent for adult mental health list indicators for which either the CCG as a whole, or one of its constituent local authorities, is in the worst 25% of areas nationally. This should give us a clear indication of what to prioritise to improve outcomes.

3.2.1 Outcomes for children and young people

The local picture: adult and older people mental health Outcomes data where South Tees CCG area is in the worst or highest risk quintile nationally

<table>
<thead>
<tr>
<th>Risk Factors</th>
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<tbody>
<tr>
<td>Parents in drug treatment</td>
</tr>
<tr>
<td>Young people providing considerable care</td>
</tr>
<tr>
<td>Children under 20 in poverty</td>
</tr>
<tr>
<td>Children under 16 in poverty</td>
</tr>
<tr>
<td>Traveller children: % school children who are Gypsy/Roma</td>
</tr>
<tr>
<td>% of households that have lone parents with dependent children</td>
</tr>
<tr>
<td>% of households with dependent children where no adult is in employment</td>
</tr>
<tr>
<td>% of households with dependent children where at least one person has a long term health problem or disability</td>
</tr>
<tr>
<td>Domestic Abuse rate</td>
</tr>
<tr>
<td>Parents in alcohol treatment</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Prevalence and Service Use</th>
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</thead>
<tbody>
<tr>
<td>Estimated prevalence of any mental health disorder</td>
</tr>
<tr>
<td>Estimated prevalence of emotional disorders</td>
</tr>
<tr>
<td>Estimated prevalence of conduct disorders</td>
</tr>
<tr>
<td>Estimated prevalence of hyperkinetic disorders</td>
</tr>
<tr>
<td>Young people hospital admissions for self-harm</td>
</tr>
<tr>
<td>Child hospital admissions due to alcohol specific conditions</td>
</tr>
<tr>
<td>Young people hospital admissions due to substance misuse</td>
</tr>
<tr>
<td>Child hospital admissions for unintentional and deliberate injuries</td>
</tr>
<tr>
<td>Young people hospital admissions for unintentional and deliberate injuries</td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th>Social Care</th>
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<tbody>
<tr>
<td>New cases of children in need</td>
</tr>
<tr>
<td>Children in need</td>
</tr>
<tr>
<td>New child protection cases</td>
</tr>
<tr>
<td>First time entrants to the youth justice system</td>
</tr>
<tr>
<td>All entered to the youth justice system</td>
</tr>
<tr>
<td>Children in need due to abuse, neglect or family dysfunction</td>
</tr>
<tr>
<td>Looked after children: Rate per 10,000</td>
</tr>
<tr>
<td>Emotional well-being of looked after children</td>
</tr>
<tr>
<td>Rate of children who were the subject of a child protection plan at the end of the year</td>
</tr>
<tr>
<td>Repeat child protection cases</td>
</tr>
<tr>
<td>Children leaving care: Rate per 10,000</td>
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</tbody>
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<table>
<thead>
<tr>
<th>Sexual Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under-18s births rate per 1,000</td>
</tr>
<tr>
<td>Under-16s conception rate per 1,000</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Education</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary school pupil absence: % of half days missed 2012/13</td>
</tr>
<tr>
<td>Secondary school pupil absence: % of half days missed</td>
</tr>
<tr>
<td>Pupils with Learning Disability: % of school pupils with Learning Disability</td>
</tr>
<tr>
<td>Pupils with behavioural, emotional and social support needs</td>
</tr>
<tr>
<td>16-18 year olds not in education, employment or training</td>
</tr>
</tbody>
</table>
It is clear that there are significant life challenges to children and young people living in the South Tees area. Many of the indicators and outcomes in the diagram suggest that children’s and young people’s mental health is at risk.

**High numbers of young people in the criminal justice system** could indicate high underdiagnosed conduct disorders, as well as an increased risk of depression and suicide within that population.

**High numbers of young people leaving care and high numbers of young people not in education, employment or training** (NEET) suggest increase risk of suicide, depression and anxiety. It is important that we ensure the services we commission are able to respond to the need of these groups to enable early detection and treatment.

High numbers of: parents with alcohol, drug and mental health problems, cases of domestic violence, children repeatedly in care, new cases of children subject to child protection, and children in need due to abuse, neglect or family dysfunction. Abuse and trauma are significantly associated with mental health problems both as young people and adults and unhappiness with family relationships are a significant risk factor for self-harm, depression, personality disorder and suicide, as well as increasing behaviours such as smoking, drinking alcohol and substance misuse.

**High numbers of families where English is not spoken well and high numbers of migrant workers.** These are known to be high risk groups for poor mental health and are known to find access problematic. We need to ensure that our services are culturally sensitive so people from these groups can access services early and easily.

High numbers in school of children with a learning disability and high numbers on school action plus and with a statement of need to emotional and behavioural difficulties: people living with learning disability are significantly more likely to present with mental health problems and are likely to develop long term physical health problems. A coordinated, easy access pathway is important to prevent poor outcomes in term of mortality and morbidity. Emotional and behavioural difficulties in school are good indicators of poor adult mental health. Unsupported/diagnosed conduct disorder leads to poor outcomes and significant costs in adulthood. Good evidence exists to support early identification and treatment and support for schools.

High numbers estimated to have mental health disorders and very high rates of hospital admissions for self-harm as well as alcohol and substance misuse; these outcomes and indicators could suggest a failure to identify emotional distress earlier and/or lack of services accessible in primary care.

**Highest numbers of young first time mothers,** first time motherhood brings significant risk of developing perinatal depression, (1 in 10 new mothers, and post-partum psychosis 1-2 in 1000 new mothers) and this rate is increased particularly for young single mothers.
3.2.2 Current commissioned services and spend on Children and Young People’s services

The CCG currently commissions services at level three and some services at level two. Tees, Esk and Wear Valleys NHS FT is the main provider of commissioned services to meet this need.

We have recently significantly invested in local CAMHS. The Clinical Commissioning Group remains committed to the transformation programme aligned to this investment and will align work with other children’s commissioning bodies to ensure best value and outcomes across the emotional and mental health system.

3.2.3 Outcomes for adults and older people

The local picture: adult and older people mental health Outcomes data where South Tees CCG area is in the worst or most high-risk quintile nationally

<table>
<thead>
<tr>
<th>Levels of Mental Health and Illness</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression and Anxiety prevalence</td>
</tr>
<tr>
<td>% reporting a long-term mental health problem</td>
</tr>
<tr>
<td>Estimated % of people aged 16+ with Psychotic Disorder</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Suicide rate (males)</td>
</tr>
<tr>
<td>Rate of recovery for IAPT treatment</td>
</tr>
<tr>
<td>Emergency Hospital Admissions for intentional self-harm</td>
</tr>
<tr>
<td>Excess under-75 mortality rate in people with a serious mental health problem</td>
</tr>
<tr>
<td>Premature under-75 mortality rate in people with a serious mental health problem</td>
</tr>
<tr>
<td>Numbers in settled accommodation and employment with severe mental illness</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antidepressant prescribing</td>
</tr>
<tr>
<td>Number of people with a mental illness in residential or nursing care</td>
</tr>
<tr>
<td>Number of bed days</td>
</tr>
<tr>
<td>Provision of psychological interventions within specialist mental health services</td>
</tr>
<tr>
<td>In-year bed days</td>
</tr>
<tr>
<td>Numbers on a section of Mental Health Act</td>
</tr>
<tr>
<td>Numbers on short term orders of Mental Health Act</td>
</tr>
<tr>
<td>GP prescribing of medication for psychosis</td>
</tr>
<tr>
<td>% of mental health service users who were inpatients in a psychiatric hospital</td>
</tr>
<tr>
<td>Use of ‘First choice’ antidepressants</td>
</tr>
<tr>
<td>Proportion of generic SSRIs as a percentage of all items</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of people waiting less than 28 days for IAPT treatment</td>
</tr>
<tr>
<td>Rate of people completing IAPT treatment in population</td>
</tr>
<tr>
<td>Numbers of patients with SMI with blood glucose or HbA1c check in preceding 15 months</td>
</tr>
<tr>
<td>% of smokers on GP registers offered cessation advice or referral in previous 15 months</td>
</tr>
<tr>
<td>% of people in contact with mental health services with a crisis plan in place</td>
</tr>
</tbody>
</table>
High prevalence of depression and anxiety, given the demographics (which indicate high risk and deprivation data) this would suggest high need for psychological therapy (IAPT) and Mental Health Service access.

High under 75 mortality, high suicide rate in males, high emergency admissions for self-harm, drug and alcohol: this suggests an issue with physical health care, health promotions and health screening. This is a key a priority for improvement. This use of emergency admissions for drug and alcohol suggests the need to provide more effective services in community and is a key area for improved outcomes and cost efficiency. The self-harm admissions are similarly high and suggest need to review crisis care and the use of liaison psychiatry.

The numbers of domestic violence and households with parents on drug /alcohol treatment: this suggests and unmet mental health need. The importance of addressing this outcome is well known in terms of prevention and over utilisation of emergency services

Higher utilisation of Inpatient services and high use of mental health act detentions and low numbers of secondary community care contacts when compared to comparators and high numbers of people utilising A&E and emergency admissions for drug and alcohol and self-harm: these outcomes suggest a priority for review of crisis car pathway and urgent care and also access to community mental health services. More people utilising high cost crisis services as opposed to planned community services. Similarly low numbers of community contacts.

Low provision of psychological interventions within specialist mental health services. This is an area for improvement given the emphasis on recovery and choice in mental health policy, and may link to the high crisis outcomes. Low rate of recovery for IAPT treatment would suggest that IAPT services need reviewing to their effectiveness against spend.

Low numbers of people in contact with mental health services when being assessed for alcohol treatment may also indicate a need to strengthen transition between mental health services and substance misuse services.

Low numbers of people in settled accommodation and low numbers of people with SMI in employment will be a barrier to recovery for people living with long term mental health problems and needs addressing as part of a recovery focus.

High numbers of carers assessed and high numbers of client with crisis plans would suggest good involvement of both carers and users in their care and support, however low emergency admissions due to mental health problems, and high use of detentions under the mental health act, for short term and long term orders, would suggest that crisis management needs to be understood better.

High numbers of families where English is not spoken well and high numbers of migrant workers: these groups are a known high risk group for poor mental health and are known to find access problematic.
We need to ensure that our services are culturally sensitive so people from these groups can access services early and easily.

3.3 Feedback from General Practice

Between December 2014 and February 2015, we carried out a survey of GP practices to find out what the main priorities were that GPs would like to see reflected in the strategy. Many issues were raised by respondents, and there was a broad spectrum of engagement with mental health services, some respondents only using psychological therapy services (IAPT) and others having patients in secondary services.

Here are some of the messages that came up from multiple respondents, and how these relate to the strategy.

Several respondents mentioned the need to recognise the social factors that have a significant impact on mental health: financial problems, housing issues, unemployment, family breakdown and chaotic lifestyles. This is recognised in the thirteenth commissioning principle: Commission services that empower people to become resilient in the face of challenges including family breakdown, isolation and deprivation.

Similarly, the need for good access to non-pharmaceutical solutions such as psychological therapies for common mental health problems was brought up. We aim to commission for recovery focussed services and evidence-based approaches, including non-pharmaceutical interventions.

Issues of communication were brought up, with varying reports on the quality and timeliness of communication from mental health services. As a CCG we recognise the need for safe and smooth transitions across services, including good communication with GPs, and have included this in our commissioning principles.

3.4 Patient and Public Involvement

We have a duty under the Health and Social Care Act 2012 to involve the public and people who access services in the full commissioning cycle and in the delivery of services. Many of the national drivers and policies have been developed with significant collaboration with the public and people who live with mental health problems.

We have ensured that we have developed our strategy with a broad engagement and involvement of local people, people who live with mental health problems and a wide range of stakeholders: GPs, local authority colleagues, Public Health, NHS and voluntary and community sector providers. This was done through:

- Two public events, one in Middlesbrough and one in Redcar
- Consultation work in partnership with a local children’s charity
- Publishing our draft strategy online and inviting comment through an open online survey
- Direct email feedback to CCG staff from partner organisations
- Sharing the draft strategy through the Middlesbrough Local Implementation Team (LIT) forum
- Direct email to stakeholders including managers at Tees, Esk and Wear Valleys NHS FT

The two public events focused on asking what our priorities should be, and asking attendees to highlight those they felt were most important. Some of the priorities that were highlighted were not within the scope of this document, but all feedback is recorded in Appendix 1.

The priorities that were highlighted as being most important and which fit within the strategy’s scope were:

- The need for whole person care – not a system where people fall between diagnostic criteria and are therefore not eligible for any service
- The need for advocacy and support for carers
- The need for person-centred care, and seeking outcome data from clients and family/carers
- Patient education
- Awareness of mental health problems among older people (not only dementia)
- Availability and accessibility of services including counselling and support in the community
- Prevention and early intervention
- Clear communication from services
- The need for greater GP awareness of mental health
- Longer-term solutions for specialist conditions, focusing on recovery
- Joint commissioning and joint working
- Importance of the family
- Engaging with subgroups of the population
- Access to the Crisis Assessment Suite

Respondents to our open online survey particularly highlighted the following priority areas:

- Children and young people
- Rapid access to assessment and treatment
- Support for carers, including young carers

The consultation with children and young people found that their top five priorities, from on a selection of statements based on the priorities we had identified, were:

1. Offer young people emotional and mental health services we know will help them
2. Less children and young people will self-harm and use alcohol
3. Young people who get help from children’s mental health services will be helped by adult mental health services so they can continue to receive the help they need
4. Support pregnant women and new parents so they can give their baby the best start in life
5. Ensure those with complicated needs including mental health are given access to funding to support their needs through personal health budgets
3.5 Key Principles for Mental Health commissioning

Drawing on the national and local information described above, we have identified a set of key principles for Mental Health commissioning. These summarize the messages from current national guidance and local priorities, and help us ensure our priorities and intentions are grounded in best practice and what works, as well as clear national directions of travel.

These can be summarized in four areas: access to the right services at the right time, services that consider the whole person, services that empower people to act, and evidence-based commissioning.

**Access to the right services at the right time**
- Commission services to enable early detection and intervention
- Commission to enable access and reduce waiting times
- Commission to ensure access to vulnerable groups and tackle health inequalities
- Commission to support prevention and health promotion and less use of high cost crisis and inpatient care

**Services that consider the whole person**
- Commission for the whole person, integrating physical health and mental health pathways
- Commission ensure safe and smooth transitions across services
- Commission to support and involve families and carers
- Commission jointly across boundaries including those between health and social care, primary and secondary care, mental health and physical health services and those dealing with substance misuse and mental illness

**Services that empower people to act**
- Commission to enable personalisation and choice
- Commission services that empower people to become resilient in the face of challenges including family breakdown, isolation and deprivation
- Commission for recovery focussed services and evidence-based approaches, including non-pharmaceutical interventions

**Evidence-based commissioning**
- Commission for meaningful involvement and collaboration in service improvement with people who use services
- Commission intelligently using good outcome measures, local and national metrics
4. CCG Mental Health Strategy for 2015-2020

In order to realize our vision across all the 6 mental health policy objectives, we have reviewed all the drivers and influences at national, regional and, local level and recommended a set of priorities that will focus our commissioning strategy over the next five years.

These will be divided in to children and young people and adult and older people.

4.1 Children and Young People

By 2020, we want to improve the mental health of children and young people in the South Tees area in the following ways.

Firstly, by implementing priorities linked to the ongoing Tees-wide CAMHS Transformation programme:

- ensuring high quality of care through the implementation of the newly developed evidence based service specification for the CAMHS service and associated pathways
- reducing the rate of admissions of children and young people who self-harm and use alcohol, increase the access to community based talking services
- improving transition arrangements between CAMHS and adult mental health services to ensure that there is no risk of untreated illness at this critical time
- ensuring that local people get the best possible start in life, including mental health support for expectant and new mothers – the CCG will review current arrangements for perinatal mental health to ensure timely and appropriate access to the correct level of specialist mental health treatment and support in line with best practice
- ensuring that children with complex needs including mental health issues are given full and equal access whilst being assessed under the new Children’s Act responsibilities and where appropriate are able to take advantages of opportunities offered by personal health budgets including those children in special schools
- developing a pathway for children with sensory process disorder
- developing resilience in young carers
- developing a robust collaboration process for children young people and their families to influence the commissioning and review of commissioned services
- working towards holistic care for children and young people across physical and mental health
- ensuring compliance with the waiting time and access standards for mental health services, as well as supporting the national priorities to enhance Early Intervention in Psychosis services, and to develop talking therapies for children and young people at tier two.

We will commission with reference to the principles laid out in the Tees-wide children and young people’s mental health strategy (Partnership, Prevention, Earlier Intervention, Access and Joint Pathways, and Continue to transform specialist services).
We are committed to working jointly to deliver the ambitions of Future in Mind\textsuperscript{xxvii}: tackling stigma and improving attitudes to mental illness; introducing more access and waiting time standards for services; establishing ‘one stop shop’ support services in the community and improving access for children and young people who are particularly vulnerable.

The report also calls for a step change in the way care is delivered moving away from a tiered model towards one build around the needs of children, young people and their families.

The aim is whole system improvement through partnership; planning and joint aligned commissioning resulting in integrated and timely services from prevention through to acute care. Also through investing in prevention and intervening early in problems before they become harder and more costly to address. All local areas will be required to develop a Transformation Plan for local services.

We have also identified several priorities from local intelligence and engagement:

- Preventing high-cost interventions in emergency and crisis services for mental health-related issues through prevention and early intervention
- Local groups have highlighted the increased risk and levels of need for young LGBT (Lesbian, Gay, Bisexual and Trans) people, ensuring adequate access and awareness among young people and reviewing service provision.
- The high number of children on child protection due to family dysfunction and high numbers of parents in drug or alcohol treatment indicate a priority for access to coordinated adult mental health services and substance misuse services and social care services where children are present.
- Young people vulnerable to developing mental health problems need to be identified and supported to access services. This is especially urgent for young people leaving care, young people in the criminal justice system, children in the care system and children who have been abused.
- There are a high number of young people living with a learning disability within the population who will need good access to integrated services.

4.2 Adults and Older People

By 2020, we want our services for adults and older people to better reflect the priorities listed in our “Key Principles”: access to the right services at the right time, services that consider the whole person, services that empower people to act, and evidence-based commissioning.

- To increase access and early intervention - The continuing focus for future development is for increased access and early intervention for people experiencing mental health problems and a recovery approach for people with long term conditions to maximise potential and allow people to live fulfilling and rewarding lives.
- To build on GPs’ existing training and skills in responding to social and psychological need, recognising the importance of primary care in mental health provision
• To improve access to Psychological Therapies - We will continue to focus on improving access and choice to psychological therapies and measure improved access to psychological services (IAPT) for people with depression and/or anxiety disorders:

• To ensure parity of esteem between physical health and mental health

• To improve Perinatal Services - In light of NICE Guidance we will consider current arrangements for perinatal mental health with the potential for developing a specialist perinatal community service. To review and commission and review psychiatric liaison services

• To encourage providers to adopt a Recovery Approach - We will continue to ensure providers implement a recovery approach for children and adults with long term mental health conditions to maximise their potential and improve quality of life.

• Ensuring that people with mental health conditions known to secondary mental health services have their physical health needs actively addressed.

• Addressing health inequalities as they relate to mental health services, particularly in relation to people at higher risk of mental illness as identified in section 4.4

• Developing psychiatric liaison services to ensure people with long term conditions and people who access acute care have their mental health needs identified and addressed.

• Addressing the challenge of responding holistically for people with mental health and alcohol or substance misuse issues

• Ensuring quality and effectiveness in the core secondary mental health community and inpatient services

• To develop and implement a robust collaboration process to involve service users and carers in each stage of the commissioning cycle

• To develop stronger mental health commissioning capacity and knowledge within the CCG infrastructure

• To develop a Joint Local Implementation Plan for National Mental Health Strategy - We will develop a joint implementation plan for the National Mental Health Strategy with both Local Authorities

• To support the Armed Forces covenant - We continue to be actively involved in the Tees Armed Forces local network group to ensure the principles of the Armed Forces Network Covenant are met for the armed forces and that the NHS plays an active part in this locally

4.3 Local joint commissioning priorities

For the priorities below, we need to work collaboratively with our commissioning colleagues in public health, local authority, police and the third sector to ensure the mental health needs are identified and met:

We recognise the importance of the Joint Strategic Needs Assessment and the need for agencies to work together to measure and understand levels of need in South Tees.

• Developing a crisis care pathway, so that everyone experiencing crisis can access the most appropriate service in a timely and dignified way
• Developing services that work with maternity and primary care teams
• Child protection and safeguarding
• Changing systems to build resilience into young people in South Tees, allowing them to ‘bounce back’ from adversity
• Support for vulnerable people across criminal justice system, care leavers, families living with domestic violence and emotional abuse, families where English isn’t spoken well.
• Helping people with mental illnesses recover in terms of employment, housing and social integration

4.4 Equality and Diversity

We need to be mindful of equality and diversity when commissioning mental health services. There are marginalised groups in our communities that are at a higher risk of developing mental health problems, including people who are:

- young first-time mothers;
- living with long-term conditions
- living with disabilities, including learning disabilities;
- people who have experienced abuse or bullying;
- victims of crime;
- living as migrants;
- from minority backgrounds;
- from the Lesbian, Gay, Bisexual, and Transgender communities;
- in the justice system;
- looked after young people and people leaving care as adults;
- living with sight or hearing impairment;
- older and living alone or in isolation.

In our engagement work, several of these groups were raised individually, including the LGBT community, mothers and isolated older people. The vision of the CCG, improving health together, covers all members of our communities and we will take care to ensure that we understand the needs of those vulnerable to mental health problems and ensure equitable, non-discriminatory access to appropriate services.
References

3. Suhcke et al. 2007
5. A Call to Action: Achieving Parity of Esteem, DH, 2013
9. Mental Health Foundation, 2012 (http://www.mentalhealth.org.uk/our-news/blog/120629/)
12. Mental Health Matters (http://www.mentalhealthmatters.com/screen-carers-for-depression-say-doctors-leaders/)
16. Adult common mental health disorders profile Middlesbrough/ Redcar and Cleveland, South Tees CCG Community Mental health Profile, Public Health Profiles (Public Health England).
17. Future In Mind, DH 2015 (www.gov.uk)
# NHS South Tees Clinical Commissioning Group

## Governing Body

**Agenda Item: 2.3**

**Wednesday 29 July 2015**

<table>
<thead>
<tr>
<th>Purpose of Paper</th>
<th>For Decision</th>
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</thead>
<tbody>
<tr>
<td><strong>Title</strong></td>
<td>Individual Funding Request (IFR) Panel – Terms of Reference</td>
</tr>
<tr>
<td><strong>Responsible</strong></td>
<td>Peter Race, Chair of Audit Committee</td>
</tr>
<tr>
<td><strong>Author of the Report</strong></td>
<td>Lisa Forster, Senior Commissioning Support Officer (NECS)</td>
</tr>
<tr>
<td><strong>Recommendation(s)</strong></td>
<td>The Governing Body are asked to ratify the revised terms of reference-subject to alternative wording being agreed to reflect South Tees CCG internal process regarding reporting of IFR panel minutes.</td>
</tr>
</tbody>
</table>

**Summary**

The IFR Panel members have reviewed the Terms of Reference in place, in line with the timescales for annual review. A number of minor amendments are proposed to accurately reflect the current practice of the Panel. Section 7.3 clarifies that the panel discussion forms a recommendation but the ultimate accountability remains with the CCG decision maker within delegated authority arrangements. Clear distinction between appeals and reconsideration of a case are detailed in section 8 and 9. Members are asked to note that Section 10 Reporting does not reflect current practice for South Tees CCG. For South Tees CCG the minutes come into the Quality, Performance and Finance Committee and it is proposed that alternative wording be suggested to reflect the reporting arrangements for South Tees. It is felt that wording to include reporting to an ‘other appropriate committee’ would be acceptable to the other CCGs across the North East and Cumbria who have already adopted the terms of reference.

**Financial Implications**

There are no financial implications associated with the terms of reference.

**Legal/Regulatory Implications**

Whilst there are no implications, it is important to note that the terms of reference are pertinent to each individual CCG but also to the IFR process as a whole across the North East as all CCGs contribute to the IFR Panels.

**Assurance Framework/Risk Register Implications**

There are no implications associated to this area.

**Details of relationship to the NHS Constitution**

Not applicable

**Details of Patient and Public Involvement and/or Implications**

The terms of reference do not require public/patient involvement as they are in place to describe the purpose and structure of the group including roles and responsibilities.

**Has an Equality Analysis been completed?**

The terms of reference did not require an equality analysis as they are in place to describe the purpose and structure of the group including roles and responsibilities.
<table>
<thead>
<tr>
<th>Attachments</th>
<th>A copy of the revised terms of reference are included.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Please detail any Committees or Forums at which this paper has previously been tabled</td>
<td>The terms of reference have been discussed at both the South and North locality IFR panels.</td>
</tr>
</tbody>
</table>
INDIVIDUAL FUNDING REQUESTS PANEL

TERMS OF REFERENCE

1. Constitution

1.1 The Governing Body of NHS South Tees Clinical Commissioning Group (CCG) hereby resolve to establish an Individual Funding Request Panel (The Panel) which will report to the Quality, Performance and Finance Committee.

2. Principal Functions

2.1 The main functions of the Individual Funding Request Panel (The Panel) are as follows:

2.1.1 To consider all Individual Funding Requests and recommend to CCG Decision Makers whether to support or not support these individual requests on the basis of the information provided with the request to the Individual Funding Request Panel. Requests will be assessed for access to services within the commissioning authority of the CCG.

2.1.2 To develop and recommend clinical 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.

3. Membership

3.1 The Individual Funding Request Panel shall collectively assess requests across CCG locality areas as per Appendix 1. The collective CCG Panel will have a membership which comprises:

- Chair (Nominated CCG lay member)
- CCG decision maker from the respective CCGs (two nominated from each CCG area for cover arrangements. At least one CCG rep from any area of the panel to be in attendance. If no CCG decision maker from patient area in attendance, recommendation to be sent to CCG representative for endorsement)
Clinical Advisors from the respective CCG areas (in attendance to offer advice and technical support)

- Medicines Management representative (in attendance to offer advice and technical support)
- Mental Health and Learning Disabilities representative (in attendance to offer advice and technical support)
- Contracting/Commissioning representative (in attendance to offer advice and technical support)
- Local IFR Administrator (if not already acting in the capacity of contracting representative)

3.2 Where a Decision Maker is not present, a recommendation will be made based on the discussion held at each meeting by members of the Panel for review by the Decision Maker. Ultimate accountability however lies with the CCG Decision Maker as they have the delegated authority from the Governing Body of South Tees CCG to make funding decisions on behalf of such Board.

4. Quorum

4.1 No business shall be transacted at a meeting unless at least a Chair, two CCG decision makers and a Clinical Advisor is present. The IFR Administrator must also be in attendance and will support the presentation of cases where required and take notes of each meeting.

4.2 An Officer in attendance for an Executive Director (Officer Member) but without formal acting up status may not count towards the quorum.

4.3 If the Chair or a panel 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. Consideration/decisions can be deferred to the next meeting or, in urgent circumstances, be considered via an extraordinary meeting if required.

5. Frequency of meetings

5.1 Meetings will be convened monthly, at a time to be agreed, with the ability to call an extra Panel in the event of a backlog of cases or stand down a Panel in the event of no cases. This will be reviewed in the light of the number of applications received and the development of protocols which define criteria for approving or rejecting requests.

5.2 Three Panels will be held per month, a Cumbrian, a North and a South Panel (as outlined in appendix one).

6. Remuneration

Remuneration for those representatives that undertake this duty outside of existing roles will be made at the agreed rate in line with the relevant CCG policy or individual CCG rate as agreed with the individual concerned.
7. **Urgent Requests**

7.1 If an urgent decision is required outside of a scheduled meeting and the request cannot be heard by the alternative out of area panel or an exceptional Panel cannot be convened, the application information will be communicated to members of the Panel via secure e-mail.

7.2 The information will be anonymised and communicated to each of the Panel members via NHSnet or safehaven facsimile in line with the agreed process and a decision will be made within 5 working days of receipt.

7.3 Recommendations will be made based on feedback received by members of the Panel. Ultimate accountability however lies with the CCG decision maker as they have the delegated authority from the Quality, Performance and Finance Committee to make funding decisions on behalf of the CCG.

7.4 The decision will be securely communicated to the applicant by e-mail, facsimile, telephone or via the electronic system in place with confirmation by letter and the outcome communicated formally heard at the next available Funding Panel meeting.

8. **Reconsideration**

8.1 A reconsideration request should be made within three months of original decision, via documented correspondence stating why the reconsideration request is being made and must include any new information / evidence.

8.2 On receipt of an application for reconsideration, the IFR Administrator will screen the original application, the notes of the Panel decision, all correspondence, any new information and the reconsideration request.

8.3 Where a recommendation is made to the CCG Decision Maker that valid grounds for a reconsideration have not been established, applicants will be informed in writing.

8.4 Where it is evident that substantial new information has been made available over and above the contents of the original request, the CCG Decision Maker will confirm as to whether the request should be reconsidered within the panel or whether a decision can be reached outwith the Panel.

9 **Appeals**

9.1 Where there are grounds for an appeal hearing, i.e. where there is evidence that the Decision Maker/Panel may not have acted in accordance with the agreed IFR process, considered the relevant evidence, considered material factors only or appropriately applied the criteria in making this decision, a recommendation will be made to the CCG Decision Maker to send the case to the out of area panel.
9.2 Panel members who were present at the original IFR Panel hearing are not eligible to sit on the appeals panel, therefore an appeal hearing must be undertaken by the out of area IFR Panel for reconsideration in line with their agreed meeting schedule. The CCG responsible for the case should ensure a decision maker attends the appeals panel but this must be an alternative CCG decision maker to the original hearing.

9.3 The outcome of the appeal panel is the final decision and will be communicated by written correspondence usually within 5 working days of the appeals panel meeting. For all cases the IFR Admin as role of co-ordinator, will write on behalf of the CCG and Funding Panel, to the referring clinician, with the decision(s) and reason(s) for the decision(s) reached by the Panel. It is expected that the referring clinician will then discuss the outcome of the Panel with the patient(s) concerned.

10. Reporting

10.1 The minutes of the Panel shall be formally recorded and submitted to the Governing Body in its private section of the meeting. The Chair of the Panel shall draw to the attention the Governing Body to any issues that require disclosure to the full Governing Body.

11 Other Matters

11.1 The Panel shall be supported administratively by the IFR Admin, whose duties in this respect will include:

- Agreement of the agenda with the Chair and the collation and distribution of the papers;
- Taking the minutes and keeping a record of matters arising and issues to be carried forward;
- Circulating the minutes to all Panel members, confirmation of the minutes is required from the Chair and Clinical Advisor/CCG decision maker prior to the decision letter being sent to the referring clinician. Panel members will aim to confirm acceptance within 5 days of circulation.
- Advising the Panel on pertinent matters;
- Maintain a register of all applications considered and the outcome of each (via the electronic system in place);
- In their role as co-ordinator, will write on behalf of the CCG and Funding Panel to the referring clinician with the decision(s) and rationale(s) for the decision(s) reached by the Panel.

12 Review of Terms of Reference

12.1 The Governing Body will review these Terms of Reference annually.
## Appendix 1 - Panel Arrangements

<table>
<thead>
<tr>
<th>Panel</th>
<th>Cluster Area</th>
<th>CCG</th>
</tr>
</thead>
<tbody>
<tr>
<td>South Panel</td>
<td>Tees</td>
<td>NHS Hartlepool and Stockton-on-Tees Clinical Commissioning Group</td>
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<td></td>
<td></td>
<td>NHS South Tees Clinical Commissioning Group</td>
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<tr>
<td></td>
<td>Durham</td>
<td>NHS Durham, Dales, Easington and Sedgefield Clinical Commissioning Group</td>
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<td>NHS North Durham Clinical Commissioning Group</td>
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<td>NHS Darlington Clinical Commissioning Group</td>
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<tr>
<td>North Panel</td>
<td>North of Tyne</td>
<td>NHS Northumberland Clinical Commissioning Group</td>
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<td>NHS Newcastle West Clinical Commissioning Group</td>
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<td>NHS North Tyneside Clinical Commissioning Group</td>
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<td>South of Tyne</td>
<td>NHS South Tyneside Clinical Commissioning Group</td>
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<td></td>
<td></td>
<td>NHS Sunderland Clinical Commissioning Group</td>
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<tr>
<td></td>
<td></td>
<td>NHS Gateshead Clinical Commissioning Group</td>
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<tr>
<td>Cumbria Panel</td>
<td>Cumbria</td>
<td>NHS Cumbria Clinical Commissioning Group</td>
</tr>
</tbody>
</table>
Appendix 2 – Process Flow Charts

Flow 1 – Standard consideration process

1. Referring clinician submits request for funding
   - IFR Admin reviews request
   - Has sufficient information been provided?
     - Yes
     - No
     - Yes: Decision maker approves or declines request
     - No: IFR Admin requests additional information from referring clinician

2. Advice received from clinical advisor
   - Is request an obvious decision?
     - Yes: Decision maker approves or declines request
     - No: IFR Admin requests input from a clinical advisor

3. Advice from clinical advisor sent to decision maker for consideration
   - Decision not able to be made and case is sent to Panel by decision maker

Flow 2 – Panel Consideration Process

1. Case considered at next available Panel
   - IFR Admin produces Panel minutes and circulate to Panel members
   - Each CCG decision maker confirms minutes are accurate
   - Has a decision on funding been agreed by panel?
     - Yes: IFR Admin generates decision letter and sends to referring clinician
     - No: IFR Admin requests additional information from referring clinician

2. Additional information received
   - Information to be reconsidered by Panel
   - Decision maker approves or declines request
   - IFR Admin makes a recommendation to decision maker
   - IFR Admin generates decision letter and sends to referring clinician
Flow 3 – Reconsideration Process

Reconsideration request received from referring clinician

Was the original decision made within three months of this request

Yes

IFR Admin to process as new case

No

Is request an obvious decision?

Yes

Decision maker approves or declines reconsideration request

IFR Admin generates decision letter and sends to referring clinician

No

IFR Admin requests input from a clinical advisor

Advice received from clinical advisor

Flow 4 – Appeal Process

Appeal received from referring clinician

Does the applicant demonstrate previous consideration of the case has not followed due process?

Yes

IFR Admin assigns case to appeals section of out of area IFR Panel

IFR Admin recommends rejection of appeal and advises referring clinician accordingly

No

Out of Area IFR Panel reviews application and determines whether due process has been followed

Out of area IFR Panel confirm due process has been followed

Out of area IFR Panel agrees due process has not been followed

IFR Admin to reschedule consideration at In Area Panel

Application considered at In Area Panel
# Agenda Item: 2.4

Wednesday 29 July 2015

<table>
<thead>
<tr>
<th>Purpose of Paper</th>
<th>For Decision</th>
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<tbody>
<tr>
<td><strong>Title</strong></td>
<td>Quality, Performance &amp; Finance Committee Terms of Reference</td>
</tr>
<tr>
<td><strong>Responsible</strong></td>
<td>Jacqui Keane – Corporate Governance &amp; Risk Officer</td>
</tr>
</tbody>
</table>

## Recommendation(s)

The Governing Body is asked to ratify the decision of the Quality, Performance and Finance Committee for the approval of the amended Terms of Reference.

## Summary

As agreed by the Quality, Performance & Finance Committee, amendments have been made to the Terms of Reference as it is good governance practice to review them on an annual basis.

The Governing Body is asked to ratify the decision of the Quality, Performance & Finance Committee which approved the revised Terms of Reference on 24 June 2015.

## Financial Implications

N/A

## Legal/Regulatory Implications

Enables the Committee to carry out the duties and responsibilities delegated to it under the CCG’s constitution.

## Assurance Framework/Risk Register Implications

N/A

## Details of relationship to the NHS Constitution

N/A

## Details of Patient and Public Involvement and/or Implications

N/A

## Has an Equality Analysis been completed?

N/A

## Attachments

Quality, Performance & Finance Committee Terms of Reference

Please detail any Committees or Forums at which this paper has previously been tabled

Quality, Performance & Finance Committee – 24 June 2015
NHS South Tees Clinical Commissioning Group
Quality, Performance and Finance Committee
Terms of Reference

1. Constitution

1.1 The Quality, Performance and Finance Committee (the Committee) is established in accordance with NHS South Tees Clinical Commissioning Group’s (the CCG) constitution, standing orders and scheme of delegation. These terms of reference set out the membership, remit, responsibilities and reporting arrangements of the Committee and shall have effect as if incorporated into the Clinical Commissioning Group’s constitution and standing orders.

2. Membership

2.1 The Committee shall be appointed by the CCG as set out in the CCG’s constitution and shall include core CCG members made up of the Accountable Officer, the Chief Finance Officer, the Executive Nurse responsible for quality and safeguarding, at least 2 GP Members of the Governing Body along with individuals who are not core members of the CCG such as nominated members of the Commissioning Support Service to include Senior Commissioning, Provider and Finance Managers where appropriate.

2.2 Other members may be co-opted onto the Committee and may serve in an advisory capacity only e.g. Workstream Leads.

2.3 The Secondary Care Doctor will Chair the Committee. However, in the absence of the Secondary Care Doctor, another member of the Governing Body will Chair the Committee, as agreed by the Chair and Chief Officer.

3. Secretary

3.1 The Secretary to the Committee shall attend to take minutes of the meeting and will be responsible for drawing the Committee’s attention to best practice, national guidance and other relevant documents as appropriate.
4. **Quorum**

4.1 No business shall be transacted at a meeting unless at least three of the core members are present, to include the Accountable Officer or the Chief Finance Officer and one member of the Governing Body.

4.2 In addition, the quorum shall include representation from individuals with expertise in each of the portfolio areas namely quality, performance and finance to provide advice to the Committee and/or participate in decision making. These individuals may be the relevant core members identified in 2.1, but if the core member leading one of these portfolio areas has sent apologies to the meeting, then a deputy must be in attendance.

5. **Frequency and notice of meetings**

5.1 The Committee must consider the frequency and timing of meetings needed to allow it to discharge all of its responsibilities. A benchmark of six meetings per annum at appropriate times in the reporting is suggested.

6. **Remit and responsibilities of the Committee**

6.1 The Committee is responsible for assuring the Governing Body that commissioned services are being delivered in a high quality and safe manner, and performance is managed according to the agreed terms of the Service Agreements and Legally Binding Contracts and that appropriate corrective action is being taken to address areas of underperformance, including changes to future contracts where necessary.

6.2 This includes ensuring that services commissioned:
- Are safe, effective and deliver a positive experience for patients
- Deliver continuous improvement in quality
- Operate within the agreed financial control totals
- Deliver the QIPP (quality, innovation, productivity and prevention) challenge within financial resources, in line with national requirements (including excellent outcomes), and local joint health and wellbeing strategies
- Fulfil their statutory responsibilities with regards to safeguarding

6.3 For the remainder of this document the term “contract” may be taken to cover all forms of agreements with providers of services, irrespective of whether that agreement is legally binding.

6.4 Principal duties include:
Quality Improvement and Assurance

- Provide assurance to the Governing Body that commissioned services are being delivered in a high quality and safe manner
- Oversee and be assured that effective management of risk is in place to manage and address clinical governance issues.
- Have oversight of the process and compliance issues concerning serious untoward incidents requiring investigation (SUI’s); being informed of all Never Events and informing the Governing Body of any escalation or sensitive issues in a timely manner.
- Provide the Governing Body with assurance that appropriate systems and processes are in place for safeguarding
- Seek assurance on the performance of NHS organisations in terms of the Care Quality Commission, Monitor and any other relevant regulatory bodies.
- Receive and scrutinise independent investigation reports relating to patient safety issues and agree publication plans.
- Ensure a clear escalation process, including appropriate trigger points, is in place to enable appropriate engagement of external bodies on areas of concern.
- Ensure that appropriate CQUIN schemes are negotiated into contracts where appropriate and that a robust process of validation of providers’ compliance is in place throughout the year;
- Consider reports on CQUIN performance by exception which identify those elements of CQUIN that have not been achieved within the expected timescales or any concern regarding the general quality of services being delivered by any particular provider.

Finance, Contract Monitoring and Performance

- To provide assurance that CCG is managing within its financial allotments including managing within the amount specified. To ensure that the allocation of the CCG is optimised and offers value for money (ie being used effectively, efficiently and economically).
- Oversee and be assured that effective management of risk in relation to finance, contracts and performance, in particular QIPP
- Ensure that contract performance is monitored on a monthly basis (monthly is the default – other periods may be agreed for certain contract types as appropriate).
- Explore and test explanations for significant variations from plan including the robustness of demand management initiatives.
- Ensure that actual and forecast contract over-performance or under-performance is quantified in financial terms and activity terms.
- Maintain an overview of all KPIs and quality standards in each contract
- Agree which of the underperforming contracts need to be brought to the attention of the Governing Body for further discussion
• Monitor the delivery of the QIPP (quality, innovation, productivity and prevention) challenge within financial resources, in line with national requirements (including excellent outcomes).
• The QPF Committee shall approve budgets for GVIS.
• Receive and consider the Minutes from the Independent Funding Review Panel.

Contract Development
• Make suggestions for amendments to future contracts in light of ongoing contract management issues

Contract Enforcement and Remedy
• Ensure that robust arrangements are in place to ensure that providers are immediately alerted to any deviation from the planned level of performance and that robust action plans to remedy the situation are developed
• Ensure that any failure by a provider to fulfil the terms of its contract results in the enforcement of whatever contractual remedies are applicable. Exceptionally the Committee may make recommendations to the Governing Body regarding waiving the enforcement of such remedies.

Patient Involvement and Engagement
• Review the adequacy and effectiveness of arrangements for monitoring local performance against national quality metrics relating to patient experience, communication and engagement and ensure patient and public views are considered as part of the process
• Receive regular reports on the CCG’s work on public and patient engagement.

7. Relationship with Governing Body and other Committees

7.1 The minutes of the Committee meetings shall be formally recorded by the Secretary and submitted to the In-Committee section of the Governing Body. Members of the Committee should declare any conflicts of interest and the Secretary should minute them accordingly. The Chair of the Committee shall draw to the attention of the Governing Body any issues that require disclosure to the relevant statutory body, or require executive action.

7.2 To receive regular reports from the other supporting groups including the Quality and Safeguarding group.

7.3 To receive the minutes from supporting groups.
8. **Conduct of the Committee**

8.1 The Committee shall conduct its business in accordance with national guidance, relevant codes of practice including the Nolan Principles and the Conflict of Interest policy.

8.2 An annual report of its performance, membership and terms of reference will be submitted to the Governing Body, either as an independent report or via the CCG’s Annual Report.

9. **Other Governance Issues**

9.1 Due to the commercial sensitivity of the information being discussed, all papers will be treated as commercial in confidence.

9.2 All members must declare any interests, which will be included in the minutes of the meetings and where there is a conflict of interest the Chair will notify the member whether they should withdraw from the meeting, the discussion and/or voting.

10. **Annual General Meeting**

10.1 The Chair of the Committee will attend the Annual General Meeting prepared to respond to any questions on the Committee’s activities.

Approved: February 2014
Ratified: March 2014
Re-reviewed: June 2014
Ratified by Governing Body: July 2014
Review: June 2015
Ratified by Governing Body - TBC
**NHS South Tees Clinical Commissioning Group**

**Governing Body**

**Agenda Item: 3.1**

**Wednesday 29 July 2015**

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<th>Purpose of Paper</th>
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<tbody>
<tr>
<td>Title</td>
<td>Quality and Safeguarding Report</td>
</tr>
<tr>
<td>Responsible</td>
<td>Jean Golightly, Executive Nurse</td>
</tr>
<tr>
<td>Author of the Report</td>
<td>Jean Golightly, Executive Nurse</td>
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<td>Recommendation(s)</td>
<td>The Governing Body to receive the report and note its contents</td>
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**Summary**

Key Quality and Safeguarding issues for the CCG

1. The CQC report following December 2014 inspection of South Tees Hospitals NHS Foundation Trust (STHFT) published and the overall grading is “Requires Improvement”.
2. The regulator Monitor has published details of further regulatory actions for STHFT in relation to their license conditions.

**Financial Implications**

N/A

**Legal/Regulatory Implications**

- Health and Social Care Act 2012, “quality duty”
- No Secrets’ (2000) guidance
- Mental Capacity Act 2005
- Mental Capacity Act Deprivation of Liberty Safeguards (MCA Dols) 2009
- Human Rights Act 1998
- Equality Act 2010
- Safeguarding Vulnerable Groups Act 2006
- Care Act 2014

**Assurance Framework/Risk Register Implications**

Quality issues as they arise are risk assessed and placed on the corporate risk register in accordance with CCG requirements

**Details of relationship to the NHS Constitution**

The NHS aspires to the highest standards of excellence and professionalism. 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 aspires to put patients at the heart of everything it does. Values: Working together for patients, commitment to quality of care

**Details of Patient and Public Involvement and/or Implications**

As part of delivering the Quality Agenda, patients and the public are involved in providing assurance of the quality of care delivered by the CCG’s commissioned services

**Has an Equality Analysis been completed?**

Not applicable

**Attachments**

None

**Please detail any Committees or Forums at which this paper has previously been tabled**

Information has previously been routed through QPF committee
1.0 Purpose of report
The purpose of this report is to provide NHS South Tees Clinical Commissioning Group (STCCG) Governing Body with a Quality and Safeguarding exception report which headlines the key issues within the CCG’s commissioned services and provides assurance that actions are being undertaken where appropriate. This paper reflects the position as at the end of May 2015.

2.0 Introduction
This report provides information pertaining to the CCG’s main healthcare providers with an NHS contract:

2.1 South Tees Hospitals NHS Foundation Trust (STHFT)
2.2 Tees, Esk and Wear Valley NHS Foundation Trust (TEWVFT)
2.3 North East Ambulance Service (NEASFT)
2.4 Where appropriate independent sector providers are also included.

Additional information is also included in relation to the CCG’s statutory duties and responsibilities in relation to Safeguarding Children and Adults.

3.0 Key Quality and Safeguarding issues for the CCG
3.1 The Care Quality Commission (CQC) report following December 2014 inspection of STHFT published and the overall grading is “Requires Improvement”.
3.2 The regulator Monitor has published details of further regulatory actions for STHFT in relation to their license conditions.

4.0 NHS South Tees Hospitals Foundation Trust (STHFT)
4.1 Regulator Actions
4.1.1 CQC: Following their inspection of the whole Trust in December 2014 the CQC has now published the report of their findings on their website. This is available on the following link:
http://www.cqc.org.uk/provider/RTR

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<thead>
<tr>
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<td>Are services at this trust responsive?</td>
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<td>Are services at this trust well-led?</td>
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4.1.1.1 As Lead Commissioner for this provider STCCG will work in conjunction with the Trust and other Commissioners to assist with the development and subsequent monitoring of an appropriate action plan to address the requirements for improvement.

4.1.2 Monitor: The Trust were found to be in breach of their license conditions in October 2013 due to failure to achieve the referral to treatment 18 week target for admitted patients, rate of Clostridium difficile infection, mortality
rate, and Never events. Subsequently the concerns were widened to include the financial deficit.

4.1.2.1 Improvements were seen in all the above areas with the exception of Clostridium Difficile (C Diff) infection rates, with the Trust exceeding their performance trajectory for 2014-15, and continuing to exceed this in 2015-16 for year to date. In June 2015 Monitor increased the scope of its regulatory action at the Trust to include the following required actions:

4.1.2.1.1 **The trust will receive expert help to develop and implement an improved plan to cut rates of C.difficile infection, following enforcement action by the health sector regulator.**

4.1.2.1.2 **The trust’s leadership will have to report back to Monitor on a monthly basis and make sure that the improvements are sustainable.**

4.1.2.1.3 **If improvements in infection control are not made and sustained the regulator may take further action.**

4.1.2.2 STCCG continue to work closely with the Trust and other CCGs to investigate and address these continuing quality and performance issues.

4.2 Mortality: The NHSE Quality dashboard continues to show the Trust as an outlier for Hospital Standardised Mortality Ratio (HSMR). Previous Governing Body Quality reports have contained detailed information about the actions underway to both investigate and address this concern.

4.3 Healthcare acquired infection (HCAI)

4.3.1 Methicillin Resistant Staphylococcus Aureus (MRSA): For the year 2015-16 to date the Trust has reported 2 hospital acquired bacteraemia cases associated with this organism. On appeal, 1 case was subsequently attributed to another CCG. As the Trust had 4 cases during 2014-15 it remains a concern that the policies and protocols for prevention, early identification and decolonisation appear to still require further work to embed them into routine practice.

4.3.2 Clostridium Difficile (C diff): Due to the Trust’s continuing poor performance against this year’s increased annual trajectory Monitor have issued further regulatory actions in respect of the Trust’s breach of its license conditions. Details have been provided above under the Regulator: Monitor section.

4.3.2.1 STCCG working with Hambleton, Richmondshire and Whitby CCG (HRWCCG), and other CCGs are also reviewing their own programmes and actions to identify additional opportunities to support improvements for patients. It is planned to coordinate these for maximum impact across the whole healthcare system and will result in a combined CCG C diff action plan.
4.3.2.2 As the impact of this issue is a concern for a number of CCGs across a large and diverse geographic area, it will continue to be an area of significant joint work for all health organisations. The Public Health England (PHE) Antibiotic prescribing event for hospital consultants and GPs scheduled for July 2015 will be an indication of the close cooperation to follow.

5.0 NHS North East Ambulance Service Foundation Trust (NEASFT)

5.1 Patient Safety Serious Incidents (SIs): The Trust continues to have low level reporting of SIs and this has shown no improvement on 2014-15 figures, with 29 incidents reported in both years. Following discussion at the March 2015 Clinical Quality Review Group (CQRG), the Trust has shared their fundamental review of the processes and governance structures supporting this area of work and this is expected to be visible in their newly formatted Experience, Complaints, Litigation and Incidents & PALS (ECLIPs) Report. STCCG Executive Nurse has continued to express her concern at the extended period that some of the SIs has remained open and the NEAS responsible Executive has agreed to investigate further.

5.2 Regulatory: Care Quality Commission (CQC) has accepted the latest action plan showing completion of all required actions in relation to the recommendations from their last visit. They plan to undertake a further visit to the Trust in Quarter 4, 2015-16 as part of their routine cycle.

5.3 The July CQRG meeting is scheduled to include a discussion to evaluate the Winter Pressures schemes. Early indications are that some of these schemes have been very innovative, and subsequently well received by patients and staff.

5.4 111: As the NHS 111 Regional Clinical Governance meeting continues to provide a nationally respected approach to reviewing the service it has been agreed to continue reporting this via the CQRG.

5.5 The Star Chamber meeting to review and approve the process of cost improvement quality impact analysis took place on the 14th April 2015. Detailed information was provided by the Trust on the cost improvement schemes and subsequent information has been provided to increase the level of assurance derived. Moving forward outstanding schemes are to be discussed at CQRGs throughout the year.

6.0 NHS Tees, Esk and Wear Valley Foundation Trust (TEWVFT)

6.1 Patient Safety Serious Incidents (SIs): The NHSE commissioned Independent Investigation into the Mental Health Homicide (Mr.F) was published in June 2015. The Trust has reviewed this and produced an action plan to address the report recommendations.

6.1.1 Working in conjunction with the NHSE Regional Investigation team, Lead Commissioner STCCG is undertaking a review of all TEWVFT Mental Health Homicides to identify any associated themes from the incidents and related case action plans. It is anticipated that this information will be used to inform an extraordinary CQRG with the Trust and also subsequent Commissioner Assurance Visits (CAV).

6.2 Adult and Children's Safeguarding training compliance. Concerns around the compliance levels with mandatory training were raised via CQRG. Following escalation to the Contract Management Board (CMB) a subsequent analysis and remedial action programme were presented at the May CQRG. Although acknowledged as a high priority area for action within the local Senior Management Team, with concomitant Trust Board awareness and scrutiny, the Trust has yet to achieve the compliance levels that are nationally recommended and contractually mandated. This will be discussed in depth at the July CQRG and next steps considered.

6.3 Regulators: Care Quality Commission (CQC)
6.3.1 Following their inspection in January 2015 they have received an overall Trust rating of “Good” for their services provided. Inspectors judged the care provided by staff to be good across all the core services.

6.3.2 The CQC highlighted that the trust had a strong leadership team that promoted the delivery of good quality care with a clear statement of vision and values.

6.3.3 Some areas for improvement or concern were noted and the Trust has submitted actions plans to the CQC to address these. These will be discussed further at the forthcoming CQRG meeting on the 16 July.

7.0 Safeguarding

7.1 Adult Safeguarding

7.1.1 Partnerships:

7.1.1.1 Teesside Safeguarding Vulnerable Adults Board (TSVAB) development day took place in June; topics discussed were development of a vision, strategy, business plan, annual report and building links between the Board and Local Executive Groups.

7.1.2 Middlesbrough Local Executive Group (LEG):

7.1.2.1 The Chair informed the meeting that the CQC had informed the TSAB that they would attend meetings twice a year and Tees Safeguarding Adults Board (TSAB) members had been requested to inform the Business Unit with any relevant items for discussion with CQC.

7.1.2.2 STHFT reported having a new Safeguarding Policy as of 1st April, new procedures have been implemented. A key difference is that the Matrons are now the first point of contact for the centre.

7.1.2.3 As part of the outcomes from a Serious Case Review (SCR) last year, Middlesbrough Borough Council (MBC) has undergone a Lessons Learned Review. Currently there are no guidelines in relation to Lessons learned Reviews as it was agreed by the TSAB to put on hold formal arrangements, until the current Hartlepool case was concluded. An update is to be presented at the next TSAB meeting.

7.1.2.4 It was reported by Adult Safeguarding Manager, NECS that all Clinical Quality Audits and reviews will be completed by September 2015, for all care homes with nursing beds provision. Reviews are shared with MBC and CQC and discussed at the monthly professional intelligence sharing meetings. The main issues noted during audits are in relation to documentation of records, medication, training & competencies of staff.

7.1.3 Middlesbrough Borough Council (MBC): Multiagency Safeguarding Adults activity

7.1.3.1 A provider of nursing care within Middlesbrough who has placed a voluntary suspension on admissions into the home and will undertake an internal investigation into concerns raised by the Local Authority following an Adult Safeguarding Alert. Social Worker and Adult Safeguarding Lead for STCCG will monitor the home and action plan produced by the Provider, prior to next multi professional meeting.

7.1.4 Redcar and Cleveland Local Executive Group (LEG): Multiagency Safeguarding activity
7.1.4.1 It was reported that the Transforming Care agenda led by NHSE has been implemented through the sub regions over the past 6 months resulting in a number of people being discharged from inpatient beds. NHSE has set up a Regional Task Force Group which will be looking at the Commissioning Framework to ensure that people are appropriately placed into new patient settings or discharged safely and with the necessary support.

7.1.4.2 The NHS Accountability Framework for safeguarding was published in June 2015. The refreshed document is built upon the original in relation to roles and responsibilities (NHSE and CCG) in accordance with the safeguarding agenda, leadership, assurance, statutory duties etc.

7.1.4.3 Safeguarding awareness campaigns were discussed by the LEG and the Business Unit reported they were trying to establish a consistent approach to reporting arrangements within the LEG meetings and this had been raised with the Performance Audit and Quality (PAQ) Sub-Group.

7.1.4.4 Redcar & Cleveland Borough Council (RCBC) reported as having a designated Deprivation of Liberty's (DoLS) Team in place with 3 primary Best Interest Assessors who deal solely with DoLS Referrals.

7.1.4.5 It was noted that the CQC would be attending 2 meetings a year of the TSAB.

7.1.4.6 All Clinical Quality Audits and action plan reviews within Care Homes with nursing beds will be completed by the CCG in September 2015.

7.1.5 Redcar and Cleveland Borough Council (RCBC): Multiagency Safeguarding Adults activity
7.1.5.1 There is currently 1 provider of Learning Disability care within RCBC who was recently placed into Serious Concerns Protocol (SCP) due to a number of Safeguarding Alerts received, suspension in place for any new potential admissions. The home is being closely monitored against action plans submitted by the provider by RCBC and the CCG, a further SCP meeting is arranged for August 2015.

7.2 Safeguarding Children on Teesside:
7.2.1 Serious Case Reviews (SCR): From the 4 recent SCR undertaken on Teesside (2 in Stockton, 1 in Middlesbrough and 1 in Redcar & Cleveland) a number of common and recurring themes have emerged which are summarised below:
7.2.1.1 Neglect is a common denominator in all the cases;
7.2.1.2 Drugs and alcohol misuse by parents/carers along with neglect results is a Toxic combination for children.

7.2.2 Issues highlighted in SCRs especially for health are:
7.2.2.1 Communication between health professionals to other safeguarding agencies e.g. social services.
7.2.2.2 Failure to bring children to health appointments (Did Not Attends) and lack of robust pathways to tackle the issue of children lost to follow-up.
7.2.2.3 Over-empathy with parents/carers leading to professional optimism and missing disguised compliance.
7.2.2.4 Lack of direct work with children therefore not eliciting the “Voice of the Child”.
7.2.2.5 Inconsistency in the understanding and applications of thresholds in regards to neglect and poor understanding of neglect by the professionals.
7.2.2.6 Inconsistent risk assessment and professional challenge.
7.2.2.7 Child Protections Plans should only be discontinued when in a multi-professional setting it is judged that the child is no longer suffering or likely to suffer significant harm.

7.2.3 Failure to bring children for health appointments (Did Not Attend (DNA)); DNA of children has been a recurring issue and this has been repeatedly raised in SCRs. Following recommendations from the recent SCRs NTHFT, STHFT & TEWVFHT have revised and finalised their DNA Pathways. Initial feedback from NTHFT & STHFT indicates that it is working well in the Paediatric Department and it is being rolled out and monitored in other departments which see children as well as seeing adults who have care of children.

7.2.4 Initial Health Assessment (IHA) of Looked after Children (LAC) is not well streamlined in either NTHFT or STHFT. A recent audit of IHA showed that the requirement for IHA is not being met in either of the Foundation Trusts. The audit recommendation is to be monitored by the Designated Nurse for LAC.

7.2.5 There are on-going discussions regarding the examination of historic child sexual abuse cases in NTHFT as the Consultant Paediatricians feel that they do not see sufficient numbers of cases to maintain their competency in this field of work. It is anticipated that this work will need to be undertaken by STHFT.

7.3 Local Safeguarding Children’s Board (LSCB) Data: The number of children with a Child Protection Plan, Children in Need and Looked After Children remain much higher in all the 4 LSCBs on Tees as compared to the National and Regional numbers.

7.3.1 Neglect is the most common category for children under Child Protection Plan.

7.4 Key Themes from LSCBs Development Sessions: Early Help Strategy, Communication, Interagency Working, Review of the current effectiveness of the LSCBs and how they can be more effective, How to capture effectively the voice of the child, and significant challenges from Neglect, Domestic Violence, Substance Misuse and Child Sexual Exploitation.

9.0. Recommendation
The Governing Body is asked to receive this report for information and discussion.

Author:
Jean Golightly, Executive Nurse
July 2015
## Purpose of Paper

### For Discussion

<table>
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<th>Title</th>
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<tr>
<td>Responsible</td>
<td>Jean Golightly, Executive Nurse, NHS South Tees CCG</td>
</tr>
<tr>
<td>Author of the Report</td>
<td>Chris Brown, Head of Quality and Safeguarding, NHS South Tees CCG</td>
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<tr>
<td>Recommendation(s)</td>
<td>To note its contents and approve the Annual Safeguarding Children and Adults report 2014-15.</td>
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### Summary

This report provides the governing bodies of NHS Hartlepool and Stockton-On-Tees Clinical Commissioning Group (HAST CCG) and NHS South Tees Clinical Commissioning Group (ST CCG) with assurance that they are compliant with their statutory duties and responsibilities in relation to safeguarding children, looked after children and adults at risk of abuse or neglect. Evidence includes:
- Leadership
- Collaborative & system wide working
- Policies, procedures
- Commissioned Services, monitoring & compliance
- Support, advice and guidance

The key challenges, achievements in 2014/15 and the safeguarding objectives, for 2015/16 are also outlined.

### Financial Implications

Contributions to the Local Safeguarding Children Boards (LSCBs) and the Teeswide Safeguarding Adult Board (TSAB) are detailed in the report.

### Legal/Regulatory Implications

- Children Act 1989, 2004
- Care Act 2014
- Human Rights Act 1998
- Equality Act 2010
- Mental Capacity Act 2005
- Deprivation of Liberty Safeguards, 2009

### Assurance Framework/Risk Register Implications

The corporate risks in relation to the vacant post of Designated Doctor LAC and the absence of a named GP, children are included on the risk register.

### Details of relationship to the NHS Constitution

It relates to the following principles: The NHS aspires to put patients at the heart of everything it does. The NHS works across organisational boundaries and in partnership with other organisations in the interest of patients, local communities and the wider population. The NHS is accountable to the public, communities and patients that it serves.

### Details of Patient and Public Involvement and/or Implications

Safeguarding Boards provide public information in relation to its activity and involve/consult with representatives.

### Has an Equality Analysis been completed?

N/A
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<th>Attachments</th>
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1. **Purpose of the Report**

1.1 This report provides the governing bodies of NHS Hartlepool and Stockton-on-Tees Clinical Commissioning Group (HAST CCG) and NHS South Tees Clinical Commissioning Group (ST CCG) with assurance that they are compliant with their statutory duties and responsibilities in relation to safeguarding children, looked after children and adults at risk of abuse or neglect.

The report delivers:

- an overview and analysis of safeguarding children, looked after children and adults at risk of neglect and abuse activity;
- an outline of the national context and the statutory requirements of the Clinical Commissioning Group (CCG) as a health commissioner;
- how the CCG’s demonstrate leadership, collaborative and system wide working and effective implementation of quality assurance processes in relation to its commissioned health services during the reporting period 1st April 2014 – 31st March 2015 and;
- the key challenges and achievements, and also sets out the CCGs safeguarding key objectives for 2015-2016.

The report is underpinned by the CCGs Safeguarding Work Programmes for this period.

The report is structured to address in the first instance:

- safeguarding children, and looked after children,
- safeguarding adults

2. **Safeguarding Children and Looked After Children**

2.1. **National Context, Legislation and Statutory Guidance**

2.1.1. **Safeguarding Children**

The Children Act (1989 & 2004) continues to provide the legal framework for safeguarding children. **Section 11** of the Act places specific duties on a range of organisations, including the NHS, to ensure their functions, and any services that they contract out to others, are discharged having regard to the need to safeguard and promote the welfare of children. This key legislation is supported by statutory and other supplementary guidance.

Working Together 2013 provides the key statutory guidance on how agencies should work together to safeguard children. The guidance clearly identifies that
CCGs, as major commissioners of local health services, are responsible for safeguarding quality assurance through contractual arrangements with all their provider organisations.

It also states that CCGs, ‘should employ, or have in place, a contractual agreement to secure the expertise of designated professionals, i.e. designated doctors and nurses for safeguarding children and for looked after children’.

This statutory guidance was updated in March 2015.

HAST CCG and ST CCG have agreed joint arrangements, with a Designated Nurse for Safeguarding and Looked After Children (LAC) and Designated Doctors for Safeguarding Children in post. Following a review, in February 2015, it was agreed by both CCGs that the resource for the Designated Nurse and LAC would be increased to 2 posts, which will generate capacity for the CCGs, with each CCG having its own designated post holder. There is a Memorandum of Understanding (MOU) in place, with HAST CCG as the host employer for the posts of Executive Nurse, Designated Doctor, and Head of Quality and Safeguarding (Designated professional adults). ST CCG employs its own Designated Nurse, safeguarding children and LAC.

In addition, the Designated Nurse has received support from the Safeguarding Children Officer (SCO) who is employed by the North of England Commissioning Support Unit (NECS). This arrangement provides the dedicated resource to assist the CCGs in fulfilling their statutory duties and responsibilities. The SCO has significant experience in operational safeguarding children and LAC practice within health.

There are currently no Named General Practitioners (GPs) for Safeguarding Children across Tees. Although this is not a statutory requirement it is acknowledged in the Accountability Framework: Safeguarding Vulnerable People in a reformed NHS (2013) as an important role to drive up the quality of Primary Care’s contribution to safeguarding children. The safeguarding children professionals in the CCGs and supported by NECS have continued to work with NHS England Cumbria and North East (NHSE) during 2014-15 to mitigate against any potential risks. NHSE commenced consultation on proposals to refresh the Accountability Framework: Safeguarding Vulnerable People in a reformed NHS in March 2015, the CCGs have provided feedback to NHSE and will ensure compliance with any changes post April 2015 on its publication.

2.1.2. Looked After Children (LAC)

The Children Act 1989 (2004) stipulates that health commissioners have a duty to comply with requests from the local authority to help them to provide support and services to children in need (which includes LAC). In addition, the NHSE
Accountability and Assurance Framework in a reformed NHS (2013) underlines this statutory responsibility.

The Department for Children Schools Families Statutory Guidance on Promoting the Health and Wellbeing of LAC (2009, DCSF) contains a number of commissioner assurances relating to the health of LAC (Section 9 of the guidance).

A Designated Doctor for LAC is not in post in the CCGs and as such this is out of line with the recommendations from DCSF’s Statutory Guidance. The CCGs Executive Nurse and Designated Nurse have provided leadership, support and input to mitigate against any potential risks during the year. Regular updates have been provided to each of the CCGs governing bodies Governance and Risk Committees throughout this period.

2.2. Safeguarding Children and Looked After Children and Commissioned Services

2.2.1. NHS Provider Trusts commissioned by the CCGs

During 2014/15 the Designated Professionals have offered and provided expert advice, support, and developmental guidance in relation to safeguarding and LAC to provider organisations commissioned by the CCGs.

The key activity undertaken is outlined below:

- Attendance at bimonthly/quarterly North Tees and Hartlepool NHS Foundation Trust (NTHFT), South Tees Hospitals NHS Foundation Trust (STHFT) and Tees and Esk Wear Valleys (TEWV) Mental Health Trust, Safeguarding Children Governance Groups. This allows the Designated Professionals to have an overview of issues across the health economy.

- Provision of expert advice to Safeguarding Children Teams in particularly complex cases or in cases that are likely to be of interest to the media, liaising with the CCG and Communications Teams in NECS.

- Following their introduction in 2013/14, the Designated Nurse has led and firmly established as chair the following CCG/Provider health forums across Tees:
  - Tees Wide Designated Nurse and Named Nurse Safeguarding Children Forum.
  - Designated Professionals and Named Doctor Safeguarding Children Group
• Tees Wide Looked After Children LAC) Health Professionals Forum

• The Designated Nurse has continued quarterly 1:1 meetings with the Named Nurses/ Lead Senior Nurses for Safeguarding and Looked After Children in TEWV, STHFT and NTHFT. These meetings have provided a key mechanism for the CCG and Providers to work together to resolve issues as well as address identified areas for development.

The areas of specific note resulting from these forums which resulted in actions for NHS Trust providers are outlined below:

• Child Sexual exploitation (CSE) - health services role, responsibilities, and expectations regarding local processes and associated pathways (including relevant and appropriate information sharing not just in relation to children) was clarified with initiation thereafter by Trust health providers.

• The Lampard report (February 2015), produced as a result of the Saville investigation, its findings and recommendations for Trust providers was highlighted, with a clear signal of commissioner expectations, with the submission of Trust evidence of implementation, subsequently provided as part of the CCGs quality assurance processes.

The Designated Doctor (safeguarding children) also attends monthly child protection peer review meetings at NTHFT providing group supervision to paediatricians.

2.2.2. Non-NHS Providers

The Safeguarding Children Team has continued to provide expert advice and assistance to Public Health Commissioning Managers specifically in relation to Sexual Health Services, following a Care Quality Commission Children Looked After and Safeguarding review (CLAS) in Stockton in 2013/14. This has centred specifically on monitoring progress against the service’s actions which are detailed in the CCG Commissioner led action plan. The implementation of this action plan and outcomes has been shared across Tees via the 4 Local Safeguarding Children’s Boards (LSCBs).

2.3. Primary Care (General Practice)

Although the CCG do not commission Primary Care, the NHSE Accountability and Assurance Framework (2013) is clear that the Designated Professionals should work closely with NHSE to drive up the quality of safeguarding practice in Primary Care. The Designated Nurse and SCO have worked closely with NHSE Cumbria and North East to support this aim in General Practice (GP) across Teesside. A Safeguarding Children and General Practice Action Plan is in place, key aspects focused upon in 2014/15 are:
- Safeguarding children training for GPs/Practice staff, which was funded and commissioned on a non-recurrent basis by NHSE, securing an external trainer who provided, ‘face to face’ single agency training, at level 2 and level 3, and;

- The continuation of a programme of GP Practice Safeguarding and LAC support visits which are based on the GP Safeguarding Children and Young People toolkit. The total number of visits undertaken between 1.4.15 and 31.3.15 is outlined in Table 1 below:

<table>
<thead>
<tr>
<th>CCG</th>
<th>Area</th>
<th>Number of GP Practices</th>
<th>Number of Visits completed 2013/14</th>
<th>Number of Visits completed 2014/2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>HAST CCG</td>
<td>Stockton</td>
<td>25</td>
<td>3</td>
<td>15</td>
</tr>
<tr>
<td></td>
<td>Hartlepool</td>
<td>15</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>ST CCG</td>
<td>Middlesbrough</td>
<td>25*</td>
<td>6</td>
<td>12</td>
</tr>
<tr>
<td></td>
<td>Redcar &amp;</td>
<td>24*</td>
<td>4</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>Cleveland</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Total</strong></td>
<td><strong>89</strong></td>
<td><strong>14</strong></td>
<td><strong>38</strong></td>
</tr>
</tbody>
</table>

Table 1: Total number of GP Practice Support visits, 2013/14 and 2014/15

NB: *GP practice profile for ST CCG has changed during 2014/15, with only 46 GP practices in ST CCG. Total number of GP practices across Tees is now 86.

Quarterly reports have been produced by the SCO to demonstrate implementation of the action plan, detailing activity relating to training, attendance and feedback; and outlining outcomes from the support visits.

A summary of priority actions, identified as result of the above is detailed below:

1. **Community Link Practitioners** - to undertake a review of the current information sharing processes between community practitioners i.e. Health Visitors, Community Nurses and School Nurses) with Primary Care. Primarily this is aimed at improving information sharing regarding the care of vulnerable children and their families.

2. **Record keeping** – To develop a registration form which will provide basic details for the GP in identifying vulnerable children (including ‘looked after’ status and private fostering arrangements) in line with the recommendations following the Climbié Inquiry.
3. **GP training** – Building on the success of the 2014/15 externally commissioned training, to clarify NHSE funding and commissioning intentions in 2015/16 in relation to the safeguarding children training programme for Primary Care (GP Practices)

The Safeguarding Children and General Practice Action Plan will be refreshed in 2015/16 to reflect any outstanding actions, and progressed in collaboration with NHSE.

In addition, the Guidance for Health Professionals Protocol for the management of Injuries or bleeding in an Immobile Child who present in Primary Care/ Community settings (2014); spearheaded by the Designated Nurse and endorsed by the 4 LSCBs in 2014, has been shared with GP practices through the support visits, training and via the Local Medical Council (LMC). This is published on the Tees LSCBs procedures website.

http://www.teescpp.org.uk/guidance

The introduction of a new GP Strategy Pro Forma, also led by the Designated Nurse, and endorsed by all 4 LSCBs is to be formally shared with GP practices, April 2015 onwards.

2.4. **Work within the Clinical Commissioning Groups (CCGs)**

2.4.1. **Quality Assurance.**

The Designated Nurse has worked closely with the Executive Nurse and colleagues in NECS to refine and establish effective systems, and processes to ensure the CCGs are in receipt of regular information and subsequent assurances relating to children’s safeguarding and LAC. The following which are now routinely in place, is consistent with the principles of the CCGs Quality Strategic Framework (QSF):

- The provision of monthly reports to inform the CCGs respective Delivery and Executive team meetings and bi-monthly reports to the governing bodies Quality, Performance and Finance Committees (QPF). Information includes an update relating to the Safeguarding Children and LAC Work Programme, identification of specific issues relating to provider organisations; partner agencies (particularly via Local Safeguarding Children Boards (LSCBs), whilst also referring to Serious Case Reviews/ Learning Lessons Reviews (SCR/LLR) and statutory inspection activity.

- Providing constructive challenge and scrutiny at the bi-monthly/quarterly Clinical Quality Review Groups (CQRG), a sub group of the CCGs Contract Management Board (CMB) when the agenda is relevant to Safeguarding and LAC. This supports effective triangulation of information taking account
of provider’s submitted reports, and soft intelligence from a range of sources including partner agencies and LSCBs. Key areas in 2014/15 that have been subject to challenge relate to Providers compliance with the CCGs Local Quality Indicator (LQI) requirements pertaining to Safeguarding Children and LAC training. This has resulted in escalation to the relevant CCG Contract Management Board (CMB) Trust meetings and intensified scrutiny and monitoring.

- Annual review and refresh of the Local Quality Indicator (LQI) requirements pertaining to Safeguarding Children and LAC which are negotiated into all commissioned services contracts, effective from 1st April 2015. Each provider evidences compliance against these through submission of a regular Governance or Quality report in accordance with contractual requirements.

- Alongside CCG clinical professionals and NECS colleagues the Designated Nurse attends and contributes to Provider Assurance visits, gaining assurance through the testing of internal safeguarding children and LAC arrangements, ensuring policies, procedures are understood and implemented by frontline staff delivering care and treatment to patients.

In addition attention has centred on:

2.4.2. Workforce (CCG Mandatory Training)

The CCGs compliance with safeguarding children’s training for the period 01.04.14 -31.03.15 is as follows.

HAST CCG compliance with level 1, children’s safeguarding training was 100%, with 24/24 individuals completing this foundation level. Children’s safeguarding refresher training must be completed every 3 years in accordance with the Children’s Safeguarding Policy. This data reflects compliance within the 3 year cycle.

ST CCG compliance with level 1, children’s safeguarding training was 100%, with 16/16 staff members completing this foundation level.

The Executive Nurse and the Designated Professionals are compliant with level 2 and level 3 training.

2.4.3. Briefings – National investigations, Independent Inquiries and reports

The CCGs have received briefings produced by the Designated Nurse, referencing the implications for the CCGs in relation to:

- The Lampard report (February 2013)
The Independent Inquiry into CSE in Rotherham

2.4.4. Internal Audit outcome and recommendations

The CCGs received the outcome of Audit North’s (AN) internal audit of CCG safeguarding arrangements in June 2014, which were ‘judged’ as providing ‘Significant Assurance’. There was only one recommendation, which required attention relating to a refresh of the CCGs safeguarding policies to ensure they reflected local arrangements and internal CCG governance processes. This action has been included in the CCG’s Governance and Risk Committee, Policy update and review programme to be completed during early 2015/16.

2.4.5. Learning from complaints and compliments

There have been no reported complaints or compliments received by the CCGs in relation to safeguarding children during this period.

2.4.6. Surveillance and Information sharing (system wide)

The Executive Nurse and Designated professionals as members of NHSE Safeguarding Quality Surveillance Forum, a sub group of the Quality Surveillance Group (QSG) have shared soft intelligence and information pertaining to specific issues and provided feedback to the CCGs as to the appropriate action taken on a system wide basis. An example, includes, the gap identified in the sharing of information to and from Primary Care in Multiagency Risk Assessment Conferences (MARAC). NHSE agreed to lead and coordinate a Task and Finish Group to complete this piece of work in 2015/16.

2.4.7. Commissioning

The Designated Nurse and colleagues from NECS, Provider Management and joint commissioning, and NTHFT reviewed the service specifications for the LAC and Safeguarding Children Service within the Trust. This formed part of a larger Community Service Review with its own programme timelines.

The Designated Nurse also contributed to discussions regarding the change to commissioning arrangements relating to key services involved in safeguarding and LAC provision, i.e. School Nursing and the Health Visiting (as of October 2015).

A report was also submitted by the Designated Nurse to the CCGs in relation to out of area Health Assessments, their administration and verification, citing commissioning proposals.
2.5. **Statutory Inspections and reviews**

There have been no statutory inspections of children’s services in 2014/15.

The Designated Nurse has continued to work with other health providers across Tees to prepare for future reviews.

2.6. **Inter-agency Safeguarding Children Arrangements**

Both South Tees and HAST CCGs are clear and committed partners to their respective LSCBs. This commitment is demonstrated by the regular attendance and involvement of the Executive Nurse and Designated Professionals at Board meetings, Executive Committee meetings, sub-groups of the LSCBs and development sessions.

HAST CCG and ST CCG have made a financial contribution to each LSCB during 2014-15 as detailed in Table 2 below.

<table>
<thead>
<tr>
<th>CCG</th>
<th>LSCB</th>
<th>Financial Contribution (£)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hartlepool &amp; Stockton on Tees CCG</td>
<td>Hartlepool LSCB</td>
<td>£31,519</td>
</tr>
<tr>
<td></td>
<td>Stockton-on-Tees LSCB</td>
<td>£53,055</td>
</tr>
<tr>
<td>South Tees CCG</td>
<td>Middlesbrough LSCB</td>
<td>£41,846</td>
</tr>
<tr>
<td></td>
<td>Redcar &amp; Cleveland LSCB</td>
<td>£33,463</td>
</tr>
</tbody>
</table>

**Table 2: CCG Financial contributions to the LSCBs**

The Designated Nurse has continued as Vice Chair of all 4 Tees Learning and Improving Practice Sub Group (formerly SCR Sub Committees) in 2014/15.

The SCO remains a member of all 4 Tees LSCBs Performance Sub Groups (or equivalent). These groups are primarily aimed at monitoring and evaluating the effectiveness of what is done by Board Partners individually and collectively to safeguard and promote the welfare of children as stipulated in Regulation 5 of the LSCBs Regulations 2006. The SCO’s attendance at these groups provides oversight regarding all health providers’ contribution to operational safeguarding practice; the SCO also shares information from Primary Care (GP Practices) allowing triangulation between the GP support visits and impact of safeguarding children training. It also provides an opportunity to identify issues regarding systems processes.

For example, in 2013/14 Stockton LSCB reported compliance for submission of reports for Initial and Review Case Conferences by GPs as 60%. However the SCO identified that the requests for the reports had, in some instances, not
been issued to the correct GP and therefore not returned. Focused work has been undertaken during 2014/15 to address the weaknesses within the Local Authorities/Primary Care systems to prevent this issue being repeated. This has particularly centred on introducing secure email addresses to facilitate the sending and receipt of conference reports.

Each LSCB has mechanisms for engaging children and young people in the work of the Board which ultimately influences the work of the Board. This includes ‘Junior Safeguarding Boards’ and ‘Young Inspectors’ groups. The Safeguarding Children Team for the CCGs ensure this very important ‘voice’ of children and young people influences other appropriate aspects of their work of the Safeguarding Team within the CCGs.

The Designated Nurse is a member of the Stockton Multi-Agency Looked After Children Partnership (MALAP) and the Middlesbrough Forum for Looked After Children (FLAC). These groups provide the Corporate Parenting Board function for each Local Authority and take forward the strategic level work programme for LAC. The Designated Nurse has progressed active involvement during 2014/15 in similar groups in Redcar and Cleveland and Hartlepool.

As was reported in 2013/14, in 2014/15 neglect continues to be the biggest category for children who are the subject of Child Protection Plans and a key priority area for LSCBs. Addressing the impact of Domestic Abuse on the safety and wellbeing of children and young people also continues as a key focus in all localities.

The statistical data relating to the number of children in each locality who were the subject of Child Protection Plans as of 31st March 2015 is subject to final verification, and will be reported to the CCG on its publication by the LSCBs.

The issue of Child Sexual Exploitation (CSE) continues to receive significant national and regional attention. There is a Tees wide Vulnerable Exploited Missing and Trafficked Strategy (VEMT). A key purpose of the strategy is to respond proactively to the risks associated with CSE. The Tees wide VEMT Group takes forward a Strategic Work Plan and each of the 4 LSCBs has its own VEMT sub group (or equivalent) to take forward the specific local strategic and operational issues. The Designated Nurse is the health representative on the Tees wide Strategic Group providing health expertise into the work plan and acting as the key link to NHS and non NHS provider organisations. The Executive Nurse also attended an LA scrutiny committee to partake in a review into Child Sexual Exploitation in March 2015 which demonstrates its profile.
2.6.1. Statutory Inspections of Local Safeguarding Children Boards

In 2013 Ofsted announced a new framework for reviews of LSCBs and inspections of Local Authorities (LAs). Although the review and inspection take place at the same time the judgements/grading are separate and neither limits the judgement of the other. This review process results in a grading for the LSCBs.

Hartlepool Local Authority and Hartlepool Safeguarding Children Board (HSCB) received an inspection/review under this new framework in December 2013. Although the LA received an overall grading of ‘good’ HSCB failed to reach this standard and the judgement was ‘requires improvement’. The Designated Nurse during 2014/15 has contributed to the development of a vison for HSCB, identification of key priorities and subsequent action planning.

The three remaining LA Areas and LSCBs across Tees have yet to be inspected under this new framework. However the Designated Nurse has contributed towards each LSCB’s preparations by attending relevant inspection preparation task and finish groups.

2.7. Serious Case Reviews/Learning Reviews (SCRs/LLRs)

A key change in the Statutory Guidance Working Together 2013; requires LSCBs to have a local learning and improvement framework which is shared across local organisations who work with children and families. The local framework covers the full range of reviews and audits which are aimed at driving improvements to safeguard and promote the welfare of children.

The different types of review include:

- **Serious Case Review** (SCR): for every case where abuse or neglect is known or suspected and either:
  a) a child dies; or
  b) a child is seriously harmed and there are concerns about how organisations or professionals worked together to safeguard the child

- Child Death Review (see section 1.8) review of all child deaths up to the age of 18;
- review of a child protection incident which falls below the threshold for an SCR, (referred to locally as Leaning Reviews)

A total of 5 SCRs were either initiated and/or completed across the 4 LSCBs on Tees. The table below outlines numbers in each area. LLRs, initiated, or where action plans are being monitored are also included.
Table 3: SCRs and LLRs

<table>
<thead>
<tr>
<th>LSCB</th>
<th>SCR</th>
<th>LLR</th>
</tr>
</thead>
<tbody>
<tr>
<td>HSCB</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>SSCB</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>MSCB</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>RCSCB</td>
<td></td>
<td>1</td>
</tr>
</tbody>
</table>

Stockton LSCB published a Serious Case Review concerning Gavin in October 2014. Details can be found at:


The Designated Nurse has undertaken a significant role in relation to SCRs and LLRs which can be summarised as follows:

- provision of health expertise into the SCR Learning Improving Practice group (sub-group of LSCB) to inform and enable a recommendation to be made to the LSCB Chair as to whether a case meets the criteria for any form of case review;
- supplying support to health agencies involved in the production of chronologies, reviews of practice, staff interviews and associated reports to inform the SCR, LLR or single agency review;
- undertaking quality assurance of data and reports submitted by the involved health providers;
- working with the SCR/LLR Case Panel to review the data submitted by all involved agencies, towards assisting the author of the SCR/LLR in the production of a comprehensive report with relevant recommendations;
- monitoring the implementation of action plans arising from SCRs/LLRs to ensure lessons are learnt and embedded in practice.

SCRs, LLRs and associated action plans are monitored by the LSCBs. The CCG receives assurance of commissioned health services actions at CQRG and updates are provided at QPF.

2.8. Key Challenges for all 4 Tees LSCBs

The 4 LSCBs across Tees are distinct in their approach, local work programmes and plans to safeguard children, and looked after children, although subscribe to Teeswide methods and contribute to partnerships as deemed relevant. However there are a number of common challenges applicable to and encountered by each of the 4 LAs in 2014/15, as follows:

1) To seek and receive assurance from partner agencies that they are responding appropriately to the needs of vulnerable children in their locality.
There are additional difficulties for the 4 Tees LSCB localities due to the higher indices of deprivation and subsequent increased demands on services as well as the additional negative impact on families as a result of welfare reform and cuts to services;

2) To efficiently manage the effects of organisational change experienced by Local Authorities and partner agencies ensuring appropriate senior representation and engagement in a Board’s functioning;

3) Access to consistent funding in order that they can continue to meet their statutory responsibilities;

4) The securing of appropriate and consistent engagement from partner agencies into the sub-groups of the boards in order to effectively progress the work plans;

5) How to effectively capture the views of children and young people about the services they receive and the general outcome.

The CCGs as statutory partners of LSCBs fully acknowledge these challenges, and remain committed to each LSCB, and will provide appropriate leadership, support and input to mitigate any risks to the functioning of the Boards in 2015/16.

2.9. Tees Child Death Overview Panel (CDOP)

2.9.1. In line with “Working Together to Safeguard Children”, it is a statutory requirement for agencies to notify their LSCB of all child deaths up to the age of 18 years. The LSCB is responsible for ensuring that a review of each death of a child normally resident in the LSCB’s area is undertaken by a Child Death Overview Panel (CDOP).

The Tees Child Death Overview Panel (CDOP) is currently hosted by the Redcar and Cleveland LSCB but is accountable to and a sub group of all 4 LSCBs in the Tees area.

The Panel has a fixed core membership drawn from agencies represented on the LSCBs; the Designated Doctor safeguarding children represents the CCGs. Other relevant professionals are co-opted onto the Panel to discuss specific cases as and when appropriate.

CDOP reviews the deaths of children and young people who fall broadly into the following categories:

- **Neonatal Deaths** - these deaths occur within the first 28 days of birth and are often attributed to perinatal events;
• **Unexpected Deaths** - are defined as being the death of an infant or child (less than 18 years old) which was not anticipated as a significant possibility for example, 24 hours before the death occurred;

• **Expected Deaths** - where a child's death is expected, such as where an End of Life Care Pathway has been in place.

The Tees Designated Paediatrician for Child Death Reviews has convened and chaired Local Case Discussions (LCDs) for all Unexpected Child Deaths in the area, which are held in the locality the child lives. The Panel has met on a bi-monthly basis during 2014-15 to review the deaths of children across Teesside.

In the case of an unexpected death, it was identified by CDOP and highlighted to the 4 LSCBs during 2013/14 that a process known nationally as a Rapid Response Process (RRP) which occurs within a 24-48 hour time period where professionals meet or discuss the unexpected death was not in place across Teesside.

The Designated Nurse for Safeguarding Children subsequently prepared an Options Paper in relation to RRP which was discussed and the recommendations accepted by the 4 LSCBs in early 2014/2015. Following the recruitment and appointment to administrative support, RRP is expected to be operational by summer 2015.

2.9.2. **Tees Child Death Statistics**

The statistics for 2014/15 are currently not available as they are subject to approval by CDOP. Following approval and sharing with the 4 LSCBs this information will be published as an addendum to this report.

Table 4 shows the total number of child deaths per area for the 6 complete years up until 2013/14 of the Tees CDOP.

<table>
<thead>
<tr>
<th></th>
<th>2008-09</th>
<th>2009-10</th>
<th>2010-11</th>
<th>2011-12</th>
<th>2012-13</th>
<th>2013-14</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hartlepool</td>
<td>5 (1)*</td>
<td>9 (1)*</td>
<td>9 (3)*</td>
<td>3 (1)*</td>
<td>3 (0)*</td>
<td>5 (2)*</td>
<td>34</td>
</tr>
<tr>
<td>Stockton</td>
<td>15 (3)*</td>
<td>10 (4)*</td>
<td>18 (8)*</td>
<td>25 (8)*</td>
<td>14 (5)*</td>
<td>17 (7)*</td>
<td>99</td>
</tr>
<tr>
<td>Middlesbrough</td>
<td>20 (9)*</td>
<td>18 (8)*</td>
<td>12 (6)*</td>
<td>11 (3)*</td>
<td>12 (4)*</td>
<td>9 (4)*</td>
<td>82</td>
</tr>
<tr>
<td>Redcar &amp; Cleveland</td>
<td>12 (8)*</td>
<td>8 (5)*</td>
<td>13 (1)*</td>
<td>6 (2)*</td>
<td>8 (4)*</td>
<td>5 (2)*</td>
<td>52</td>
</tr>
<tr>
<td>TOTAL</td>
<td>52</td>
<td>45</td>
<td>52</td>
<td>45</td>
<td>37</td>
<td>36</td>
<td>267</td>
</tr>
</tbody>
</table>
Table 4: Number of child deaths per area.

**Key:** * Unexpected Deaths

Information pertaining to child death case classification reflecting modifiable factors will also be published as an addendum to this report as outlined above.

### 2.9.3. Independent Review of Tees CDOP

The 4 Tees LSCBs commissioned an Independent Review of CDOP and the Review Report was published in December 2013; the report’s recommendations was accepted by the 4 Tees LSCBs and resulted in the following changes which became effective in June 2014. The impact of these changes is also highlighted.

- The CDOP chair will rotate between the Directors of Public Health from each of the 4 Local Authorities. This arrangement is working well and is viewed positively by all the Tees LSCBs.

- The CDOP administration has been absorbed within the business unit of the host Local Authority.

- The neo-natal deaths are being reviewed at the two neonatal units on Teesside; robust independent scrutiny is taking place through the chairing arrangements, with STHFT and NTHFT cross chairing the meetings. The Designated paediatrician for CDOP also attends. This is also working well and welcomed by the members of CDOP.

CDOP produce an annual report which will provide its own overview and analysis of activity and confirmation of any relevant changes to its functioning. The expected date of publication for the reporting period 01.04.14-31.03.15 is July 2015.

### 2.10. Key Challenges and Achievements during 2014-15

The report highlights the depth and breadth of the work undertaken by the Executive Nurse and Designated professionals to ensure the CCGs fulfil their statutory duties and responsibilities in relation to safeguarding children and looked after children. During 20014/15 the following challenges and achievements are outlined:

- The establishment of positive and productive relationships with partner agencies has continued to be a challenge as partners continue to experience restructures and changes in roles and responsibilities, particularly in relation to the Police, Probation and Children’s Social Care. However, these are beginning to embed and effective through contributions to the numerous sub groups, and task related activity.
• For the Designated Nurse with LAC responsibility this has been constructive, with evidence of the identification of issues, active solutions and driving forward these improvements. An example includes the development and introduction of the quality assurance LAC audit tool in relation to Initial Health Assessments (IHAs).

• There continues to be a number of Serious Case Reviews/Learning Lessons Reviews across Tees. This remains a pressure on resources within the Team which has been managed through effective team work.

• Working collaboratively with NHSE as part of system wide assurance, has ensured that the safeguarding children profile is maintained in primary care (GP services).

• The Designated Nurse and Executive Nurse have ensured that the CCGs have been able to fulfil their statutory duties and responsibilities in the absence of a Designated Doctor for LAC. The Designated Doctor Safeguarding Children has also contributed and provided support, specifically in relation to undertaking LAC audits of IHAs.

• The Designated Nurse for Safeguarding Children and LAC post became vacant in January 2015, with the SCO supporting the Executive Nurse to manage and ensure an effective response to the Work Programme, and partner’s expectations.

• The CCG’s commitment and agreement to fund additional Designated Nurse Safeguarding children and LAC capacity, is viewed as positive, with appointments expected in May 2015 following advertisement in April 2015.

• NHSE confirmation of agreed funding for a named GP, with recruitment and an appointment to be achieved by NHSE by July 2015.

2.11. Key Objectives for Safeguarding Children and LAC 2015-16

The following objectives will be reflected in the Safeguarding Children and LAC Work Programme, 2015/16.

• The 2 Designated Nurses once in post will continue to work with the support of the Executive Nurse and the SCO in NECS to build on the successes of 2014-15.

• The Designated Professionals will support the other areas across Tees in their preparations for possible CQC CLAS Reviews. In addition the Designated Professionals will provide relevant health support in preparations for any LSCB Inspections.
• The Designated Professionals will provide expertise into the effective monitoring of compliance of the refreshed Quality Requirement’s in provider contracts, providing support to providers in order for them to achieve the standards as agreed.

• Working with the Designated Professional (Safeguarding Adults) to manage the expanding agenda in safeguarding relating to Prevent (Counter Terrorism), human trafficking, forced marriage and female genital mutilation. (CO*)

• To work with NHSE to support the primary care safeguarding agenda through agreed co-commissioning arrangements and the appointment of a named GP. (CO*)

• To ensure the CCGs compliance with the refreshed NHS Accountability & Assurance Framework (2015) (CO*)

• To implement the new SI Framework (March 2015), ensuring CCG compliance with the safeguarding reporting, and investigation requirements. (CO*)

**Key**: CO*, refers to common objective, i.e. it also relates to safeguarding adults (refer to section 3.12)
3. Safeguarding Adults

3.1. National Context, Legislation and Statutory Guidance

The Care Act 2014 provides a comprehensive legal framework for safeguarding adults at risk of abuse and neglect. It specifically references the statutory duty and responsibility of CCGs to be core members of Safeguarding Adults Boards. In addition it has the following implications for safeguarding which the CCG must ensure in terms of its own compliance and that of its commissioned services. This is effective from 1st April 2015:

- Safeguarding Adults Boards (SABs) are on a statutory footing with core members, raising its profile, and the need to evidence organisational accountability;
- Safeguarding enquiries are a corporate duty for councils and they can request the CCG or any organisation to carry out these and compliance is required;
- Safeguarding Adult Reviews (SARs) are mandatory when certain triggering situations have occurred and parties believe that safeguarding failures have had a part to play;
- There is a duty to co-operate over the supply of information on relevant agencies;
- It places a duty on councils to fund advocacy for assessment and safeguarding for people who do not have anyone else to speak up for them;
- It places a duty of candour on providers about failings in hospital and care settings, and creates a new offence for providers of supplying false or misleading information, in the case of information they are legally obliged to provide.

The Department of Health, Care and Support Statutory Guidance (DH, October 2014) supports implementation of the Care Act 2014. Chapter 14 relates to Adult Safeguarding.


The Mental Capacity Act 2005 (MCA) creates a framework to provide protection for people aged 16 plus who cannot make decisions for themselves. It contains provision for assessing whether people have the mental capacity to make decisions, procedures for making decisions on behalf of people who lack mental capacity and safeguards. The underlying philosophy of the MCA is that any decision made, or action taken, on behalf of someone who lacks the capacity to make the decision or act for themselves must be made in their best interests.
The MCA came into force on 1 October 2007. It is supported by a Code of Practice.

The CCG is statutorily responsible for ensuring that the organisations from which it commissions services provide a safe system which safeguards vulnerable children and adults, including adults who lack mental capacity. The CCGs are also responsible for ensuring that all staff employed by them are aware of their responsibilities under the MCA and that they operate at all times in accordance with the MCA and the accompanying code of practice.

The Mental Capacity Act Deprivation of Liberty Safeguards (MCADols) were introduced into the MCA 2005 through the Mental Health Act 2007 (which received Royal Assent in July 2007). Implementation of MCADols commenced in 2009 and applies to persons aged 18 plus. As a commissioner of services a CCG’s role and responsibility in relation to MCADols is to ensure that the services it commissions are compliant. Changes to legislation as a result of case law will require CCGs to respond accordingly. The outcome of the Cheshire West Supreme Court Judgment post April 2014 has had significant resource implications for the CCGs commissioned services in relation to patients funded by the CCG in hospitals, care homes and the community who meet the new ‘acid test and require legal authorisation of a deprivation of liberty.

The Human Rights Act (1998) is another significant piece of legislation which informs the multiagency safeguarding agenda. The CCG has obligations under the Human Rights Act 1998 that, as a public body, it must at all times act in a manner compatible with the rights protected in this Act and safeguard these for patients and staff in its commissioned services and direct employment. Human rights are underpinned by a set of common values and have been adopted by the NHS under the acronym FREDA. The FREDA principles represent:

- Fairness, e.g. fair and transparent grievance and complaints procedures
- Respect, e.g. respect for same-sex couples, teenage parents, older people
- Equality, e.g. not being denied treatment due to age, sex, race etc.
- Dignity, e.g. sufficient staff to change soiled sheets, help patients to eat/drink
- Autonomy, e.g. involving people in decisions about their treatment and care.

The Equality Act (2010) is relevant as it protects people from discrimination, defining discrimination under nine ‘protected characteristics; it also explains people’s rights.
The Safeguarding Vulnerable Groups Act (2006) provides the legislative framework for the Vetting and Barring scheme. CCGs as commissioners need to ensure that the services it commissions and the staff it employs comply with these requirements in relation to individuals working with vulnerable adults or children.

In addition the document, Safeguarding Vulnerable People in the Reformed NHS, Accountability and Assurance Framework (NHS Commissioning Board, March, 2013) issued as guidance, sets out the responsibilities of NHS key players in relation to safeguarding adults. The duties and responsibilities of CCGs are explicit in this document and require CCGs to comply.

In relation to adult safeguarding it refers to the Care Bill 2012 now the Care Act (2014) and the expectation of comparable arrangements with children.

It refers to CCGs being statutorily responsible for ensuring that the organisations from which they commission services provide a safe system that safeguards adults at risk of abuse or neglect. It expects CCGs to be fully engaged with local Safeguarding Adults Boards (SABs), working in partnership with local authorities to fulfil their safeguarding responsibilities including contributing to SCRs.

Of particular importance and relevance is reference to CCGs having a safeguarding adult’s lead and a lead for the Mental Capacity Act, supported by the relevant policies and training.

Finally, there are a series of documents developed for the NHS in 2010/11 that specifically address safeguarding adults that remain relevant in terms of informing and guiding NHS policy and practice. These are:

- Safeguarding Adults: The role of the Commissioner (DH, March 2011)
- Safeguarding Adults: The role of Managers and Boards (DH, March 2011)
- Safeguarding Adults: The role of health practitioners (DH, March 2011)
- Safeguarding Adults Self-Assessment and Assurance Framework (DH, March 2011)
- Clinical Governance and adult safeguarding an integrated process (DH, Feb 2011)

The safeguarding agenda also includes (but not exclusively) the following areas:

Multiagency Public Protection Arrangements (MAPPA): The Criminal Justice Act (CJA) 2003 provides for the establishment of MAPPA. These arrangements
are designed to protect the public, including previous victims of crime, from serious harm by sexual violent offenders. MAPPA is not a statutory body in itself but a mechanism through which agencies can better discharge their statutory responsibilities and protect the public in a coordinated manner. The CCG (previously a Primary Care Trust) under section 325(3) of the Criminal Justice Act (2003) has a ‘duty to co-operate’ with the MAPPA Responsible Authorities (police, prisons, probation) and this duty extends to permitting the sharing of relevant information in order to identify and manage the risks posed by offenders.

CCGs are required to contribute to Domestic Homicide Reviews (DHRs), under Sections 9(2) & 9(3) Domestic Violence, Crime and Victims Act 2004. If directed by the Secretary of State, a CCG has a duty to conduct a domestic homicide review. If holding or participating in a domestic homicide review, a CCG has a duty to have regard to any guidance produced by the Secretary of State.

The Prevent strategy (HM, 2011) is part of the preventative strand of the governments counter terrorism strategy CONTEST. Health is a significant sector identified in this strategy, and it places on both Commissioners and Providers of health care the following challenges:

- To develop the knowledge and awareness of front line workers
- To ensure safeguarding policy and procedures (adults and children) embed the principles of Prevent towards mainstreaming of this agenda.

CCGs have been working with NHSE Cumbria and North East during 2014/15 to ensure that the Prevent agenda is addressed in accordance with Department of Health (DH) requirements and the requirements of the new Counter Terrorism and Security Act (CT&S) 2015. The key implications for the NHS are summarised as follows:

Section 26 of the CT&S Act 2015 places a duty on certain bodies (“specified authorities” listed in Schedule 6 to the Act), in the exercise of their functions, to have “due regard to the need to prevent people from being drawn into terrorism”.

NHS Trusts and NHS Foundation Trusts are identified as specified authorities and must comply with this duty. Statutory guidance has been published and is available at:


Section 38 of the CT&S Act places a duty to co-operate on all partners of a Channel panel to assist the police and the panel in carrying out their functions under the CT&S Act. Schedule 7 to the CT&S Act lists the partners that are
required to co-operate with the panel. CCGs are listed as panel members and must comply with this duty. Statutory guidance has been published and is available at:


HAST CCG and STCCG have a Designated Professional for Adult Safeguarding and MCA. This post forms part of the Safeguarding children and adults team. The post is shared between the two CCGs and there is a Memorandum of Understanding (MOU) in place which has HAST CCG providing hosting arrangements for the post as explained in section 2.2.1.

The Head of Quality and Safeguarding is the Designated Professional and is supported by the Adult Safeguarding Officer (ASO) who is employed by NECS. During 2014/15 additional capacity has been secured in NECS, identifying a dedicated resource (Clinical Quality Manager (CQM) with a safeguarding portfolio) to support the adult safeguarding agenda initially for a 12 month period.

There are no named GPs for Safeguarding Adults across Tees which is the same as children's safeguarding, it is acknowledged in the NHS Accountability and Assurance Framework that this is an important role in providing clinical support and expertise within primary care services. The Designated Professional has worked with NHSE Cumbria and North East to mitigate any potential risks.

3.2. Adult Safeguarding and Commissioned Services

3.2.1. NHS Provider Trusts

The Designated Professional (adult safeguarding) has continued to provide expert advice and support in relation to safeguarding to CCG commissioned services, in particular Trust provider organisations during this period.

Each provider Trust has established an adult safeguarding steering group or committee of which the CCG is a member. These clinical forums enable discussion and action planning regarding Trust wide strategic and operational safeguarding issues and meet at least quarterly.

In addition, there has been bespoke activity undertaken with individual Trusts. Work has been undertaken with North Tees and Hartlepool NHS Foundation Trust (NTHFT) and South Tees NHS Foundation Trust in relation to PREVENT to ensure they are familiar with the reporting and recording requirements locally as a result of regional NHSE changes. The LQIs have been updated to reflect the new requirements, and include Trusts evidencing compliance against a
local assurance framework. Work has also progressed with Trust providers to ensure their internal systems and processes for reporting and recording safeguarding incidents and tracking of activity continue to focus on and including outcomes.

3.2.2. Care Homes

The CQM and ASO, mandated by the Executive Nurse for Tees have continued to undertake the following in respect of care homes, working collaboratively with each LA to achieve meaningful outcomes. It also addresses and responds to the recommendations of the Francis Inquiry I and II and is reflected in the CCG overarching Quality and Safeguarding programme of work:

- Provided expert advice, guidance in respect of individual queries and concerns raised relating to safeguarding concerns, quality standards and nursing care provision attending multiagency strategy meetings and undertaking investigations.

- Targeted activity and provided the resource to support and drive forward quality improvements and standards in care homes using the Clinical Quality Assessment Tool (CQA) or nursing expertise as appropriate.

- Reached local agreement with SBC to implement the Pilot Framework relating to medicines in care homes (safe handling, administration and safeguarding) which will inform and support the CCG Quality Assurance Framework. This will be implemented in 2015/16, and not as originally planned in 2014/15, due to organisational changes in respective organisations.

- Contributed to LA provider meetings through information sharing and effective liaison with CHC teams.

In addition there has been the sharing of intelligence and CQA information with the Care Quality Commission (CQC) on a regular basis, informing CQC inspection preparation to local care homes.

A planned programme of Quality Assurance visits to care homes with nursing across the 4 Local Authority areas has also been undertaken by the CQM and ASO, which has provided a baseline of the standard and quality of care delivered based on the CQA tool. The CQA tool covers 9 domains: End of Life, Nutrition & Hydration, Dementia, Care Management, Urinary Continence Management, Care Planning, Supervision & Leadership, Infection Control & Prevention, Pressure Care Management, and Falls Risk Management. Information has been triangulated with safeguarding activity and CQC inspection reports. Action plans subsequently developed by the care homes in response to CQA recommendations have been monitored, and follow up
reviews undertaken. The activity undertaken during this period is detailed in Table 5a and 5b.

**HAST CCG**

<table>
<thead>
<tr>
<th>Local Authority Area</th>
<th>Number of care homes with nursing</th>
<th>Number of CQA’s completed</th>
<th>Number of Reviews completed</th>
<th>Number of CQAAs outstanding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hartlepool</td>
<td>6</td>
<td>6</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Stockton</td>
<td>18</td>
<td>6</td>
<td>3</td>
<td>12</td>
</tr>
</tbody>
</table>

Table 5a: CQA Profile

**ST CCG**

<table>
<thead>
<tr>
<th>Local Authority Area</th>
<th>Number of care homes with nursing</th>
<th>Number of CQA’s completed</th>
<th>Number of Reviews completed</th>
<th>Number of CQAAs outstanding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Middlesbrough</td>
<td>17</td>
<td>7</td>
<td>1</td>
<td>10</td>
</tr>
<tr>
<td>Redcar and Cleveland</td>
<td>11</td>
<td>7</td>
<td>2</td>
<td>4</td>
</tr>
</tbody>
</table>

Table 5b: CQA Profile

The emerging themes arising from the CQA Programme which are relevant and consistent with CQC findings and actions arising from safeguarding concerns include:

- Record keeping
- Staff training and competencies
- Staff supervision
- Contemporary Policies and Procedures, staff understanding and consistency in implementation/adherence

An independent report was commissioned by the CCGs to examine the governance arrangements relating to CQA, and identify opportunities to strengthen the quality assurance approach. The recommendations, which included review and refresh of the tool, and commitment to fund additional CQA capacity, will be considered by the CCGs in 2015/16 as part of its planned programme of work, and development of commissioning intentions.

The CQA has been used extensively in nursing homes for older people, although its use across NHS funded care with care home provision for people with learning disabilities has been tested in isolated cases. This is considered to be an area for further development in 2015/16 noting the scandal of Winterbourne View, and the Transforming Care agenda, which is underpinned by a programme of work that promotes the provision of safe high quality care for people with learning disabilities.

### 3.3. Primary Care (General Practice)
As previously highlighted there are currently no Named GPs for safeguarding adults across Tees. However, in accordance with the principles underlying the Accountability Framework the Designated professional has undertaken specific work in liaison with NHSE to drive forward the adult safeguarding agenda in primary care.

An analysis of GP responses to the Adult safeguarding questionnaire was completed by the ASO in order to obtain a baseline of current practice and understanding of the agenda. These results were shared with NHSE and will inform the basis of NHSE and the CCGs Safeguarding Adult Work Programme in 2015/16 which will centre on the following:

- Policies – CCG/NHSE to provide a standard policy template for safeguarding adults and MCA to all GP practices,
- Training – CCG/NHSE to sign post to contemporary adult safeguarding, MCA, MCADols, Prevent, and Domestic abuse training, including that which is offered by the TSAB
- Named GP – Work with NHSE to secure the expertise of a named GP to provide, advice and support to general practice in relation to adult safeguarding and MCA
- Adult Safeguarding standards – to share information with general practice regarding the CCGs adult safeguarding standard’s and encourage adoption.

Specific work undertaken by the Designated Professional with NHSE to develop a Standard Operating Procedure (SOP) for Serious Incident reporting relating to safeguarding (children and adults), was completed in November 2014. It was agreed to pilot this across Tees, Durham and Darlington localities in February 2015. The publication of the new Serious Incident Framework (March 2015), will necessitate a review of the SOP to ensure it is consistent with the national reporting requirements. NHSE are leading on its review as part of the work of the QSG safeguarding sub group and will report in June 2015 the outcome.

SOPs relating to MAPPA, Multiagency Risk Assessment Conference (MARACs) and Primary care safeguarding incidents are at different stages. The MAPPA SOP is in development, and planned meetings with the MAPPA Coordinators arranged to agree a draft. It is envisaged this will be presented for discussion at a future QSG meeting in summer 2015. Primary care safeguarding incident reporting is being encouraged through NECS Safeguarding incident risk management system (SIRMS), and a SOP is in place, whilst MARAC is to be progressed.

3.4. Work within the CCGs

3.4.1. Quality Assurance
The Designated Professional has continued to work with the Executive Nurse and Designated Nurse children’s safeguarding and the wider Quality and safeguarding team (NECS) to agree systems and processes that enable the sharing of relevant and timely safeguarding information for the purposes of CCG assurance. Section 2.4 outlines what is now routinely in place for children and this approach to quality assurance equally applies to adults including MCA and MCADoLs. This is consistent with the principles of the CCGs Quality Strategic Framework (QSF).

In addition attention has focused on:

3.4.2. Workforce (CCG Mandatory Training)

The CCGs compliance with safeguarding adult training in 2014/15 is as follows:

HAST CCG compliance with level 1, adult safeguarding training was 100%, with 24/24 individuals completing this foundation level. Adult safeguarding refresher training must be completed every 3 years in accordance with the CCGs Adult Safeguarding Policy. This data reflects compliance with the 3 year cycle.

ST CCG compliance with level 1, adult safeguarding training was 100%, with 16/16 staff members completing this requirement.

During 2015/16, the TSAB will produce a revised training strategy and multiagency training programme. The Designated Professionals will ensure that the CCGs are fully informed and able to access as appropriate relevant training. The current training package access by the CCG will also be reviewed to ensure it reflects TSAB and Skills for Health safeguarding adults’ standards.

The Designated Professional developed and coordinated an MCA Training Programme, funded by NHSE (£54K) to targeted groups as agreed with NHS England. This included: Primary Care (General Medical Practice, ST CCG locality), Dentists (Teeswide), Care Homes (Redcar and Cleveland), Continuing Health Care (CHC) teams (Tees), CCG, NHSE Commissioners (including Safeguarding Professionals), STHFT (Medical and nursing staff).

The Programme also funded:

- A NTHFT, MCA/DoLs and Learning Disability Event;
- The TSAB to host an MCA/DoLs and Adult Safeguarding Conference;
- A competency based MCA training and development resource and bespoke events programme for community pharmacists, led and coordinated by Manchester University. This is a 2 year programme which will be completed in 2015/16.

The outcomes of the Programme have been shared with NHSE.
The Executive Nurse and Designated Professional (Adults) and NECS dedicated adult safeguarding resource have attended and successfully completed the NHSE funded Executive Leadership training course in 2014/15. This constitutes Level 3 training which demonstrates CCG compliance.

3.4.3. Briefings – National investigations, Independent Inquiries and reports

The CCGs have received briefings produced by the Designated Professional (Adult Safeguarding), referencing the implications for the CCGs in relation to:

- The Supreme Court Judgement, MCA DoLs (March 2014)
- NICE Guidance – Domestic Violence (February 2014)
- NICE Guidance – Managing Medicines in Care Homes (March 2014)

3.4.4. Internal Audit outcome and recommendations

As outlined in section 2.4 the CCGs received the outcome of Audit North’s (AN) internal audit of CCG safeguarding arrangements in June 2014, which were ‘judged’ as providing ‘Significant Assurance’. The CCG’s Adult Safeguarding Policy and MCA and DoLS Policy will be refreshed to reflect AN’s recommendation, in accordance with the CCG’s Governance and Risk Committee, Policy update and review programme during early 2015/16.

3.4.5. Learning from complaints and compliments

There has been 1 reported complaint and no compliments received by HAST CCG in relation to safeguarding adults during this period.

There have been no reported complaints or compliments received by ST CCG in relation to safeguarding adults during this period.

3.4.6. Surveillance and Information sharing (system wide)

As detailed in section 2.4 the Executive Nurse and Designated professionals as members of NHSE Safeguarding Quality Surveillance Forum, a sub group of the Quality Surveillance Group (QSG) have shared soft intelligence and information pertaining to specific issues and provided feedback to the CCGs as appropriate with the action taken on a system wide basis. An example, includes, the sharing of concerns relating to a national care home provider on Tees and a local provider with multiple homes.

3.4.7. Commissioning

The Designated Professional provide comments in relation the development of
the CCGs commissioning intentions, regarding the Medicines Optimisation proposals to strengthen annual medication reviews of residents in care homes working with primary care.
3.5. Peer Reviews

There have been no peer reviews of safeguarding adults during 2014/15.

3.6. Interagency Safeguarding Adults Arrangements

Both CCGs on Tees are committed partners to the Teeswide Safeguarding Adults Board (TSAB), its sub groups and the four Local Authority Local Executive Groups (LEGs) and associated groups.

The CCGs make a financial contribution to the Teeswide Safeguarding Adult Board (TSAB) as detailed in the table overleaf:

<table>
<thead>
<tr>
<th>Financial contribution by CCG to the Teeswide Safeguarding Board</th>
</tr>
</thead>
<tbody>
<tr>
<td>HAST CCG</td>
</tr>
<tr>
<td>ST CCG</td>
</tr>
</tbody>
</table>

Table 6: TSAB, CCG financial contributions

Both HAST and South Tees CCGs agreed that financial contributions in 2014/15 will be towards a Teeswide Business Unit which is hosted by Stockton Borough Council (SBC). All partner agencies confirmed their commitment to the Teeswide Board becoming the statutory Adult Safeguarding Board pending the introduction of the Care Act 2014. HAST CCG have also committed additional non recurrent resource of £50K to the TSAB. The shadow arrangements for the Board have been tested during 2014/15, which has presented a number of challenges, refer to section 3.5.2.

The Designated Professional continues to chair the bi-monthly Teeswide Policy and Procedures Group and has undertaken specific pieces of work including leading a Workshop to assist in agreeing a framework for the revision of the TSAB policy and associated procedures. As a member of the TSAB Learning Training and Development sub group and Performance Audit and Quality Assurance sub group the Designated Professional, CQM, and ASO has informed each groups work agenda and activity in relation to the wider health economy.

In addition the Designated Professional is a member of the 4 Local Authority Local Executive Groups (LEGS) which meet quarterly and have focused primarily on locality issues but also spearheaded a number of key developments.

The Local Authority Safeguarding Adults Return (SAR) replaced the Abuse of Vulnerable Adults (AVA) data collection relating to adult safeguarding referrals
in 2014/15. Information is reported to the Health and Social Care Information Centre (HSCIC) and analysed by the National Adult Social Care Intelligence Service (NASCIS). The published data for the period 2014/15 has not yet been released and is excluded from this report. An addendum to this report will be provided which highlights the specific issues pertaining to health services following release and analysis of this data by Local Authorities at each Local Committee and the TSAB and no later than September 2015.

Similarly information relating to MCADols activity for the period 2014/15 will also be included in this addendum.

The TSAB annual report 2014/15 which will incorporate an overview of analysis of data, referencing trends and themes will be produced during July and August 2015. Information from this report will also be considered in relation to producing the addendum.

There are a number of other key groups which the Designated Professional is a member of and has contributed to the agenda. These include:

MAPPA Strategic Management Board (SMB), which is a multiagency partnership that oversees the Multiagency Public Protection Arrangements (MAPPA) process. As a Duty to cooperate agency this has involved ensuring the CCG as a commissioner is able to inform and support MAPPA arrangements.

3.7. Safeguarding Adult Reviews (SARs), Lesson Learned Reviews (LLRs)

3.7.1. The Care Act (2014) outlines the circumstances for undertaking a Safeguarding Adult Reviews (SAR) be undertaken.

A summary of the role of the Designated Professional in relation to a SAR is detailed as follows:

- To provide expertise, inform and advise the Safeguarding Adult Review panel who consider where the case meets the criteria for a case review
- To produce and or support the production specifically in relation to primary care, Continuing Health Care (CHC) chronologies, reviews of practice, staff interviews and associated reports to inform the SAR of single agency reviews
- To quality assure single agency reports in relation to primary care and CHC specifically
- To work with the SAR case panel to review all information submitted by agencies, towards assisting the author in the production of a comprehensive overview report with relevant recommendations.
- To contribute to the monitoring and implementation of action plans from SARs to ensure lessons learnt are embedded in practice.
If the criteria are not met for a SAR consideration is given to carry out a LLR.

3.7.2. A total of 2 Safeguarding Adult Reviews (previously known as Serious Case Reviews (SCRs) were either initiated and/or completed in 2014/15. A further case in Hartlepool was to be considered post April 2015. The table below outlines the numbers pertaining to each Local Authority area. LLRs, initiated, or where action plans are being monitored are also included.

<table>
<thead>
<tr>
<th>Local Authority Area</th>
<th>ACR</th>
<th>LLR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hartlepool</td>
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</tr>
<tr>
<td>Stockton</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Redcar and Cleveland</td>
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</table>

Table 7: SARs and LLRs

SARs, LLRs and associated action plans are monitored by the TSAB. The CCG receives assurance of commissioned health services actions at CQRG and updates are provided at QPF.

3.7.3. The Serious Concerns Protocol (SCP) - Responding to Serious Concerns about a Service provided for Adults at risk of abuse or neglect

This protocol was developed and introduced in response to an increase in number of individual serious concerns as well as multiple safeguarding referrals received by the LA relating to a single provider in the care sector (includes domiciliary, nursing and care home provision). This protocol is part of a suite of protocols adopted, implemented and monitored by the TSAB and local committees.

The Executive Nurse, CQM, ASO and Designated Professional have been represented at or involved in a total of 7 SCP meetings during 2014/15 concerning a number of nursing care provider organisations.

The role of the CCG Executive Nurse, Designated Professional, CQM and ASO in an SCP is as follows:

- To provide expertise, professional advice, guidance and decision making in relation to NHS commissioned services
- To share information and intelligence about a care provider to inform the investigatory process
- To ensure a Clinical Quality Assessment is undertaken in care homes if identified as appropriate, produce a report with recommendations and share this with the provider and LA
• To contribute and agree an integrated multiagency action plan to drive forward improvements, and monitor this through the SCP process whilst also align to LA contract processes

• To ensure effective liaison with the LA, Care Quality Commission (CQC) and care provider, providing clarity to actions, expectations and outcomes

• To work collaboratively with Local Authority commissioners to ensure that there is a joined up approach to Quality Assurance and service improvement

• To identify, signpost and agree solutions in relation to nursing care

• To provide progress updates to the CCG Executive and Delivery Teams as part of the CCG internal governance processes

The CCG considers that the SCP has worked exceptionally well, as a result of effective multidisciplinary and partnership working across the health and social care economy during this period. It was identified by the LA and CCG through the SCP process that undertaking a Lessons Learned Review would be beneficial. The PPP sub group, of the TSAB will lead the revision of the protocol in 2015/16 to ensure this is undertaken as best practice.

A summary of SCP activity and outcomes is attached as appendix 1.

3.8. Key Challenges for the TSAB and LEGs

There are a number of challenges that need to be acknowledged:

• The testing of the new shadow structures and governance arrangements to ensure all agencies remain engaged and committed to these arrangements, proved difficult initially due to the lack of progress in recruiting to posts within the Business Unit. The reporting arrangements between the LEGs and the TSAB required further clarity and refinement specifically in relation to SCRs and LLRs.

• The TSAB needs to recruit a substantive Business Manager (BM) with appropriate experience to lead, shape and support the TSAB and its associated structures. This has proved challenging in 2014/15 An interim BM has been in post during this period who has assisted in progressing the TSAB agenda including recruitment to posts in the Business Unit. A substantive appointment was secured in March 2015.

• The TSAB recruited an Independent chair, in April 2014. This role has evolved and is beginning to shape and direct the work of the TSAB ensuring it fulfils its statutory duties and responsibilities.
• Agencies capacity to support the TSAB local sub groups and LEGS will require careful consideration and potential review.

3.9. Domestic Homicide Reviews (DHRs)

The Designated Professional, as a member of the panel, has provided expert advice, guidance and input into 1 Domestic Homicide Review (DHR) undertaken in Hartlepool, during 2014/15.

A joint primary care and acute Trust independent management review was completed and a report produced by the Designated Professional on behalf of NHS England and Deputy Director of Nursing at NTHFT. The findings and recommendations were provided to the review panel. The panel convened at the request of the Community Safety Partnership is awaiting feedback from the Home Office, which is expected in June 2015.

3.10. Mental Health Homicide Reviews (MHH)

NHSE’s Single Operating Model for the Investigation of Mental Health Homicides (MHH) (2013), outlines the case criteria for triggering an independent MHH investigation. It also refers to the roles and responsibilities of CCGs, in ensuring providers action plans resulting from such investigations are progressed, lessons learned shared and embedded with assurance reported to NHSE.

ST CCG as lead commissioner of TEWV NHS FT, a provider of mental health services have been sighted on 1 MHH action plan and are awaiting the outcome of another MMH Independent report, which is due to be published in May 2015.

The Executive Nurse has requested an Extraordinary CQRG with the Provider, to seek assurance and evidence of the response and outcomes to MHH reviews which will be arranged in summer 2015, following receipt of the Trusts action plan to the imminent MMH independent report.

3.11. Key Challenges and Achievements during 2014/15

The CCG Safeguarding Adult Team comprising of the Designated Professional, CQM and ASO has been subject to a number of challenges as well as securing a range of achievements in 2014/15.

• There have been an increased number of care homes placed under the Serious Concerns Protocol (SCP) during 2014/15 across Tees, however due the increase in capacity this has enabled an effective coordinated response to the quality and safeguarding concerns, ensuring implementation of actions, monitoring of outcomes and the ability to drive forward improvements. In relation to a specific care provider in Hartlepool,
this necessitated working with the acute Trust and mental health Trust in order to gain assurance that residents in receipt of nursing care were safe and care was appropriate and meeting their needs prior to closure of the care home.

- Providing a balanced but effective response to safeguarding concerns in relation to primary care working with NHSE, NECS Medicines Optimisation team and NECS dedicated adult safeguarding resource.

- The proposed implementation of the Local Quality Incentive Scheme, which included a safeguarding element, with LAs in SBC and HBC was not progressed as a decision was made by the CCGs to focus on completion of the CQA programme.

- The Designated Professional has responded positively and in a timely manner to the request for chronologies, single agency reviews and progress updates for action plans in response to SCRs, DHRs.

- Leading on a regional piece of work on behalf of NHSE in relation to Prevent resulting in the development of a local assurance framework which has been recommended for adoption by CCGs in the NHSE Cumbria and North East. Both CCG’s have included this in its LQIs in contracts.

- The SOP for reporting SI’s agreed via the QSG to pilot in February represents an example of best practice, this has been to a large extent superseded by the new SI framework (March 2015)

- The outcome of the internal audit by Audit North (AN) is positive and reflects the leadership of the Executive Nurse.

- The Designated Professional (adult Safeguarding) secured a secondment to NHSE for a period of 7 months, with a portfolio that included safeguarding, transforming care for people with learning disabilities and continuing health care, providing an opportunity to lead, influence ,and effect system wide learning. The work relating to Prevent evidences this.

### 3.12. Key Objectives for Safeguarding Adults, 2015/16

The following objectives will be reflected in the Safeguarding Adults Work Programme, in 2015/16.

- The Designated Professional will continue to work with the support of the Executive Nurse and the NECS Quality and safeguarding team to strengthen the teams approach to adult safeguarding, develop the expertise of the Clinical Quality Manager (CQM) (with a safeguarding adults portfolio) and ASO, building on the successes of 2014/15. This will involve ensuring that the role of the Designated Professional, CQM, ASO and individuals in
the wider Quality and Safeguarding team work more effectively to embed robust internal and external systems and processes to inform and support the adult safeguarding agenda. Integral to this is the ongoing and active engagement of all external partners but it is also reliant on the involvement of NECS CHC team, Medicines Optimisation, Provider Management and Joint Commissioning (not exclusively) in achieving success.

- The Designated Professional will work with the CQM, NECS and CCG colleagues to ensure effective implementation of a Quality Assurance Framework for Care Homes, following confirmation and agreement by the CCGs of the CQA tool refresh which will enable and support Early Warning Signs of deterioration in quality of care, triggered through safeguarding concerns, local intelligence, or clinical quality assessments/audit, recognising that this is dependent on the capacity within the team to deliver this effectively.

- The LQIs for Adult Safeguarding which have been refreshed in 2014/15 will be monitored by the Designated Professional in 2015/16 to ensure compliance, providing support to providers to ensure these standards are met.

- The Designated professional will continue to ensure the implications for the CCGs of the Care Act (2014) in relation to adult safeguarding and Supreme Court judgement in relation to the MCA/DoLs are understood and reflected in key policies, and quality assurance processes. This will ensure the CCG fulfils its duties and responsibilities as a statutory organisation and as a commissioner of NHS services.

- To implement co-commissioning arrangements in relation to safeguarding and Primary Care in accordance with an agreed MOU, SOP or protocol between the CCGs and NHSE. (*CO*)

- Working with the Designated Professionals (Children’s safeguarding and LAC) to manage the expanding agenda in safeguarding relating to Prevent (Counter Terrorism), human trafficking, forced marriage and female genital mutilation.(CO*)

- To ensure the CCGs compliance with the refreshed NHS Accountability & Assurance Framework (2015) (CO*)

- To implement the new SI Framework (March 2015), ensuring CCG compliance with the safeguarding reporting, and investigation requirements.(CO*)
4. Summary

HASTCCG and STCCG have undertaken a comprehensive programme of work in relation to safeguarding, in which they are able to demonstrate compliance with their statutory duties and responsibilities. The CCG is sighted on the following corporate risks and the mitigated actions that are in place which have been monitored during 2014/15.

- The absence of a Designated Doctor for LAC
- The absence of a Named GP for children’s safeguarding

These are priority areas that will be addressed in 2015/16.

Similarly, the role of Named GP for Safeguarding adults will be explored with NHSE.

In 2015/16, the CCGs will continue to develop its approach and responses to safeguarding building on the lessons learned from 2014/15.

The Annual CCGs Safeguarding Work Programmes 2015/16 and associated Plans will be produced to incorporate the key areas identified for specific attention and action in this report. Monitoring and reporting arrangements will be in accordance with the CCGs approved governance arrangements.

Report Sponsor: Jean Golightly, Executive Nurse, NHS Hartlepool and Stockton on Tees Clinical Commissioning Group and NHS South Tees Clinical Commissioning Group

Author: Chris Brown, Head of Quality and Safeguarding, NHS Hartlepool and Stockton on Tees Clinical Commissioning Group and NHS South Tees Clinical Commissioning Group
References

Care and Support Statutory Guidance issued under the Care Act 2014 (October 2014)


Children Act 1989; Great Britain. 1989: Elizabeth II.

Children Act 2004; Great Britain. 2004: Elizabeth II.

Ofsted Inspection Framework for the inspection of services for children in need of help and protection, children looked after and care leavers (single inspection framework) and reviews of Local Safeguarding Children Boards: Ofsted 2013

Report of The Children And Young People’s Health Outcomes Forum co-chaired by Professor Ian Lewis and Christine Lenehan. 2012

Safeguarding Children and Young people: roles and competences for health care staff intercollegiate document; Royal College of Paediatrics and Child Health 2010

Safeguarding Vulnerable People in the Reformed NHS; NHS Commissioning Board 2013

Statutory Guidance on Promoting the Health of Looked After Children: Department for Children, Schools and Families and the Department of Health 2009

The Francis Inquiry Report Department of Health, February 2013

The Local Safeguarding Children Boards Regulations; Great Britain 2009: Elizabeth II

Transforming Care: A National Response to Winterbourne View Hospital Department of Health December 2012

Working Together to Safeguard Children 2013: Department for Education 2013
### Appendix 1, Summary of Serious Concerns Protocol (SCP) activity 1.4.14 – 31.3.15

<table>
<thead>
<tr>
<th>Local Authority Area</th>
<th>SCP</th>
<th>Overview of key issues</th>
<th>Actions and Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hartlepool</td>
<td>1</td>
<td><strong>Local care provider with a small number of care homes:</strong> Multiple concerns relating to leadership, management, care practice, staff competencies, documentation (records) and care delivery.</td>
<td>The Care Quality Commission (CQC) issued warning notices. The provider was unable to demonstrate compliance. The provider served notice to CQC of its intention to cease operating. All residents were supported by the CCG and LA to move to alternative placements. Care provider ceased to operate. Home closure.</td>
</tr>
<tr>
<td>Stockton</td>
<td>1</td>
<td><strong>National care provider:</strong> Leadership, management, culture, communication between staff and external professionals.</td>
<td>Joint action plan produced, overseen by SBC and the CCG. Compliance reviews undertaken, sustained improvements demonstrated, resulting in the routine monitoring of the provider via LA contract management processes.</td>
</tr>
<tr>
<td>Middlesbrough</td>
<td>2</td>
<td><strong>Local care provider:</strong> Unannounced inspection by CQC – identified concerns relating to records, medication, care and welfare.</td>
<td>Multiagency action plan, joint visits undertaken between ST CCG and LA to assess improvement. Concerns addressed, improvement evidenced. This resulted in the routine monitoring of the provider via LA contract management processes.</td>
</tr>
<tr>
<td>Middlesbrough</td>
<td>2</td>
<td><strong>National care provider:</strong> Anonymous whistle-blower – concerns raised regarding record keeping and safe staffing. Unannounced CQC visit, identified improvements, but raised concerns, regarding nutritional screening, and monitoring of patient weights.</td>
<td>Joint action plan developed, monitored, some evidence of improvement demonstrated. This resulted in routine monitoring of the provider via LA contract management processes.</td>
</tr>
<tr>
<td>Local Authority Area</td>
<td>SCP</td>
<td>Overview of key issues</td>
<td>Actions and Outcome</td>
</tr>
<tr>
<td>----------------------</td>
<td>-----</td>
<td>-----------------------</td>
<td>---------------------</td>
</tr>
<tr>
<td>Redcar and Cleveland</td>
<td></td>
<td><strong>National care provider:</strong> Unannounced inspection by CQC identified concerns relating to medication, care and welfare, documentation. Multiagency action plan – progress monitored, improvements progressed</td>
<td>The Care Quality Commission (CQC) issued warning notices. Active monitoring of provider remains. (as at 31.3.15)</td>
</tr>
<tr>
<td>Redcar and Cleveland</td>
<td>3</td>
<td><strong>Local care provider:</strong> Concerns identified included, leadership, management, poor standards of care documentation, and care delivery.</td>
<td>Joint action plan developed, joint monitoring review visits undertaken between CCG and LA. Evidence of improvement demonstrated. This resulted in routine monitoring of the provider via LA contract management processes.</td>
</tr>
<tr>
<td>Redcar and Cleveland</td>
<td></td>
<td><strong>Local care provider:</strong> Unannounced inspection by CQC identified concerns relating medication, records, cooperation with other providers, care and welfare and nutritional needs.</td>
<td>Provider demonstrated sustained improvements, as part of its action plan, evidenced by joint visits undertaken by ST CCG and the LA. This resulted in routine monitoring of the provider via LA contract management processes.</td>
</tr>
</tbody>
</table>
### Purpose of Paper

<table>
<thead>
<tr>
<th>Purpose of Paper</th>
<th>For Discussion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Title</td>
<td>Finance Report</td>
</tr>
<tr>
<td>Responsible</td>
<td>Simon Gregory, Chief Finance Officer</td>
</tr>
<tr>
<td>Author of the Report</td>
<td>Simon Gregory, Chief Finance Officer</td>
</tr>
<tr>
<td>Recommendation(s)</td>
<td>The Governing Body is asked to note;</td>
</tr>
<tr>
<td></td>
<td>• The current forecast outturn for 2015-16.</td>
</tr>
<tr>
<td></td>
<td>• The CCG’s reserves and pipeline of current and expected projects</td>
</tr>
<tr>
<td></td>
<td>• The strategic issues that will have a financial effect in future years</td>
</tr>
<tr>
<td></td>
<td>• The opportunities for reviewing efficiencies identified in benchmarking data</td>
</tr>
</tbody>
</table>

### Summary

This report provides a summary of the final financial position for the year to June 2015. The report also includes high level benchmarking information that will inform future financial plans and should be considered with the CCG’s commissioning intentions for 2016-17.

### Financial Implications

As set out in the report.

### Legal/Regulatory Implications

- **Section 14Q NHS Act 2006**
  Each CCG must exercise its functions effectively, efficiently and economically.

- **Section 223H NHS Act 2006**
  Financial duties of clinical commissioning groups: expenditure
  (1) Each clinical commissioning group must, in respect of each financial year, perform its functions so as to ensure that its expenditure which is attributable to the performance by it of its functions in that year does not exceed the aggregate of—
  (a) the amount allotted to it for that year under section 223G,
  (b) any sums received by it in that year under any provision of this Act (other than sums received by it under section 223G), and
  (c) any sums received by it in that year otherwise than under this Act for the purpose of enabling it to defray such expenditure.

- **Section 223I NHS Act 2006**
  Financial duties of clinical commissioning groups: use of resources
  (3) A clinical commissioning group must ensure that its revenue resource use in a financial year does not exceed the amount specified by direction of the Board.

### Assurance Framework/Risk

There are no additional Risk Register implications.
<table>
<thead>
<tr>
<th>Register Implications</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Details of relationship to the NHS Constitution</td>
<td>The CCG operates in line with all elements of the constitution.</td>
</tr>
<tr>
<td>Details of Patient and Public Involvement and/or Implications</td>
<td>N/A</td>
</tr>
<tr>
<td>Has an Equality Analysis been completed?</td>
<td>N/A</td>
</tr>
<tr>
<td>Attachments</td>
<td>Finance Report</td>
</tr>
<tr>
<td>Please detail any Committees or Forums at which this paper has previously been tabled</td>
<td>None</td>
</tr>
</tbody>
</table>
1. **Introduction**

1.1. This report provides a summary of the current financial position for the year to June 2015 including forecast outturn and reserves.

1.2. This report updates the Governing Body on potential future pressures and includes some high level benchmarking information that will inform future financial plans.

2. **Forecast Outturn**

<table>
<thead>
<tr>
<th>Risk</th>
<th>Target Detail</th>
<th>Year to Date Position</th>
<th>Forecast Position</th>
<th>£000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Revenue Allocation – Programme</td>
<td>To deliver a 1% surplus</td>
<td></td>
<td></td>
<td>£5,028</td>
</tr>
<tr>
<td>Performance against the running cost limit</td>
<td>To keep expenditure within allocation</td>
<td></td>
<td></td>
<td>£6,076</td>
</tr>
<tr>
<td>Internal Audit Reports</td>
<td>No more than 2 limited or non-assurance reports in year</td>
<td></td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>Better Payment Practice Code</td>
<td>To pay CCG creditors within 30 days of receipt of invoices or goods</td>
<td></td>
<td></td>
<td>98.89%</td>
</tr>
<tr>
<td>QIPP Delivery</td>
<td>To deliver £4.6m savings in year</td>
<td></td>
<td></td>
<td>£4,280</td>
</tr>
</tbody>
</table>

2.1. At this point in the year, the CCG has one month of validated activity information that has been used for financial projections. The CCG is currently on target to deliver the forecast outturn position.

2.2. The QIPP target of £4.6M in 2015-16, is inclusive of a 10% reduction in the running cost allowance to the Value of £716K. The CCG running cost budget has been set and is on target to deliver this QIPP saving. This will be another challenging year for delivering the QIPP target as there is significant reliance on South Tees FT being able to reduce the level of unplanned care to meet the target of a 3.5% reduction for 2015/16. Early indications show that although emergency activity is reducing, the costs are not reducing at the same rate. This poses a risk to the delivery of QIPP and BCF performance. We intend to review the IMPROVE implementation of new community based services as these schemes should also be shown as QIPP attainment.

2.3. The South Tees Hospitals NHS FT contract is forecast to be on plan at the end of this year based on the early data. As at May, and compared with the same period last year, early un-validated data indicates that emergency activity has reduced by 10% for the same period; this is in line with the activity for the second half of 2014-15.

2.4. The CCG is currently facing significant growth in the cost and activity in relation to Continuing Health Care. A formal monthly Contract Management Board has been established with the
commissioning support unit to ensure that the CCG receives better information on the performance of the service and a better understanding of the pressures faced in the medium to long term. This will allow the CCG to improve how it makes future plans and establish a strategic direction for the service. The CCG is discussing options for the future with both the commissioning support unit and the local authorities.

2.5. The CCG has set aside uncommitted reserves to mitigate the risks to maintain financial balance, until evidence that the QIPP projects are having a positive impact on the financial position.

3. Reserves and Contingency

3.1. Reserves

<table>
<thead>
<tr>
<th>Reserve</th>
<th>Opening £000s</th>
<th>Committed Recurrent £000s</th>
<th>Committed Non Recurrent £000s</th>
<th>Additional Surplus £000s</th>
<th>Available Balance £000s</th>
</tr>
</thead>
<tbody>
<tr>
<td>Confirmed Funding</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0.5% Contingency</td>
<td>£2,076</td>
<td>£0</td>
<td></td>
<td></td>
<td>£2,076</td>
</tr>
<tr>
<td>1% Headroom</td>
<td>£3,929</td>
<td>£2,483</td>
<td></td>
<td></td>
<td>£1,446</td>
</tr>
<tr>
<td>Winter Pressures</td>
<td>£2,096</td>
<td>£2,096</td>
<td>£0</td>
<td></td>
<td>£0</td>
</tr>
<tr>
<td>Investment Acute Readmissions</td>
<td>£2,000</td>
<td>£0</td>
<td></td>
<td></td>
<td>£2,000</td>
</tr>
<tr>
<td>Overseas visitors adjustment</td>
<td>£135</td>
<td>£0</td>
<td></td>
<td></td>
<td>£135</td>
</tr>
<tr>
<td>Other Reserve</td>
<td>£0</td>
<td>£0</td>
<td></td>
<td></td>
<td>£0</td>
</tr>
<tr>
<td>Total Programme</td>
<td>£10,236</td>
<td>£0</td>
<td>£4,579</td>
<td>£0</td>
<td>£5,657</td>
</tr>
<tr>
<td>Admin Surplus</td>
<td>£0</td>
<td>£0</td>
<td></td>
<td>£0</td>
<td>£0</td>
</tr>
<tr>
<td>Total</td>
<td>£10,236</td>
<td>£0</td>
<td>£4,579</td>
<td>£0</td>
<td>£5,657</td>
</tr>
</tbody>
</table>

3.1.1. The CCG received a partial refund in 2014/15 for the contribution to the CHC Restitution national scheme of £931k. NHS England have advised that in 2015/16 the balance of this funding should be used to increase the CCGs planned 1% surplus. The intention may be that the funding will be allowed to be drawn down and spent in a future period yet to be formally agreed.

3.2. Future Allocations and Tariffs

3.2.1. Funding Forecast to 2019/2020

<table>
<thead>
<tr>
<th>Allocation</th>
<th>2015/16 £000s</th>
<th>2016/17 £000s</th>
<th>2017/18 £000s</th>
<th>2018/19 £000s</th>
<th>2019/2020 £000s</th>
</tr>
</thead>
<tbody>
<tr>
<td>Programme Allocation</td>
<td>£392,938</td>
<td>£399,618</td>
<td>£406,411</td>
<td>£413,320</td>
<td>£420,346</td>
</tr>
<tr>
<td>Running Cost Allowance</td>
<td>£6,076</td>
<td>£6,039</td>
<td>£6,003</td>
<td>£5,969</td>
<td>£5,969</td>
</tr>
<tr>
<td>Non Recurrent Carry Forward</td>
<td>£8,311</td>
<td>£5,028</td>
<td>£4,175</td>
<td>£4,234</td>
<td>£4,303</td>
</tr>
<tr>
<td>Better Care Funding</td>
<td>£6,775</td>
<td>£6,775</td>
<td>£6,775</td>
<td>£6,775</td>
<td>£6,775</td>
</tr>
<tr>
<td>NR CEV Overseas defund</td>
<td>£0</td>
<td>£0</td>
<td>£0</td>
<td>£0</td>
<td>£0</td>
</tr>
<tr>
<td>Quality Premium Award</td>
<td>£0</td>
<td>£0</td>
<td>£0</td>
<td>£0</td>
<td>£0</td>
</tr>
<tr>
<td>Neonatal Audiology</td>
<td>£0</td>
<td>£0</td>
<td>£0</td>
<td>£0</td>
<td>£0</td>
</tr>
<tr>
<td>Total Allocation</td>
<td>£414,100</td>
<td>£417,460</td>
<td>£423,364</td>
<td>£430,298</td>
<td>£437,393</td>
</tr>
</tbody>
</table>

New Allocations

| NR GPIT                     | £749          |
| NR GPIT                     | £440          |
| Tariff Non Rec              | £1,059        |
| Total                       | £416,348      |

Programme Growth 1.7% 1.7% 1.7% 1.7%
3.2.2. Monitor has proposed plans that allow commissioners to consider new tariff mechanisms for unplanned care from April 2016. The intention is to allow more flexible funding of integrated care models and support urgent and emergency care networks. This approach will require significant cooperation across all local providers and commissioners for it to become effective.

4. Commissioning and Investment Plans

4.1. Project Pipeline

4.1.1. The CCG is commencing work on its commissioning intentions for 2016-17. As the intentions are developed I will advise the Governing Body of the expected costs and savings of our plans.

5. Activity Trends

5.1.1. As part of the commissioning intention work we will refresh the demographic data used for the annual planning process for 2016-17.

6. Likely Impact of Innovation and Technology

6.1. Generic Medicines
   Nothing to update.

   Primary Care Medicines
   Nothing to update.

   New Drugs

6.1.2. Alogliptin is licensed for use in type 2 diabetes as dual therapy in combination with either metformin, pioglitazone, a sulfonylurea, or insulin (when treatment with these drugs alone fails to achieve adequate glycaemic control); it is also licensed for use as a triple therapy in combination with metformin and either pioglitazone or insulin.

   The main advantage of Alogliptin is its acquisition cost which is cheaper compared to all existing DPP-4 inhibitor drugs used in the UK. Alogliptin is priced at £26.60 for all doses. NICE guidance CG87 on Type II Diabetes management recommend using DPP-4 Inhibitors with the lowest acquisition cost.

6.1.3. Ullipristal – Preoperative treatment of moderate to severe symptoms of uterine fibroids. This therapy is oral and potentially has fewer side effects than current treatment which involves monthly injections of GNGH. Explicit communication from STHFT around use within license and course limited to three months duration will be needed. Cost per course: £342.39.

   Expiring Patents

6.1.4. Nothing to update since the January report.

   Secondary care drugs excluded from hospital tariffs
   Nothing to update since the January report.

   Drug shortages
6.1.6. Price increases could result in an estimated additional spend of £9,424 (£113,000 pa) within South Tees CCG per month.

### Table: Estimated Forecast of Additional Costs for remainder of 2014/15

<table>
<thead>
<tr>
<th>Product Name</th>
<th>Pack Size</th>
<th>Prices affected from</th>
<th>Drug Tariff Price (month before price change)</th>
<th>Monthly Prescribing before price change</th>
<th>Monthly Cost based on latest price</th>
<th>Additional CCG Monthly Cost (new £ vs. old £)</th>
<th>Estimated Forecast of Additional Costs for remainder of 2014/15</th>
<th>Possible Alternative Product</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mebeverine HCl_Tab 135mg</td>
<td>100</td>
<td>May-14</td>
<td>£5.06</td>
<td>£13,530</td>
<td>1,244, 104, 151</td>
<td>£19,268</td>
<td>£5,738.46</td>
<td>No</td>
</tr>
<tr>
<td>Exemestane_Tab 25mg</td>
<td>30</td>
<td>Aug-14</td>
<td>£6.94</td>
<td>£637</td>
<td>14, 470</td>
<td>£517</td>
<td>-£120</td>
<td>-£119.81</td>
</tr>
<tr>
<td>Lisinopril/Hydchloroth_Tab 20mg/12.5mg</td>
<td>28</td>
<td>Nov-14</td>
<td>£1.70</td>
<td>£365</td>
<td>32, 1,258</td>
<td>£2,101</td>
<td>£2,366</td>
<td>No</td>
</tr>
<tr>
<td>Clonidine HCl_Tab 25mg</td>
<td>112</td>
<td>Jan-15</td>
<td>£4.21</td>
<td>£2,988</td>
<td>341, 39, 479</td>
<td>£2,644</td>
<td>£345</td>
<td>£345.50</td>
</tr>
<tr>
<td>Digoxin Tab 125mcg</td>
<td>28</td>
<td>Feb-15</td>
<td>£1.07</td>
<td>£2,216</td>
<td>811, 19, 287</td>
<td>£3,368</td>
<td>£152</td>
<td>£151.93</td>
</tr>
<tr>
<td>Digoxin_Tab 250mcg</td>
<td>28</td>
<td>Feb-15</td>
<td>£1.01</td>
<td>£897</td>
<td>182, 5, 633</td>
<td>£229</td>
<td>£32</td>
<td>£32.36</td>
</tr>
<tr>
<td>Digoxin.Tab 62.5mcg</td>
<td>28</td>
<td>Feb-15</td>
<td>£1.44</td>
<td>£1,140</td>
<td>362, 7, 595</td>
<td>£1,286</td>
<td>£148</td>
<td>£148.01</td>
</tr>
<tr>
<td>Trimethoprim_Tab 100mg</td>
<td>28</td>
<td>Apr-15</td>
<td>£9.92</td>
<td>£1,904</td>
<td>199, 5, 527</td>
<td>£1,390</td>
<td>£376</td>
<td>£375.70</td>
</tr>
<tr>
<td>Trimethoprim_Tab 200mg</td>
<td>14</td>
<td>Feb-15</td>
<td>£1.03</td>
<td>£10,146</td>
<td>1,807, 21, 648</td>
<td>£4,314</td>
<td>-£5,832</td>
<td>-£5,832.24</td>
</tr>
<tr>
<td>Fosinopril_Sod_Tab 10mg</td>
<td>28</td>
<td>Apr-15</td>
<td>£2.45</td>
<td>£227</td>
<td>5, 152</td>
<td>£84</td>
<td>£57</td>
<td>£57.03</td>
</tr>
<tr>
<td>Fosinopril_Sod_Tab 20mg</td>
<td>28</td>
<td>Apr-15</td>
<td>£2.03</td>
<td>£144</td>
<td>6, 215</td>
<td>£118</td>
<td>£73</td>
<td>£73.30</td>
</tr>
<tr>
<td>Mefenamic Acid_Tab 500mg</td>
<td>28</td>
<td>Apr-15</td>
<td>£5.84</td>
<td>£1,194</td>
<td>62, 3, 446</td>
<td>£1,840</td>
<td>£564</td>
<td>£564.14</td>
</tr>
<tr>
<td>Mefenamic Acid_Cap 250mg</td>
<td>100</td>
<td>Apr-15</td>
<td>£6.68</td>
<td>£240</td>
<td>38, 3, 099</td>
<td>£395</td>
<td>£156</td>
<td>£155.57</td>
</tr>
<tr>
<td>Lofepramine HCl_Tab 70mg</td>
<td>56</td>
<td>Mar-15</td>
<td>£5.36</td>
<td>£3,509</td>
<td>248, 14, 469</td>
<td>£6,330</td>
<td>£2,821</td>
<td>£2,821.43</td>
</tr>
<tr>
<td>Sod Cromoglicate_Eye Dps Aq 2%</td>
<td>13.5</td>
<td>Apr-15</td>
<td>£1.95</td>
<td>£683</td>
<td>346, 5, 079</td>
<td>£1,095</td>
<td>£1,273</td>
<td>£1,273.07</td>
</tr>
<tr>
<td>Baclofen_Tab 10mg</td>
<td>84</td>
<td>Apr-15</td>
<td>£1.16</td>
<td>£1,749</td>
<td>554, 50, 890</td>
<td>£4,362</td>
<td>£2,613</td>
<td>£2,613.18</td>
</tr>
<tr>
<td>Diclofenac 50mg</td>
<td>28</td>
<td>May-15</td>
<td>£0.93</td>
<td>£1,250</td>
<td>556, 40, 095</td>
<td>£3,795</td>
<td>£2,544</td>
<td>£2,544.28</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td></td>
<td></td>
<td><strong>£14,531</strong></td>
<td></td>
<td><strong>£53,690</strong></td>
<td><strong>£11,760</strong></td>
<td><strong>£11,760</strong></td>
</tr>
</tbody>
</table>

### Implications of new NICE Guidance on Prescribing

6.1.7. **TA 337**: Rifaximin for preventing episodes of overt hepatic encephalopathy. Rifaximin is recommended, within its marketing authorisation, as an option for reducing the recurrence of episodes of overt hepatic encephalopathy in people aged eighteen years or older. Financial impact on CCG: Costing impact from NICE costing tool for South Tees CCG is annual costs of £42,195 from year three of implementation (Year 1 £15,333/Year 2 £28,764).

### 6.2. NICE Reviews

#### Nice Clinical Guidance

<table>
<thead>
<tr>
<th>Guideline</th>
<th>Published</th>
<th>Impact</th>
<th>Savings</th>
<th>Costs</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>CG28 Depression in children and young people (recommendations on psychological therapies and antidepressants)</td>
<td>March 2015</td>
<td>All</td>
<td>No impact</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CG 61 Irritable bowel syndrome in adults (update on dietary advice)</td>
<td>February 2015</td>
<td>All</td>
<td>No impact</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CG192 Antenatal and postnatal mental health: clinical management and service guidance evidence based advice on care</td>
<td>December 2014</td>
<td>All</td>
<td>No impact</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CG191 Pneumonia (evidence based advice on care)</td>
<td>December 2014</td>
<td>All</td>
<td>No impact</td>
<td>Unknown at this stage (see above section 7.8.2)</td>
<td></td>
</tr>
</tbody>
</table>
### Nice Technology Appraisal Guidance

<table>
<thead>
<tr>
<th>Technology Appraisal</th>
<th>Published</th>
<th>Impact</th>
<th>Savings</th>
<th>Costs</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>TA322 Lenalidomide for treating myelodysplastic</td>
<td>September 2014</td>
<td>All</td>
<td>No impact</td>
<td></td>
<td></td>
</tr>
<tr>
<td>TA321 Dabrafenib for treating unresectable or metastatic positive melanoma</td>
<td>September 2014</td>
<td>All</td>
<td>No impact</td>
<td>Unknown</td>
<td></td>
</tr>
</tbody>
</table>

### Nice Public Health Guidance

<table>
<thead>
<tr>
<th>Guideline</th>
<th>Published</th>
<th>Impact</th>
<th>Savings</th>
<th>Costs</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>PH55 Oral Health: approaches for local authorities and their partners to improve the oral health of their communities</td>
<td>October 2014</td>
<td>All</td>
<td>No impact</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### 7. Medium Term QIPP Strategy

7.1. The CCG’s quality, Innovation, productivity and prevention strategy is based on a process of;
   - Benchmarking the costs, quality and performance of services against peers and national standards.
   - Working with our workstreams, clinicians, patient representatives and other partner organisations to;
     - Adopt and implement new and innovative technologies as they become available.
     - Identify inefficiencies in health care provision with a view to eliminating waste.
     - Develop the related commissioning intentions.

7.2. Acute Elective Activity Benchmarking

7.2.1. The PBR Benchmarker website allows CCGs to measure their actual levels of activity and cost against an average level of activity for a CCG of a similar population. The most recent data now covers the financial year 2015-16 and shows that the previously identified trends are continuing.

7.2.2. Appendix 1 contains a comparison of elective activity per 100,000 weighted populations for local CCGs by HRG sub chapters. These comparisons will be used to further analyse areas for review by the CCG.
7.2.3. The CCG is an outlier for the following HRG chapters.

<table>
<thead>
<tr>
<th></th>
<th>Expected £000s</th>
<th>Observed £000s</th>
<th>Variance £000s</th>
<th>8 Quarter Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>FZ - Digestive System Procedures and Disorders</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>RTR - South Tees Hospitals NHS Foundation Trust IP/DC</td>
<td>20,585.42</td>
<td>28,219.58</td>
<td>7,634.15</td>
<td></td>
</tr>
<tr>
<td>NVC35 - Ramsay - Tees Valley Treatment Centre IP/DC</td>
<td>5,465.59</td>
<td>4,800.39</td>
<td>-665.20</td>
<td></td>
</tr>
<tr>
<td>RTR - South Tees Hospitals NHS Foundation Trust OPD</td>
<td>288.42</td>
<td>71.84</td>
<td>216.57</td>
<td></td>
</tr>
<tr>
<td>NVC35 - Ramsay - Tees Valley Treatment Centre OPD</td>
<td>532.87</td>
<td>199.71</td>
<td>333.15</td>
<td></td>
</tr>
<tr>
<td><strong>JC - Skin Surgery</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>RTR - South Tees Hospitals NHS Foundation Trust IP/DC</td>
<td>3,191.89</td>
<td>5,084.36</td>
<td>1,892.47</td>
<td></td>
</tr>
<tr>
<td>NVC35 - Ramsay - Tees Valley Treatment Centre IP/DC</td>
<td>1,143.60</td>
<td>1,341.23</td>
<td>197.63</td>
<td></td>
</tr>
<tr>
<td>RTR - South Tees Hospitals NHS Foundation Trust OPD</td>
<td>3,193.83</td>
<td>5,573.75</td>
<td>2,379.92</td>
<td></td>
</tr>
<tr>
<td><strong>HB - Orthopaedic Non-Trauma Procedures</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>RTR - South Tees Hospitals NHS Foundation Trust IP/DC</td>
<td>26,407.80</td>
<td>33,129.80</td>
<td>6,722.00</td>
<td></td>
</tr>
<tr>
<td>NT457 - BMI - Woodlands Hospital IP/DC</td>
<td>913.80</td>
<td>1,226.65</td>
<td>312.85</td>
<td></td>
</tr>
<tr>
<td>NT237 - Nuffield Health - Tees Hospital IP/DC</td>
<td>3,791.89</td>
<td>4,146.20</td>
<td>354.32</td>
<td></td>
</tr>
<tr>
<td>NVC35 - Ramsay - Tees Valley Treatment Centre IP/DC</td>
<td>6,268.75</td>
<td>3,704.79</td>
<td>-2,563.96</td>
<td></td>
</tr>
<tr>
<td><strong>MA - Female Reproductive System Procedures</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>RTR - South Tees Hospitals NHS Foundation Trust IP/DC</td>
<td>6,818.28</td>
<td>7,059.55</td>
<td>241.28</td>
<td></td>
</tr>
<tr>
<td>NT457 - BMI - Woodlands Hospital IP/DC</td>
<td>226.92</td>
<td>321.92</td>
<td>94.99</td>
<td></td>
</tr>
<tr>
<td>RTR - South Tees Hospitals NHS Foundation Trust OPD</td>
<td>3,145.25</td>
<td>5,793.62</td>
<td>2,648.37</td>
<td></td>
</tr>
<tr>
<td><strong>PA - Paediatric Medicine</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>RTR - South Tees Hospitals NHS Foundation Trust IP/DC</td>
<td>2,984.77</td>
<td>4,688.67</td>
<td>1,703.91</td>
<td></td>
</tr>
<tr>
<td><strong>CZ - Mouth Head Neck and Ears Procedures and Disorders</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>RTR - South Tees Hospitals NHS Foundation Trust IP/DC</td>
<td>8,699.95</td>
<td>10,398.59</td>
<td>1,698.64</td>
<td></td>
</tr>
<tr>
<td>NT457 - BMI - Woodlands Hospital IP/DC</td>
<td>31.06</td>
<td>49.32</td>
<td>18.25</td>
<td></td>
</tr>
<tr>
<td>NT237 - Nuffield Health - Tees Hospital IP/DC</td>
<td>17.44</td>
<td>14.46</td>
<td>2.97</td>
<td></td>
</tr>
<tr>
<td>NVC35 - Ramsay - Tees Valley Treatment Centre IP/DC</td>
<td>1,020.71</td>
<td>750.39</td>
<td>-270.32</td>
<td></td>
</tr>
<tr>
<td><strong>Outpatients</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>120 - ENT</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>350 - Infectious Diseases</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>301 - Gastroenterology</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>410 - Rheumatology</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>160 - Plastic Surgery</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>330 - Dermatology</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>420 - Paediatrics</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>341 - Respiratory Physiology</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

7.2.4. It is proposed that these services are considered during the development of the CCG’s commissioning intentions for 2015-16.
7.3. Prescribing Benchmarking

7.3.1. Early April 2015 data for medicines shows that the CCG continues to have a high cost per capita prescribing cost.

<table>
<thead>
<tr>
<th>Weighted per capita prescribing costs</th>
<th>£</th>
<th>Variance from Region</th>
<th>Variance from England</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 NHS Durham Dales, Easington &amp; Sedgfield CCG</td>
<td>4.15</td>
<td>10.4%</td>
<td>21.3%</td>
</tr>
<tr>
<td>2 NHS Sunderland CCG</td>
<td>4.03</td>
<td>7.2%</td>
<td>17.8%</td>
</tr>
<tr>
<td>3 NHS South Tees CCG</td>
<td>4.00</td>
<td>6.4%</td>
<td>17.0%</td>
</tr>
<tr>
<td>4 NHS South Tyneside CCG</td>
<td>3.92</td>
<td>4.3%</td>
<td>14.6%</td>
</tr>
<tr>
<td>5 NHS Newcastle Gateshead CCG</td>
<td>3.89</td>
<td>3.5%</td>
<td>13.7%</td>
</tr>
<tr>
<td>6 NHS North Durham CCG</td>
<td>3.87</td>
<td>2.9%</td>
<td>13.2%</td>
</tr>
<tr>
<td>7 NHS Hartlepool &amp; Stockton on Tees CCG</td>
<td>3.77</td>
<td>0.3%</td>
<td>10.2%</td>
</tr>
<tr>
<td>North East &amp; Cumbria</td>
<td>3.76</td>
<td></td>
<td>9.9%</td>
</tr>
<tr>
<td>8 NHS North Tyneside CCG</td>
<td>3.61</td>
<td>-4.0%</td>
<td>5.6%</td>
</tr>
<tr>
<td>9 NHS Darlington CCG</td>
<td>3.51</td>
<td>-6.6%</td>
<td>2.6%</td>
</tr>
<tr>
<td>10 NHS Northumberland CCG</td>
<td>3.44</td>
<td>-8.5%</td>
<td>0.6%</td>
</tr>
<tr>
<td>National</td>
<td>3.42</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11 NHS Cumbria CCG</td>
<td>3.41</td>
<td>-9.3%</td>
<td>-0.3%</td>
</tr>
</tbody>
</table>

Spend per head of population (April 2015)

8. Risks and Mitigations

8.1. Risks

8.1.1. The CCG has the following risks.

<table>
<thead>
<tr>
<th>Risks</th>
<th>Full Risk Value £000s</th>
<th>Probability of Risk being realised %</th>
<th>Potential Risk Value £000s</th>
<th>Proportion of Total %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute - Excessive PbR growth and failure of non-elective QIPP</td>
<td>£2,000</td>
<td>50.00%</td>
<td>£1,000</td>
<td>33%</td>
</tr>
<tr>
<td>Continuing Care – CHC Growth</td>
<td>£1,000</td>
<td>50.00%</td>
<td>£500</td>
<td>17%</td>
</tr>
<tr>
<td>Prescribing – Growth above 4.5%</td>
<td>£1,000</td>
<td>50.00%</td>
<td>£500</td>
<td>17%</td>
</tr>
<tr>
<td>Other – Failure of BCF to reduce non elective</td>
<td>£2,000</td>
<td>50.00%</td>
<td>£1,000</td>
<td>33%</td>
</tr>
<tr>
<td>Total</td>
<td>£6,000</td>
<td></td>
<td>£3,000</td>
<td>100%</td>
</tr>
</tbody>
</table>

8.2. Mitigations

<table>
<thead>
<tr>
<th>Mitigations</th>
<th>Full Mitigation Value £000s</th>
<th>Probability of success of mitigating action %</th>
<th>Expected Mitigation Value £000s</th>
<th>Proportion of Total %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contingency held</td>
<td>£2,076</td>
<td>100.00%</td>
<td>£1,000</td>
<td>43%</td>
</tr>
<tr>
<td>Contract Reserves</td>
<td>£3,000</td>
<td>60.00%</td>
<td>£1,800</td>
<td>36%</td>
</tr>
<tr>
<td>Delay / Reduce Investment Plans</td>
<td>£2,000</td>
<td>50.00%</td>
<td>£1,000</td>
<td>21%</td>
</tr>
<tr>
<td>Total</td>
<td>£7,076</td>
<td></td>
<td>£3,800</td>
<td>100%</td>
</tr>
</tbody>
</table>
9. Conclusion

9.1. The Governing Body is asked to note;
   • The current forecast outturn for 2015-16.
   • The CCG’s reserves and pipeline of current and expected projects
   • The strategic issues that will have a financial effect in future years
   • The opportunities for reviewing efficiencies identified in benchmarking data

Simon Gregory
Chief Finance Officer
July 2015
### Purpose of Paper
For Discussion

### Title
QPF Committee Headlines

### Responsible
Simon Gregory, Chief Finance Officer

### Author of the Report

### Recommendation(s)
The Governing Body is asked to note the key themes and issues arising from the Quality, Performance and Finance Committee 24 June 2015.

### Summary
The attached infographic highlights key issues identified at the QPF Committee. The size of the information blocks is linked to the economic size of the services commissioned.

#### Quality Issues
The current areas of concern for the CCG were discussed at the QPF Committee held on 24 June 2015. For South Tees Hospitals NHS FT (STHFT) these included the Trust’s current C.Difficile levels, MRSA cases and serious incident reports not closed within the time scales. For the North East Ambulance Service NHS FT (NEAS) the main quality concern was the current CQC action.

#### Performance Issues
For STHFT the issues reviewed by performance monitoring were Ambulance Handovers, the A&E 4-hour target, the Friends and Family Test and the Cancer waits: 2 week wait, 62-day GP Urgent, 62-day from screening. For Tees, Esk and Wear Valleys NHS FT (TEWV) IAPT waiting times and recovery percentage were a concern.

#### Finance Issues
The CCG’s principle financial concern at this early stage in the year was a potential year end overspend on CHC cases.

### Financial Implications
As set out above

### Legal/Regulatory Implications

#### Section 14R NHS Act 2006
The CCG must 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. The CCG must, in particular, act with a view to securing continuous improvement in the outcomes that are achieved and, in particular, outcomes which show the effectiveness of their services, the safety of the services provided, and the quality of the experience of the patient. In discharging this duty, the CCG must have regard to any relevant guidance published by the Board.

#### Section 14P NHS Act 2006
The CCG has a duty, when exercising its functions, to –
(a) act with a view to securing that health services are provided in a way which promotes the NHS Constitution; and
(b) promote awareness of the NHS Constitution among patients, staff and members of the public.
**Section 14Q NHS Act 2006**  
The CCG must exercise its functions effectively, efficiently and economically.

**Section 223H NHS Act 2006**  
Financial duties of clinical commissioning groups: expenditure  
(1) The CCG must, in respect of each financial year, perform its functions so as to ensure that its expenditure which is attributable to the performance by it of its functions in that year does not exceed the aggregate of —  
(a) the amount allotted to it for that year under section 223G,  
(b) any sums received by it in that year under any provision of this Act (other than sums received by it under section 223G), and  
(c) any sums received by it in that year otherwise than under this Act for the purpose of enabling it to defray such expenditure.

**Section 223I NHS Act 2006**  
The CCG must ensure that its revenue resource use in a financial year does not exceed the amount specified by direction of the Board.

| Assurance Framework/Risk Register Implications | All risks identified at the QPF Committee will be added to the CCG Risk Register and recorded in the meeting minutes. |
| Details of relationship to the NHS Constitution | A key element of the QPF Committee role is to monitor the delivery of patients' NHS constitutional rights. |
| Details of Patient and Public Involvement and/or Implications | N/A |
| Has an Equality Analysis been completed? | N/A |
| Attachments | QPF Headlines Glossary |
| Please detail any Committees or Forums at which this paper has previously been tabled | Quality, Performance & Finance Committee – 24 June 2015 |
Headlines from June’s Quality, Performance and Finance report

**Acute Secondary Care**

**£173.8m**

- South Tees Hospitals FT
- Independent Sector
- NEAS
- Newc’l
- NTH
- Others
- Cat A Calls
- CCG Reconciliation
- Performance Risk
- Quality Indicator
- Unclosed Serious Incidents
- FFT response rates
- NHS Outcomes Framework
- Constitutional Indicators
- HCAIs
- MRSA
- C.diff
- Constitutional Indicators
- Ambulance handovers
- 30+ min
- 60+ min
- Constitutional Indicators
- CCG Quality Premium
- Constitutional Indicators
- A&E 4-hrs
- Constitutional Indicators
- STHFT Cancer waits
- GP 62-day
- 62-day screening
- 2 week wait

**Community Services**

**£36.3m**

- South Tees FT
- Other
- AQP

**Other**

**£24.2m**

- 111
- PTs
- Re-ablement
- Reserves

**Prescribing**

**£53.9m**

**Mental Health and Learning Disabilities**

**£49.9m**

- Performance Risk
- Quality Indicator
- IAPT
- Other
- NTW:
- Funded Nursing Care
- Other
- Specialist Packages
- BCF
- PHB

**Continuing Healthcare**

**£27.5m**

**Other Primary Care**

**£8.3m**

- GP Out Of Hours
## Appendix 1

### Glossary

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>AQP:</td>
<td>Any Qualified Provider</td>
</tr>
<tr>
<td>BCF:</td>
<td>Better Care Fund</td>
</tr>
<tr>
<td>C. diff:</td>
<td>Clostridium difficile</td>
</tr>
<tr>
<td>Cat A Calls:</td>
<td>Category &quot;A&quot; calls to 999</td>
</tr>
<tr>
<td>Community Based Services:</td>
<td>Enhanced services commissioned from GP Practices</td>
</tr>
<tr>
<td>CQC:</td>
<td>Care Quality Commission</td>
</tr>
<tr>
<td>FFT:</td>
<td>Friends and Family Test</td>
</tr>
<tr>
<td>FT:</td>
<td>Foundation Trust</td>
</tr>
<tr>
<td>HCAIs:</td>
<td>Healthcare Associated Infections</td>
</tr>
<tr>
<td>HSMR:</td>
<td>Hospital Standardized Mortality Ratios</td>
</tr>
<tr>
<td>IAPT:</td>
<td>Improving Access to Psychological Therapies</td>
</tr>
<tr>
<td>MRSA:</td>
<td>Methicillin-resistant Staphylococcus aureus</td>
</tr>
<tr>
<td>NEAS:</td>
<td>North East Ambulance NHS Foundation Trust</td>
</tr>
<tr>
<td>NTH:</td>
<td>North Tees and Hartlepool NHS Foundation Trust</td>
</tr>
<tr>
<td>NTW:</td>
<td>Northumberland, Tyne and Wear NHS Foundation Trust</td>
</tr>
<tr>
<td>QP:</td>
<td>Quality Premium</td>
</tr>
<tr>
<td>SHMI:</td>
<td>Summary Hospital-level Mortality Indicator</td>
</tr>
<tr>
<td>SI:</td>
<td>Serious Incident</td>
</tr>
<tr>
<td>STHFT:</td>
<td>South Tees Hospitals NHS Foundation Trust</td>
</tr>
</tbody>
</table>
### Purpose of Paper

**Title**  
Development of Urgent Care Strategy

**Responsible**  
Clinical Lead – Nigel Rowell  
Managerial Lead – Craig Blair

**Author of the Report**  
Julie Stevens  
Commissioning & Delivery Manager, South Tees CCG

**Recommendation(s)**  
The Governing Body is asked to note the extensive ‘listening’ exercise that has commenced in relation to the development of the CCGs Urgent Care strategy.

### Summary

Our Clear and Credible Plan 2012 - 2017 sets out our vision for future health services and our desire to transform urgent care by ‘designing a simpler, more responsive and cost-effective system, with streamlined access points that makes sense to patients and helps them get the right care in the right place’. The CCG has therefore embarked upon a ‘listening’ exercise with our public and other key stakeholders to gain their views on current urgent care services in order to influence and shape an urgent care strategy.

The engagement began on the 13th of July 2015 and will run until the 10th of August, 2015. As well as a survey, we have arranged a number of listening events with established local groups across the community as well as four public drop-in events. Results of the engagement exercise will be used to shape the strategy and proposals for future models of care.

### Financial Implications

Not applicable at this stage.

### Legal/Regulatory Implications

If our proposals do involve significant service configuration, the CCG will need to further engage with our public through a formal consultation process.

### Assurance Framework/Risk Register Implications

Non at this stage.

### Details of relationship to the NHS Constitution

The development of this strategy relates to all 7 NHS principles and values.

### Details of Patient and Public Involvement and/or Implications

This is a programme of work to engage with our public.

### Has an Equality Analysis been completed?

This will be carried out alongside development of the strategy.

### Attachments

Briefing Paper

### Please detail any Committees or Forums at which this paper has previously been tabled

This particular paper has not been tabled at any other meeting. However, the engagement documentation and discussion around the engagement timetable has been shared with our GP Clinical Council of Members Meeting, South Tees Health Scrutiny Joint Committee, South Tees System Resilience Group. Redcar and Cleveland Health and Wellbeing Board and members of the Middlesbrough Health and Wellbeing Board are cited on our intention to engage with the public and develop a strategy.
Purpose

The purpose of this briefing paper is to appraise Governing Body members of plans to develop an urgent care strategy and how we propose to engage with the public and other key stakeholders in order to influence and shape this strategy.

Background

One of the CCG’s priorities reiterated through our Clear and Credible Plan is our desire to transform urgent care by designing a simpler and more responsive system which is also aligned to national thinking. We have developed a case for change document which describes in detail our current services and the drivers for change.

The scope of this strategy will be limited to ‘urgent care’ defined as ‘the range of health services available to people who need urgent advice, diagnosis and treatment quickly and unexpectedly for needs that are not considered life threatening’. As such we will consider self-care, NHS 111, primary care, community pharmacy, minor injury units and walk in centres. However, we will also include 999 and Accident and Emergency which are more appropriately defined as ‘emergency’ services acknowledging at the present time that people do access these services to meet urgent needs. Other aspects of urgent care such as; delivering alternatives to admissions and the development of emergency care pathways whilst in hospital are being addressed through other programmes of work, such as IMProVE, Teeswide System Resilience and the Better Care Fund.

Main drivers for change

- Demand on services – General demand is increasing on all health services as a result of an ageing population and growing expectations
- There are multiple entry points for urgent care which cause confusion for patients as to when and where to access services
- The system is complex to manage with numerous services, different providers and commissioners
- There is duplication in the system
- Emerging national initiatives – 7 day working for GPs and new national directives around urgent care models, for example the requirement for CCGs to now procure integrated 111 and out of hours services (issued after completing our case for change document).
- The cost of urgent care provision is high and we need to make best use of tax payers money
- GP numbers in South Tees are below the England average
- Challenges in relation to the emergency medicine workforce at James Cook Hospital in line with national pressures around delivering care over 7 days a week
- Current contracts for walk-in centres and out-of-hours doctors come to an end in September 2016 and this presents an opportunity to change the way we deliver services
- Patients have already told us that there is confusion around services, that access to primary care can be difficult, that A & E is over-used and that there should be more promotion of pharmacy services
Our Proposals

The CCG wishes to engage and talk to the public and key stakeholders about the development of an urgent care strategy based around the patient and their needs. We want to discuss and consider how we can:

- Reduce confusion for patients by standardising/combining services where appropriate
- Ensure a seamless service for patients irrespective of how and when they enter the system
- Improve outcomes and patient safety by sharing relevant patient information electronically across the urgent care system
- Educate patients around self-care and alternative urgent care provision – increasing the use of services such as pharmacy and NHS 111
- Achieve an overall reduction in the number of A & E and Walk-In Centre attendances (particularly those related to primary care conditions)
- Increase the number of patients treated ‘at the scene’ and to reduce numbers of inappropriate 999 calls.
- Commission services which are value for money, making more efficient and effective use of our health resources

We will also continue to work with NHS England to increase the level of patient satisfaction in relation to convenience and access to general practice

Next Steps

During July and August, 2015 we will be embarking upon an informal public and key stakeholder engagement exercise, with questionnaires and listening events to gain views around current urgent care services and our potential proposals.

To achieve a comprehensive understanding of the local picture, we will:

- Engage 350 people in on-street and telephone interviews using market research methodologies.
- Involve 700 people in a programme of 40 facilitated or guided conversations that target hard to reach groups in the conversations, people with long term conditions, people living on low household incomes, BME communities, people living with disabilities and long-term conditions, people with low educational achievements, working people, young people, parents of young children.
- Hold four public drop-in events across South Tees –
  - Skelton Civic Hall 22nd July – 4.30 – 60 p.m.
  - Breckon Hill Community Centre, Middlesbrough 24th July – 11.00—2.00 p.m.
  - Beacon, Redcar 30th July – 11.00 – 3.00 p.m.
  - Know Your Money, 73 Corporation Road, Middlesbrough 5th August – 1.30 – 3.30 p.m.
- Publish and promote a survey for the public to complete and return
Engagement will ascertain public views, experience and insight on: Self-care; GP & Practice Nurse services; Pharmacist; A&E usage; Walk in centre; GP Out of Hours; NHS111.

Views will then be used to help shape our strategy. If any significant change in service delivery is proposed as part of this work, we will then embark upon a formal public consultation exercise.

The results of our public engagement exercise are expected to be collated by September 2015 when they will be shared widely with key stakeholders.

Julie Stevens
Commissioning & Delivery Manager
South Tees Clinical Commissioning Group
July 2015
NHS South Tees Clinical Commissioning Group

Governing Body

Agenda Item: 3.7

Wednesday 29 July 2015

<table>
<thead>
<tr>
<th>Purpose of Paper</th>
<th>For Information</th>
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</thead>
<tbody>
<tr>
<td>Title</td>
<td>360° Stakeholder Survey Summary Report</td>
</tr>
<tr>
<td>Responsible</td>
<td>Dr Raj Khapra</td>
</tr>
<tr>
<td>Author of the Report</td>
<td>Phillipa Poole, Partnership Project Officer</td>
</tr>
</tbody>
</table>
| Recommendation(s) | It is recommended that the Governing Body:  
• Note the content of the Survey findings.  
• Recognise and appreciate the CCG’s achievements since 2014  
• Acknowledge and support the ambitions for the CCG to improve  
and build on the success of the survey results. |
| Summary          | The report summarises our annual stakeholder survey conducted by  
Ipsos Mori on NHS England’s behalf. |
| Financial Implications | NA |
| Legal/Regulatory Implications | NA |
| Assurance Framework/Risk Register Implications | NA |
| Details of relationship to the NHS Constitution | Does it relate to any of the 7 principles -  
Principle 4 - The NHS aspires to put patients at the heart of everything it does  
Principle 7 - The NHS is accountable to the public, communities and patients that it serves |
| Details of Patient and Public Involvement and/or Implications | NA |
| Has an Equality Analysis been completed? | NA |
| Attachments      | Report attached |
| Please detail any Committees or Forums at which this paper has previously been tabled | • SMT  
• Executive meeting |
Executive Summary
This paper identifies the results from the 2015 National 360 Stakeholder Survey and details an action plan for areas of development.

The CCG has been provided with the results of the CCG 360° Stakeholder Survey which delivers a broad range of feedback about the CCG’s key working relationships over the last 12 months. NHS England conducts the survey on behalf of all CCGs, allowing stakeholders to provide feedback on working relationships with CCGs. The survey serves two purposes:

i. The survey formed a useful part of the assurance conversations in 2014 and it is hoped the survey will once again provide CCGs with important evidence for the process again this year. It will assess whether the stakeholder relationships continue to be central to the effective commissioning of services by CCGs, and in so doing improve quality and outcomes for patients.

ii. It will also provide a wealth of data for CCGs to help inform their ongoing organisational development, enabling them to continue to build strong and productive local relationships. The findings will feed into the CCGs’ organisational development plans, providing a valuable tool for the CCG to be able to evaluate progress and inform development.

The survey was conducted between 10th March 2015 and 7th April 2015.

Headlines
Of the 85 stakeholders that were asked to take part 55 completed the survey - a response rate of 65%. Overall feedback was positive; 93% of respondents had said the working relationship with the CCG was very good or fairly good and 80% were very or fairly satisfied with how the CCG had engaged over the last 12 months.

<table>
<thead>
<tr>
<th>Stakeholder group</th>
<th>Invited to take part in survey</th>
<th>Completed survey</th>
<th>Response rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>GP member practices</td>
<td>45</td>
<td>26</td>
<td>58%</td>
</tr>
<tr>
<td>Health and wellbeing boards</td>
<td>4</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Local HealthWatch/patient groups</td>
<td>5</td>
<td>4</td>
<td>80%</td>
</tr>
<tr>
<td>NHS providers</td>
<td>5</td>
<td>4</td>
<td>80%</td>
</tr>
<tr>
<td>Other CCGs</td>
<td>5</td>
<td>5</td>
<td>100%</td>
</tr>
<tr>
<td>Upper tier or unitary local authorities</td>
<td>10</td>
<td>8</td>
<td>80%</td>
</tr>
<tr>
<td>Wider stakeholders</td>
<td>10</td>
<td>8</td>
<td>80%</td>
</tr>
</tbody>
</table>

The CCG had the flexibility to determine which individual within each organisation was the most appropriate to nominate. The table shows the stakeholder breakdown.
Overall areas of achievement
We can use the results of the survey to recognise our key achievements and where we have made real progress.

- Overall engagement with all stakeholders improved year on year
- 60% stakeholders felt the CCG had taken on board suggestions
- 80% of stakeholders were very or fairly satisfied with the way the CCG has engaged over the 12 months
- 76% strongly/ tended to agree the CCG had listened to views
- 93% stated very or fairly good when asked how they rated the working relationship with the CCG

We are confident that we have effective leadership and highly valued and regarded clinical leadership within our CCG and we will continue to encourage wider GP engagement from our member practices. The report reiterates where we have done well by demonstrating our committed to sharing best practice, innovation and to developing and supporting local initiatives such as the successful South Tees Access and Response (STAR) scheme bid to the Prime Ministers Challenge Fund which the CCG has supported. We will continue to develop on our areas of achievement progressing our integration programme and continually developing our relationships across the health and social care system.

We had significant improvement from 2014 to 2015 noted within the survey for our approach to listening to views from stakeholders when provided. We are committed to engaging with and listening to stakeholders and the public a demonstrated through our IMProve project. This should be seen as a success but also an area to further develop upon over the course of the year to once again improve on our survey results next year.

Overall areas of development
In the majority of areas, our stakeholders have told us that they find us good to work with, and they feel engaged and involved in planning and development of local health services. As a CCG we are ambitious and want to continually develop and improve.

On four of the 12 topics the CCG scored less in 2015 than in 2014. Appendix 1 details the comparison data. 3 of these areas were around our commissioning decisions and effectively communicating these commissioning decisions. We have already completed a lessons learnt exercise and implemented changes to the commissioning cycle process which once again exhibits our commitment to continuous improvement.

The 4th area was around the confidence stakeholders have that the CCGs plans will deliver continuous improvement in quality. We are working more closely with partners improving communication and understanding of the CCGs commitment to improving quality when we commission services.

44% of stakeholders felt the relationships had gotten a little better, however only 24 of the 55 stakeholders completed this question. As a CCG we can ensure
stakeholders are made aware of the survey earlier by trailblazing which will aim to improve update.

Not all the questions were answered, on a number of occasions questions were skipped out and so we do not have a full picture from all of the stakeholders that took part. We can work with our nominated stakeholders to ensure they are the ones who participate in the survey.

Health and wellbeing board representatives didn’t take part in the survey. We will aim to improve this next year.

Still some (small numbers) stakeholders that don’t feel engaged with the CCG. Appendix 2 includes a summary of the key achievements and areas of development.

Summary
Feedback from the 360° survey report has been particularly useful for the CCG to measure the impact of its communication and engagement activity.

The results give the CCG the opportunity to further refine and improve on its continuous focus to engage and communicate more widely, and develop positive relationships with partners in health, the local authority and community and voluntary sectors.

We can learn from the feedback given though we must take into consideration the small sample of stakeholders that took part in the survey. We need to continue to develop and build relationships with local partners and ensure that we are clear about our clinical leadership, our plans and priorities and the way that we share messages is consistent and clear.

Next Steps
- Progress the actions in the action plan- including ensuring we trail blaze the importance of completing the survey with our identified stakeholder and creating opportunities for people to influence and shape the CCG priorities.
- Share the results of the survey with our stakeholders and encourage further involvement from all stakeholders over the course of the year.
- We need to ensure we are demonstrating how we take account of views and suggestions and feedback and when we can and can’t progress these.
- Upload the results onto our website
### Overall engagement and relationship summary

**KEY**

<table>
<thead>
<tr>
<th>Description</th>
<th>CCG in 2014 (Base: 51/55)</th>
<th>CCG in 2015 (Base: 55/55)</th>
<th>CCG Cluster (Base: 782/767)</th>
<th>All CCGs (Base: 8320/8363)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Extent of engagement by CCG in last 12 months (% A great deal / A fair amount)</td>
<td>90%</td>
<td>91%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Satisfaction with engagement by CCG in last 12 months* (% Very / Fairly satisfied)</td>
<td>80%</td>
<td>80%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Extent that the CCG has listened to views when provided (% Strongly / Tend to agree)</td>
<td>69%</td>
<td>76%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Extent that the CCG has taken on board suggestions when provided (% Strongly / Tend to agree)</td>
<td>Not comparable to 2014</td>
<td>60%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Overall rating of working relationship with CCG (% Very good / Fairly good)</td>
<td>86%</td>
<td>93%</td>
<td></td>
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<tr>
<td>Change in working relationship with CCG in last 12 months** (% Got much better / Got a little better)</td>
<td>42%</td>
<td>44%</td>
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</tbody>
</table>
## Commissioning decisions and contribution to wider discussions

### KEY

<table>
<thead>
<tr>
<th>The CCG’s 2015 result is in top third of comparison group</th>
<th>The CCG’s 2015 result is in middle third of comparison group</th>
<th>The CCG’s 2015 result is in bottom third of comparison group</th>
</tr>
</thead>
</table>
| **COMPARISON GROUP**                                    | CCG in 2014  
(Base: 51)                                             | CCG in 2015  
(Base: 55)                                             | CCG Cluster  
(Base: 798)                                         | All CCGs  
(Base: 8472)                                      |
| Extent to which the CCG engages the right individuals / organisations when making commissioning decisions  
(% Strongly / Tend to agree)                           | 73%                                                        | 69%                                                        |                                                |                                                |
| Confidence in the CCG to commission high quality services  
(% Strongly / Tend to agree)                           | 76%                                                        | 78%                                                        |                                                |                                                |
| Understanding of the reasons behind commissioning decisions  
(% Strongly / Tend to agree)                           | 75%                                                        | 67%                                                        |                                                |                                                |
| Effectiveness of CCG’s communication about commissioning decisions  
(% Strongly / Tend to agree)                           | 73%                                                        | 71%                                                        |                                                |                                                |
| Confidence that the CCG’s plans will deliver continuous improvement in quality  
(% Strongly / Tend to agree)                           | 67%                                                        | 65%                                                        |                                                |                                                |
| Extent to which the CCG has contributed to wider discussions in local health economy  
(% A great deal / A fair amount)                      | Not comparable to 2014                                    | 80%                                                        |                                                |                                                |

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Social Research Institute  
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**South Tees CCG**  
Fieldwork: 10 March - 7 April 2015  
11
### Appendix 2- Domain areas of achievement and development

<table>
<thead>
<tr>
<th>Domains</th>
<th>Key areas of achievement</th>
<th>Key areas of development</th>
<th>Next Steps</th>
</tr>
</thead>
</table>
| **1. Are patients receiving clinically commissioned, high quality services?** | 85% of member practice (22 out 26) stated arrangements for member participation and decision making was very/ fairly effective.  
81% of member practices (21 out of 26) felt very/ fairly involved in the CCG’s decision making process. This was an increase from last year (69%).  
81% of member practices (21 out of 26) felt very/ fairly confident about the systems to sustain two way accountability between the CCG and member practices.  
88% stated strongly/ tend to agree that representatives from member practices can take a leadership role within the CCG.  
General agreement from NHS Provider stakeholders that Quality is a key focus of our contracts and clinicians are involved in discussions about quality and service redesign. | 15% of member practices (4 out 26) stated arrangements for member participation and decision making was not very/ not at all effective  
5 out of 26 member practices stated not very/ not at all involved in the CCG’s decision making process. | Overall the feedback we received from our member practices and our NHS providers was positive. There are some areas that we could progress as next steps including:  
Continue to engage with member practices via practice visits, locality councils, workstreams, CCOM etc  
Encourage further clinical involvement with the CCG. We need to be flexible in how we engage with clinicians.  
Improve on the ways that direct discussions between CCG leaders and practices occur.  
This could be with wider practice teams so all clinicians and support staff are aware of the CCG including contact details and access points  
We will review the way that we explain the commissioning cycle process and the way that we communicate the decisions with wider stakeholders. It should be noted that we received positive feedback about keeping our member practices informed; we should try to mirror this with other stakeholders.  
We need to ensure our communications and engagement plan reflects the themes from the stakeholder survey. |
| **2. Are patients and the public actively engaged and involved** | 69% (38) strongly/tend to agree that the CCG involves and engages with the right individuals and organisations when making commissioning decisions.  
78% (43) strongly/tend to agree they have confidence in the CCG to commission high quality services for the local population.  
67% (37) strongly / tend to agree they understand the reasons for the decisions that the CCG makes when commissioning services. | The understanding of the way in which the CCG commissions services could be better understood across all stakeholders.  
Only 1 of the 4 Healthwatch and patient group stakeholders felt that the CCG has engaged with seldom heard groups a great deal/a fair amount. |  |
### Domains

<table>
<thead>
<tr>
<th>Domains</th>
<th>Key areas of achievement</th>
<th>Key areas of development</th>
<th>Next Steps</th>
</tr>
</thead>
</table>
| 3. Are CCG plans delivering better outcomes for patients | 84% (46) strongly/tended to agree that they had been given the opportunity to influence the CCG’s plans and priorities  
71% (39) strongly/tended to agree that when they commented on the CCG’s plans and priorities comments have been taken on board.  
80% (44) strongly/tended to agree the CCG has effectively communicated its plans and priorities.  
67% (37) strongly/tended to agree the CCG’s plans and priorities are the right ones.  
93% (51) strongly/tended to agree that improving patient outcomes is a core focus for the CCG?  
85% of our member practice (22 of 26 completed this question) strongly/ tended to agree To what extent do you agree or disagree that value for money is a key factor in decision making when formulating my CCG’s plans and priorities? | 2 of the 4 Healthwatch and patient group stakeholders agreed that the CCG has engaged with seldom heard groups a great deal/a fair amount and patients and public had the opportunity to input into the commissioning decisions. The other 2 neither agreed nor disagreed. | We will share the complaints process and ensure local people and partners are aware of the correct process and contacts.                                                                                                                                                  |

We need to communicate the financial management plans with our member practice more over the course of the year so there is better understanding of the financial position of the CCG.
<table>
<thead>
<tr>
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<th>Key areas of development</th>
<th>Next Steps</th>
</tr>
</thead>
<tbody>
<tr>
<td>73% (19 of 26 of our member practice) stated they understood very well/fairly well the financial implications of the CCG’s plans. There were similar figures for understanding of the implications of the CCG’s plans for service improvement; the referral and activity implications of the CCG’s plans and the CCG plans to reduce health inequalities and the health of the local population.</td>
<td>85% (22 out of 26 member practices) answered very well/fairly well to how well, if at all, they understand what is required of your practice in order to implement the CCG’s plans?</td>
<td>100% of the 4 NHS providers answered very well / fairly well to the following questions- How well, if at all, would you say the CCG and your organisation are working together to develop long-term strategies and plans and how well, if at all, would you say the CCG understands the challenges facing your provider organisation.</td>
<td>Similarly 100% answered strongly agree/tend to agree to what extent do you agree or disagree that your contracts with the CCG place enough emphasis on delivering positive patient outcomes?</td>
</tr>
<tr>
<td>4. Does the CCG have robust governance arrangements?</td>
<td>91% of all stakeholders strongly agreed/ tended to agree that if they had concerns about quality they could raise with the CCG and 84% felt the CCG would act on this.</td>
<td>A small minority of local authority and wider stakeholders tended not to agree that we effectively monitor the quality of services.</td>
<td>Most stakeholders are confident that the CCG would act on feedback about the quality of services. This is higher that the findings for CCGs overall.</td>
</tr>
<tr>
<td>73% of member practices were very or fairly confident that the CCG had taken necessary steps to prepare for primary care co-commissioning.</td>
<td>24% of our member practice (6 out of 26 practices) felt they</td>
<td>There is still some work to progress on quality with wider stakeholders potentially aided by the integration/ BCF work being</td>
<td></td>
</tr>
<tr>
<td>Domains</td>
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<td>Key areas of development</td>
<td>Next Steps</td>
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<tr>
<td>5. Are CCGs working in partnership with others?</td>
<td>75% (6 of the 8 local authority stakeholders) answered very well/fairly well how well, if at all, the CCG and your local authority are working together to refresh shared plans for integrated commissioning?</td>
<td>9 of the 13 questions were to be answered by the health and wellbeing board representatives.</td>
<td>Most stakeholders agree that the CCG has contributed to discussions about the wider health economy.</td>
</tr>
<tr>
<td></td>
<td>88% - 7 of the 8 local authority stakeholders answered very well/fairly well how effective, if at all, has the CCG been as part of the Local Safeguarding Children Board?</td>
<td>50% (4 of the 8) local authority stakeholders answered not well at all to what would you say the CCG and your local authority are working together to deliver shared plans for integrated commissioning?</td>
<td>This is about the same as the finding for CCGs overall.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>50% 4 of the 8 local authority stakeholders answered not well at all, to what would you say the CCG and your local authority are working together to deliver shared plans for integrated commissioning?</td>
<td>Develop relationships with health and wellbeing board representatives.</td>
</tr>
<tr>
<td>6. Does the CCG have strong and robust leadership?</td>
<td>75% of all stakeholders agreed the CCG has the necessary blend of skills and experience.</td>
<td>One of the local authorities disagreed with the skills and visible leadership which is disappointing.</td>
<td>Though we must note that this is only one person’s views we can endeavour to work more closely with LA colleagues over the coming year to improve relationships.</td>
</tr>
<tr>
<td></td>
<td>85% of stakeholders felt there was clear and visible leadership for the CCG. This was up from 78% in 2014.</td>
<td>8% of stakeholders disagreed</td>
<td>There were a small number of stakeholders</td>
</tr>
<tr>
<td>Domains</td>
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<td>Next Steps</td>
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<td></td>
<td>80% of stakeholders have confidence in the leadership of the CCG to deliver its plans and priorities.</td>
<td>with that they had confidence in the leadership of the CCG to deliver its plans and priorities.</td>
<td>that disagreed that the CCG had a clear and visible leadership. We can work with our partners over the coming year to ensure there is confidence in the clinical leadership.</td>
</tr>
<tr>
<td></td>
<td>69% of stakeholders agreed the leadership of the CCG is delivering continued quality improvement.</td>
<td>58% strongly / tend to agree the clinical leadership of the CCG is delivering continued improvements to reduce local health inequalities.</td>
<td>The majority of stakeholders have confidence in the leadership of the CCG to deliver improved outcomes and to deliver its plans and priorities. This is higher than the finding for CCGs overall.</td>
</tr>
<tr>
<td></td>
<td>78% strongly / tended to agree confidence in the leadership of the CCG to deliver improved outcomes for patients.</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>78% strongly / tended to agree that there is clear and visible clinical leadership of the CCG.</td>
<td></td>
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<tr>
<td></td>
<td>75% strongly / tended to agreed they have confidence in the clinical leadership of the CCG to deliver its plans and priorities.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>69% strongly / tended to agree the clinical leadership of the CCG is delivering continued quality improvements.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. South Tees CCG’s local questions</td>
<td>64% of the 35 stakeholders answered very good/fairly good to involving you in the work of the Integrated management and proactive care of the vulnerable and elderly (IMProVE) project.</td>
<td>A number of stakeholders didn’t feel involved in the work of the BCF.</td>
<td>Raise awareness and involvement with partners on the BCF and integration agenda.</td>
</tr>
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<td></td>
<td>45% of the 25 stakeholders answered very good/fairly good to involving you in the work of the Better Care Fund.</td>
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<td></td>
<td>44% of the 25 stakeholders answered very good/fairly good when involving stakeholders in co-commissioning.</td>
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NHS South Tees Clinical Commissioning Group

Governing Body

Agenda Item: 3.8

Wednesday 29 July 2015

Purpose of Paper | For Discussion
--- | ---
Title | Assurance Framework
Responsible | Simon Gregory, Chief Finance Officer
Author of the Report | Jacqui Keane, Corporate Governance and Risk Officer
Recommendation(s) | The Governing Body are requested to:
  - Consider and agree the update of the Governing Body Assurance Framework;
  - Consider the future approach to the management of the Assurance Framework.

Summary

The attached paper provides an update to the Assurance Framework presented to the Governing Body in March 2015 and the summary provided in May 2015 as part of the CCG’s 2014/15 Annual Report. The updates to the risks are a result of reviews by the responsible director or risk owner, together with a comprehensive review of all risks by the Executive Group at its meeting on 8 July 2015.

The Executive Group’s discussion ensures that there is a greater depth of understanding and ownership whilst also allowing for cross-cutting themes, controls or actions to be identified.

The Governing Body’s attention is drawn to the following:
- 1040 – CCG’s failure of C.Diff target as a result of providers failure of their target. This likelihood of this risk has increased.
- 1352 and 1353 are new risks relating to CHC capacity and effective use of resources. These risks replace risk number 773.
- 836 – re implementation of Better Care Fund now incorporates elements of risk 377 re QIPP which has been removed from the Risk Register.
- 1060 – GP IT budget is a new risk on the Assurance Framework as the residual likelihood score has increased.
- 1143 – surges in activity. This has been removed from the Risk Register as the residual risk has reduced to 3x2=6 due to an increase in performance.
- 1043 – STHFT financial position – removed from the Assurance Framework as risk has reduced to 3x3=9.
- 1042 – Implementation of Commissioner Requested Service – removed from the Assurance Framework due to significant actions successfully being undertaken. New score of 3x1=3.

Financial Implications | There are no distinct financial implications in implementing the Assurance Framework, however there may be financial implications associated with the actions required to mitigate risk.
| Legal/Regulatory Implications | The Assurance Framework provides the Governing Body with assurance that members are fulfilling their statutory obligations and duties of quality, care, public and patient involvement as well as the statutory financial duties. It also assists in the process for developing the Annual Governance Statement and provides assurance that risks which may affect the organisation's ability to deliver its strategic objectives are escalated and managed. |
| Assurance Framework/Risk Register Implications | The Assurance Frameworks is a strategic risk register and is the Governing Body's tool to oversee and link wider risk management issues. |
| Details of relationship to the NHS Constitution | The Assurance Framework provides a process for assuring that the organisation is fulfilling its obligations whilst managing strategic risk and this includes upholding the organisation’s obligations as defined in the NHS Constitution. |
| Details of Patient and Public Involvement and/or Implications | The Assurance Framework provides a mechanism for identifying risks which would potentially result in the organisation not fulfilling its duties relating to equality analysis and, therefore, this is not required for this document. |
| Has an Equality Analysis been completed? | The Assurance Framework is a mechanism for identifying risks which would potentially result in the organisation not fulfilling its duties relating to equality analysis and therefore this is not required for this document. |
| Please detail any Committees or Forums at which this paper has previously been tabled | Executive Group – 8 July 2015. |
The nature of healthcare naturally exposes the CCG to a number of risks. The Governing Body has considered the nature and extent of the significant risks it is willing to take in achieving the CCG’s objectives. It has been agreed that risks rated at level 12 and above would be included within the Assurance Framework. These key risks, their level and mitigating actions and assurances are summarised in the tables below.

To demonstrate a measurable improvement in the quality and safety of the services that we commission and the experiences of those who use them.

<table>
<thead>
<tr>
<th>Residual risk</th>
<th>Risk description</th>
<th>Mitigation</th>
</tr>
</thead>
<tbody>
<tr>
<td>C4xL4 = 16</td>
<td>Risk of not improving C.Diff performance and not addressing issues affecting prevalence. Consequent impact on quality and system resilience.</td>
<td><strong>Controls</strong></td>
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<td>- Board to Board meetings between CCG and Trust in line with CCG escalation process.</td>
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<td>- Trust action plans reviewed bi-monthly at Clinical Quality Review Group.</td>
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<td>- Executive level discussions</td>
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<td>- Additional external reviews being carried out to review effectiveness of systems and controls within the Trust.</td>
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<td>-- Schedule of announced and unannounced visits by the CCG to triangulate discussions and assurances that have been provided by the Trust with demonstrated practices on wards.</td>
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<td>- Continued involvement of the CCG in programme of ‘Board to ward’ visits in the Trust.</td>
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<td>- Multi-agency meetings with CCGs, Trust and Local Authority.</td>
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<td>- Reviews of reporting arrangements</td>
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<td>- Contract monitoring meetings</td>
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<td>- Primary care antimicrobial prescribing monitoring</td>
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<td>- GPs received advice and guidance re C.Diff and prescribing.</td>
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<td>- Discussions between GB GPs and STHFT Chiefs of Service</td>
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<td>- Working Group being established between STHFT and primary care re C.Diff</td>
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</table>

**Internal Assurance**

- Board to Board meeting with Trust and CCG.
- Executive Group
- Clinical Quality Review Group
- Quality Surveillance Groups
- Primary care antimicrobial prescribing is monitored via QPF Cttee.

**External Assurance**

- Care Quality Commission Reports Local Area Team.
- Enhanced scrutiny and reporting to Monitor
- CCG’s continued dialogue with Monitor
- Additional external reviews being carried out to review effectiveness of systems and controls within the Trust.
- Independent review of processes and procedures carried out in December 2013.
- Progress of evidence against action plans is rigorously challenged.
- Confirmation received by NHS England of Trust’s progress against Wilcox recommendations.

**CHANGES FROM PREVIOUS GOVERNING BODY:**

- Risk wording reframed to more accurately reflect risk.
The risk was reviewed by the Executive Nurse in June and July 2015. The risk was reviewed by the Executive Group on 8 July 2015. Additional controls and assurances identified.

To demonstrate a measurable improvement in the quality and safety of the services that we commission and the experiences of those who use them.

### 1040 – CCG failure of C.Diff target as result of main providers ability to deliver their own Clostridium difficile target

<table>
<thead>
<tr>
<th>Residual risk</th>
<th>Risk description</th>
<th>Mitigation</th>
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<tbody>
<tr>
<td>16 Extreme Risk</td>
<td>As a consequence of main provider’s failure to meet C.Diff target the CCG could be under greater scrutiny and reputational damage and scrutiny from NHS England.</td>
<td><strong>Controls</strong></td>
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<td>Board to Board meeting in line with CCG’s escalation process.</td>
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<td>Trust action plan reviewed bi-monthly at South Tees FT Clinical Quality Review Group.</td>
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<td>Exec to Exec meetings.</td>
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<td>QPF Committee reporting</td>
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<td>Governing Body reporting.</td>
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<td>Review of community acquired cases.</td>
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<td>Continued programme of announced and unannounced commissioner assurance visits which helps to triangulate other data.</td>
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<td>Medicines management educational programme established for GPs re antimicrobial prescribing in order to reduce inappropriate prescribing.</td>
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<td>Monthly GVIS reporting to include prescribing reduction information</td>
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<td>Daily monitoring of Trust’s C.Diff levels.</td>
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<td><strong>Internal Assurance</strong></td>
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<td>Regular Contract Review meetings with providers.</td>
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<td>Discussions at Quality, Performance and Finance Committee.</td>
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<td>Discussions at Executive Group</td>
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<td></td>
<td></td>
<td>Discussions at Clinical Quality Review Group Quality Surveillance Groups</td>
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<td>Primary care antimicrobial prescribing is monitored via QPF Cttee.</td>
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<td><strong>External Assurance</strong></td>
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<td>Care Quality Commission Reports Local Area Team.</td>
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<td>Enhanced scrutiny and reporting to Monitor</td>
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<td>CCG’s continued dialogue with Monitor</td>
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<td>Additional external reviews being carried out to review effectiveness of systems and controls within the Trust.</td>
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<td>Progress of evidence against action plans is rigorously challenged.</td>
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<td></td>
<td>Confirmation received by NHS England of Trust’s progress against Wilcox recommendations.</td>
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</table>

**CHANGES FROM PREVIOUS GOVERNING BODY**
- The risk was reviewed by the Executive Nurse in June and July.
- The risk was reviewed by the Executive Group on 8 July 2015.
- Risk score increased.
To demonstrate a measurable improvement in the quality and safety of the services that we commission and the experiences of those who use them.

### 770 - Identification of Safeguarding Children GP

<table>
<thead>
<tr>
<th>Residual risk</th>
<th>Description</th>
<th>Mitigation</th>
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</thead>
</table>
| 15 Extreme Risk | Without a named GP for Children’s Safeguarding the CCG is outside of the intercollegiate guidance and thus there is no specific GP resource to promote and support the safeguarding of children in primary care. | **Controls**  
The CCG Clinical Chair is providing input to this role on an interim basis.  
The responsibility to provide a Named GP sits with the NHS England Sub Regional Team. Recent agreement by NHSE to fund and support a 0.5wte post to work across South Tees and HAST CCGs.  
Executive Nurse weekly updates to CCG Executive Group meetings to ensure awareness for GP Locality Leads and other Executive GPs of any key, or emerging, issues.  
The delivery of comprehensive Safeguarding Children training programmes across the Tees four Local Authorities provides ample opportunity for the GPs to ensure that they are up to date with their education and practice.  
2014-15 NHS England has commissioned additional (over and above LSCB provision) specific GP Safeguarding children training.  
Using intercollegiate documents and NHSE guidance a job description has been drawn up and will be advertised in March 2015.  
Attendance at NHS Cumbria & North East sub-regional QSG safeguarding meetings.  
Regular meetings of the Children’s Safeguarding team ensures constancy of communication and transfer of information.  
Each GP Practice is required by the CQC to have an identified Safeguarding Lead. This person is expected to be able to provide the first level response to any safeguarding questions. |

<table>
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<tr>
<th>Initial risk rating</th>
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<tbody>
<tr>
<td>C3xL5 = 15</td>
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</table>

| Lead | Executive Nurse |

| Actions Required/ongoing | Discussions with potential candidate ongoing. |

### Internal Assurance
- Reports and discussions at QPF Committee  
- Governing Body quality updates and discussions  
- CCG safeguarding team attended Council of Members meeting in January 2014.  
- Monitoring of progress against primary care action plan.  
- Monitoring of training attendance

### External Assurance

### Gaps
No GP in place.

**CHANGES FROM PREVIOUS GOVERNING BODY**
- The risk was reviewed by the Executive Nurse in June and July 2015.  
- The risk was reviewed by the Executive Group on 8 July 2015.  
- CCG Clinical Chair providing input to this role on an interim basis.
To demonstrate a measurable improvement in the quality and safety of the services that we commission and the experiences of those who use them.

### 1352 - Capacity of Continuing Health Care Team

<table>
<thead>
<tr>
<th>Residual risk</th>
<th>Description</th>
<th>Mitigation</th>
</tr>
</thead>
</table>
| High Risk C3xL4 = 12 | The core capacity of the CHC team contributes to broader system pressures, eg. impact on delayed transfers of care in the acute sector and potential financial implications for the CCG. | Controls  
Workload and activity review carried out.  
Finances reviewed fortnightly with the CSU CHC finance team.  
Monitoring through QPF Committee.  
Increased monitoring of SLA.  
Additional investment had been allocated by the CCG to assist with pressures.  
Monitoring at CHC Contract Monitoring Board. |
| **Initial Risk Rating C3xL4=12** | | Internal Assurance  
Monitoring at CHC Contract Management Board.  
Evidence demonstrates that the higher risk packages are being carried out as greater priority.  
Gathering of improved data to ensure appropriate actions are undertaken.  
Reporting and discussions at QPF Committee. |

**Lead**  
Chief Finance Officer

**Actions Required**  
Executive Nurse discussions with Trust re timeliness of nursing assessments and avoidance of peaks & troughs in activity.  
CMB discussions with Trust re avoidance of peaks & troughs in nursing assessments.

**Controls**  
Workload and activity review carried out.  
Finances reviewed fortnightly with the CSU CHC finance team.  
Monitoring through QPF Committee.  
Increased monitoring of SLA.  
Additional investment had been allocated by the CCG to assist with pressures.  
Monitoring at CHC Contract Monitoring Board.

**Internal Assurance**  
Monitoring at CHC Contract Management Board.  
Evidence demonstrates that the higher risk packages are being carried out as greater priority.  
Gathering of improved data to ensure appropriate actions are undertaken.  
Reporting and discussions at QPF Committee.

**External Assurance**  
Financial reporting to Area Team.  
Meetings with Executive teams of Local Authorities.  
Inclusion within internal audit plan.  
NECS Service Audit Report

**Gaps**  
Further evidence required to support performance management process.

**CHANGES FROM PREVIOUS GOVERNING BODY:**

- The risk was reviewed by the Executive Group on 8 July 2015.
- Workload pressures are continuing, however, controls are continuing to be applied.
- Greater focus being placed on performance management re CHC via the dedicated CHC Contract Management Board.
- Additional actions and focus on avoiding peaks and troughs in assessment activity. Joint working being pursued to facilitate this.
**Partnership working to improve health and wellbeing of patients and communities.**

### 836 - Implementation of the Better Care Fund

<table>
<thead>
<tr>
<th>Residual risk</th>
<th>Description</th>
<th>Mitigation</th>
</tr>
</thead>
<tbody>
<tr>
<td>16 Extreme Risk</td>
<td>Implementation of Better Care Fund will require funding to be transferred from acute emergency care to support more integrated social and health care services. This will result in £14m to be released from acute Care contracts. Reputational risk of non-delivery of schemes in the BCF re system transformation, particularly around primary care transformation.</td>
<td><strong>Controls</strong>&lt;br&gt;Joint working with external agencies to ensure that all investment has health impact. Executive Group meetings. Governing Body reporting. BCF Plan completed and agreed with stakeholders. Revised emergency admissions target to 3.5% in 2015/16 five year plan to achieve the required 15%. Monitoring of process and metrics. Regular updates received via the Programme Board.</td>
</tr>
<tr>
<td>C4X4</td>
<td><strong>Internal Assurance</strong>&lt;br&gt;Meetings with Executive Teams of Health &amp; Wellbeing Board. Submission and acceptance of plan by NHS England. Integration Executive to include finance representation via the Chief Finance Officer.</td>
<td><strong>External Assurance</strong>&lt;br&gt;Plans have been approved by NHS England ‘with support’ Health and Wellbeing Board Meetings with Executive teams of Local Authorities. NHS England monitoring.</td>
</tr>
</tbody>
</table>

**Initial risk rating**<br>C4xL4 = 16

**Lead**<br>Chief Finance Officer

**Actions Required**<br>Continue joint working with partners and stakeholders to ensure all elements of 5 year plan guidance is delivered. Ongoing monitoring

**Gaps**<br>None.

**CHANGES FROM PREVIOUS GOVERNING BODY:**
- Risk reviewed by Chief Finance Officer June and July 2015.
- The risk was reviewed at the Executive Group on 8 July 2015.
- This risk has been amended to incorporate risk number 377 (QIPP)
- Additional controls identified.
Reduce waste and increase productivity’ enabling delivery of our statutory obligation to deliver financial balance.

1353 – Ineffective use of resources for management of CHC restitution cases.

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<thead>
<tr>
<th>Residual risk</th>
<th>Description</th>
<th>Mitigation</th>
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</table>
| 12 C3XL4      | Risk that additional CCG resources for CHC restitution are not utilised effectively to carry out his work. Delays in the process may create a financial risk. | Controls  
Workload and activity review carried out.  
Finances reviewed fortnightly with the CSU CHC finance team.  
Internal Assurance  
CHC Contract Management Board established.  
Gaps  
Lack of benchmarking across other CCG CHC teams. |

Initial risk rating  
C3xL4 = 12

Lead  
Chief Finance Officer

Actions Required  
Continued close monitoring.

CHANGES FROM PREVIOUS GOVERNING BODY:
- New risk
- Risk reviewed by Chief Finance Officer June and July 2015.
- The risk was reviewed at the Executive Group on 8 July 2015.
Reduce waste and increase productivity’ enabling delivery of our statutory obligation to deliver financial balance.

### 1060 – Delegation of GP IT budget

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<tr>
<th>Residual risk</th>
<th>Description</th>
<th>Mitigation</th>
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<tbody>
<tr>
<td>12 C3xL4</td>
<td>NHS England GP IT budget delegated to the CCG, however, there is a reduction on the historic spend from £7 per head of population to £3.50. This may result in rationalisation and prioritisation of GP IT expenditure with consequent impact on Practices.</td>
<td>Controls</td>
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<td>Continuing to work with the CSU re the transitional funding plan.</td>
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<td>Bridging funding secured for 2015/16.</td>
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<td>CCG met costs of medicines advice software.</td>
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<td>Meetings between CFO and GP IT Lead.</td>
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</table>

**Initial risk rating**

C3xL4 = 12

**Lead**

Chief Finance Officer

**Actions Required**

CSU IT team considering alternatives to SMS service

Continued communication in order to identify fully impact and mitigate against risks.

**Internal Assurance**

Ongoing monitoring and discussions with IT and Practices.

**Gaps**

None identified.

---

**CHANGES FROM PREVIOUS GOVERNING BODY:**

- Risk reviewed by Chief Finance Officer June and July 2015.
- The risk was reviewed at the Executive Group on 8 July 2015.
- Residual likelihood score increased.
# NHS South Tees Clinical Commissioning Group

**Governing Body**

**Agenda Item: 4.1**

**Wednesday 29 July 2015**

## Purpose of Paper

**For Discussion**

<table>
<thead>
<tr>
<th>Title</th>
<th>Commissioning Support and the Lead Provider Framework</th>
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<tbody>
<tr>
<td>Responsible</td>
<td>Amanda Hume - Chief Officer</td>
</tr>
<tr>
<td>Author of the Report</td>
<td>Alex Sinclair - Head of Programmes and Delivery</td>
</tr>
<tr>
<td>Recommendation(s)</td>
<td>Further dialogue with the governing body on the opportunities and risks surrounding the LPF process.</td>
</tr>
<tr>
<td>Summary</td>
<td>This paper is intended to provide the Governing Body with an overview of the Lead Provider Framework (LPF) and how this can be used to source commissioning support for the CCG.</td>
</tr>
</tbody>
</table>

## Financial Implications

| Utilisation of the LPF will ensure commissioning support services provide value money for the CCG |

## Legal/Regulatory Implications

| The LPF complies with EU procurement law. |

## Assurance Framework/Risk Register Implications

| The mobilisation period of any potential new provider needs to be recognised and contingencies put in place such that key CCG priorities are met whilst any potential new provider becomes established. |

## Details of relationship to the NHS Constitution

| Ensuring high quality, value for money commissioning support services |

## Details of Patient and Public Involvement and/or Implications

| Not applicable |

## Has an Equality Analysis been completed?

| No |

## Attachments

| Appendix 1 - LPF lots |
| Appendix 2 - Detail of LPF Lots |
| Appendix 3 - Overview of LPF process |

## Please detail any Committees or Forums at which this paper has previously been tabled

| Executive Management Team on 20 May 2015 |
Governing Body

29th July 2015

Commissioning Support and the Lead Provider Framework

1.0 Purpose

This paper is intended to provide the Governing Body with an overview of the Lead Provider Framework (LPF) and how this can be used to source commissioning support for the CCG.

2.0 Background

With existing service level agreements (SLAs) expiring in March 2016, CCGs are required to re-procure commissioning support services they wish to continue to purchase. The LPF has been developed in response to CCGs requirements nationally, as:

- A quicker and easier route to choosing and switching commissioning support
- An enabler for CCGs to put long term robust contracts in place with a provider of choice
- A method of accrediting providers on quality and price
- A reduced legal risk for CCGs, ensuring fair and open procurement, complying with EU law
- A supportive a managed transition, maximising continuity for commissioners

The alternative to this process would be to run a full tender process via the Official Journal of the European Union (OJEU) due to the requirement for CCGs to run an open and fair procurement for any Part A service contacts with a lifetime contract value over £111,676; however the LPF process has been designed to enable CCGs to meet procurement rules and provide support for CCGs who do not have in house procurement expertise or resource.

The newly commissioned support services must be in place by April 2016; however mobilisation of services can take a phased approach.

3.0 Scope of the LPF

The LPF offers the CCG the opportunity to collaborate with other CCGs using a ‘mini-competition’ process which will support the realisation of volume based discounts from potential providers. In adopting this approach CCGs are not bound to a single specification, single contract or single term (fixed length).

The LPF is split into two specific ‘lots’.

Lot 1 covers the ‘end to end’ commissioning support and consists of:

- Business Support Services
- Health Care Procurement and Provider Management
- Transformation and Service Redesign
- Communications and Public and Patient Engagement
- Business Intelligence
Lot 2 (split into 2 sub-lots) consists of:

- Medicines Management and Optimisation (Lot 2A)
- Individual Funding Requests and Case Management (Lot 2B)
- Supporting the commissioning of Continuing Health Care and Funded Nursing Care (Lot 2B)

Appendix 1 shows summary diagram of the LPF lots and Appendix 2 describes the detail of the services provided within the LPF ‘lots’.

4.0 Overview of LPF process

The LPF operates through a 3 stage process as follows:

- **Preparation Stage (One month)**
  - Scoping
    - Review of current services being bought
    - Development of a project plan
    - Establish a baseline position – including the potential for in-housing services
    - Agree if collaborative buying with other CCGs
  - Specification
    - Development of specifications in conjunction with NHS England
  - Tender Development
    - Work with NHS England to develop detailed tender documentation including KPIs, period of contract, evaluation process, etc

- **Tender Stage (Two months)**
  - Contact Suppliers
    - Issue documentation to suppliers
    - NHS England to run a ‘market event for face-to-face engagement with suppliers
    - Clarify questions and share responses with all suppliers
  - Evaluation
    - Evaluate responses based on the indicators set out on the tender documentation

- **Award and Mobilisation stage (Four to six months)**
  - Award Contract
    - Notify successful/unsuccessful applicants
    - NHS England to draft contract for CCG and supplier sign-off
    - Agree draft implementation plan
  - Mobilisation
    - NHS England to support with transfer of data, assets and staff where applicable (Stranded costs)
  - Contract Management
    - Implementation of contract management with further support from NHS England

A diagrammatical overview of this process can be found in Appendix 3.
5.0 ‘Buying Options’ from the LPF

The LPF enables the CCG and any partner CCGs to exploit potential volume based discounts while reducing any unnecessary fragmentation. This can be achieved through working in one of three ways; collaborative working, co-ordinated working or hybrid working.

- **Collaborative working**: uses a single set of tender documents, single specification or separate schedules for each CCG, a single provider would be awarded a contract. A single CCG would either sign a contract on behalf of others or all CCGs can be party to the agreement – the contract can be managed collectively or through a lead CCG.

- **Coordinated working**: each CCG has a set of tender documents submitted to framework bidders in parallel, each CCG evaluates and appoints preferred provider and manages their own contracts.

- **Hybrid working**: this requires a joint specification for some services and separate specs for others.

South Tees CCG is currently working collaboratively with other CCGs in the Northern region as recommended by NHS England, therefore avoiding fragmentation of commissioning support services across the region. In the collaborative model South Tees CCG will have the three options below.

**Option A**: A single contract where each Commissioner’s requirements are identical and where no separate service schedules are included.

**Option B**: A single contract with a single provider with separate schedules detailing each Commissioner’s requirements and costs.

**Option C**: A single procurement process leading to the award of contracts to the same single provider but with separate contracts between each Commissioner and the provider.

6.0 Needs assessment

On 20th May 2015 the Executive team of the CCG undertook an initial needs assessment of commissioning support services which included exploring the current commissioning support service lines and service level alongside value for money and the ability of the current commissioning support model to provide flexibility and resilience for the CCG in the future.

7.0 Next Steps

Further dialogue with the governing body on the opportunities and risks surrounding the LPF process.
Appendix 2
Commissioning Support Services in the LPF Framework

Lot 1

1.0 Business Support Services
2.0 Healthcare Procurement and Provider Management
3.0 Transformation and Service Redesign
4.0 Communications and Patient and Public Engagement
5.0 Business Intelligence

Lot 2A Medicines Management and Optimisation
Lot 2B IFR and CHC / FNC

1.0 Business Support Services

1.1 Financial Management and Accounting

Provision of strategic and operational financial management and accounting services, including but not limited to:
- financial modelling, planning, accounting and operations; reporting and analysis;
- management accounting, general accounting services; systems accounting and accounting service support;
- budget setting and control;
- systems management;
- cash management and forecasting;
- working capital and fixed asset management;
- VAT advisory and management services;
- specialist financial support;
- invoice payment and invoice query management; and
- supplies management including transactional procurement services.

1.2 Payroll

Provision of payroll services including but not limited to:
- payroll processing;
- account management; and
- payroll administration.

1.3 HR and OD

Provision of strategic and operational HR services. Services include but are not limited to:
- recruitment, selection, retention, development and departure management;
- employee administration;
- HR policy and process development;
- pension advice and administration;
- advice, implementation and compliance with HR legislation and standards;
- equality and diversity, employee well-being and Occupational Health services;
- talent management, performance management, job evaluation and leadership development;
- learning and development including statutory training requirements;
- change management and organisational design services;
organisational development;
workforce planning and management;
remuneration services; and
industrial relations.

1.4 ICT

Provision of ICT infrastructure, ICT support and strategic ICT services (including in a primary care setting). Services include but are not limited to:
- managed ICT infrastructure services including network services, storage & server management and asset and disposal management;
- disaster recovery services;
- managed data hosting;
- systems integration and interoperability;
- implementation and support of software solutions;
- service desk and desktop support;
- remote access services;
- registration authority (RA) and administration of access to clinical and business systems;
- clinical safety assurance services;
- print management;
- telephony and mobile device management;
- IT Strategy services (including support for development of strategic plans and strategy delivery, identification of best practice and market development, benefits testing and realisation);
- implementation and support to national programmes of work;
- programme and project management support;
- training; and
- access to specialist resource.

1.5 Corporate Governance and Risk Management

Provision of services for the smooth and compliant running of an organisation. Services include but are not limited to:
- business continuity planning, testing and resilience;
- compliance with information governance legislation;
- development and implementation of corporate governance and risk management frameworks;
- support in handling governance and risk issues;
- assurance and compliance services delivered within, and supporting progression beyond, legal and regulatory responsibilities across the customer organisation, including equality and diversity, health and safety, data protection and information governance advice;
- support to embed equality and diversity in practice, including through equality objective setting, publishing equality information, equality analysis, training for staff and board members and equality impact assessments; and
- information governance to ensure confidentiality and integrity of information, data security and provision of information governance toolkits.
2.0 Healthcare Procurement and Provider Management

2.1 Healthcare Procurement
Full provision of procurement support of NHS funded clinical services and/or social care services. Services include but are not limited to:

- the provision of strategic advice on healthcare procurement methodologies;
- the relevant technical infrastructure and provision of expert tactical resources to deliver a range of healthcare procurement options;
- implementation of end to end procurement service across the commissioning cycle;
- provision of access to specialist procurement expertise;
- expert advice and support to enable customers to operate within procurement regulatory requirements (for example the Public Services (Social Value) Act 2012);
- engagement of relevant stakeholders throughout the procurement process.

2.2 Market analysis and Development
Provision of market analysis and development services. Services include but are not limited to:

- analysis, benchmarking, mapping and scoping of health and social care markets;
- development of strategies for developing markets;
- supporting the development and implementation of market strategies; and
- increasing the number of providers (and the range of services offered by those providers) within local markets.

2.3 Contract Requirement definition and negotiation
Provision of contracting activities that enable the acquisition of high quality healthcare provision efficiently and effectively. Services include but are not limited to:

- the analysis of what services are needed, their scope and definition;
- providing technical advice on contract opportunities;
- negotiation/renegotiation of contracts on behalf of a customer; and
- identification and implementation of innovative commissioning models and approaches

2.4 Provider and contract management
Provision of services to manage both contracts and providers to ensure better provision and value for money. Services include but are not limited to:

- proactive management of contract performance to ensure that performance measures are met and delivery is on target and to identify and address potential contract performance issues;
- ensuring that quality is maintained; and
- advice and practical support to tackle poorly performing contracts.
3.0 Transformation and Service Redesign

3.1 Research and analysis

Provision of research and analysis services that can operate across the commissioning system and health and social care markets. Services include but are not limited to:

- undertaking primary and secondary research using quantitative, qualitative and other evidential methods;
- delivery of advice on policy development;
- economics analysis and other bespoke analytical services with the ability to translate the findings into a business plan, business case or other recommendations;
- use of variation data to identify priorities;
- use of service review techniques to identify opportunities for improvement and potential solutions and recommendations; and
- engagement with relevant stakeholders such as academic and research organisations.

3.2 Strategy and planning

Provision of strategy and planning services both locally and at scale to develop collaborative commissioning strategies including:

1) quality and improvement strategies;
2) primary care strategies;
3) strategic and operational plans;
4) small scale project planning;
5) business and / or commissioning planning.

Services include but are not limited to:

- development and use of strategy and planning tools including prioritisation management and skills and capability mapping;
- development of clear, coherent, strategies and plans;
- supporting customers to create organisational consensus;
- supporting customer understanding of the challenges within healthcare planning and delivery; and
- pre-delivery support for projects or programmes including project planning and producing business cases (including assessment of technology, innovation or other investment to secure future successes).

3.3 System commissioning and transformation

Provision to support complex projects requiring significant change, transformation or intervention. Services include but are not limited to:

- delivering the programme life cycle from strategic advice through to delivery and outsourcing;
- running an organised Programme Management Office for major change including:
  - major systems reconfiguration;
  - financial turnaround;
  - managing and/or decommissioning major failures;
  - collaborative transformation between networked/partnership organisations which are bound by geography or other relationships;
  - decommissioning lower value interventions, pathways and / or steps within pathways
- accessing subject matter experts for care transformation including commissioning, decommissioning and clinical experts;
galvanising and engaging CCG leaders (including clinical leaders) in the transformation agenda;
engaging relevant stakeholders (for example patients and the public);
using proven transformation methodologies to support a customer; and
skills transfer to support and develop the capability of customers to identify, engage in and successfully deliver system and commissioning transformational change in a sustainable way.

3.4 Pathway Optimisation Revision and Design
Provision of services to implement best practice and innovation through small to medium size projects, focused on continuous improvement of commissioning systems and clinical change based on evidence and nationally and internationally recognised best practice. Services include but are not limited to:
identification of best practice and innovation within the commissioning system;
provision of a project management office with the right project managers and clinical expertise; and support commissioning or decommissioning of smaller services and pathways.

4.0 Communications and Patient and Public Engagement

4.1 Proactive communications
Provision of planned strategic communications support, advice, planning and delivery to ensure the organisation is effectively communicating its vision, values and objectives. The complex and varied audiences include the public, patients, their carers, providers, volunteers, other stakeholders and the CCG membership base.

Services include but are not limited to:
- stakeholder management;
- development of communications strategies;
- undertaking/supporting consultations;
- corporate and internal communications;
- multi-channel communications (digital, direct mail, social media, etc.);
- behaviour change;
- proactive press/PR planning (including emergency communications planning);
- evaluation of the efficacy of the planned communications.

4.2 Reactive Communications
Provision of responsive communications, delivering communications strategies that protect and enhance the profile and reputation of the organisation. Services include but are not limited to:
- reputation management (including media handling, corporate communications, communications requirements around complaints and Freedom of Information requests);
- planning/preparedness;
- delivery at the time communications support is needed; and
- evaluation of the impact / outcome of the reactive activity.

4.3 Patient and Public Participation at a Strategic and Operational Level
Provision of services to customers that support listening, understanding and engaging with patients, their families and carers, the public and voluntary sector organisations to enable local, regional and national voice to influence commissioning decisions and co-produce and
co-design services. Services include but are not limited to:

- developing access to existing engagement mechanisms such as patient forums and voluntary sector organisations or setting up these mechanisms where they do not currently exist;
- supporting engagement of patients, the public and other key stakeholders throughout the commissioning cycle;
- working with customers to ensure that the results of engagement activity are effectively utilised;
- setting up processes to ensure genuine co-production and co-design of services; and
- supporting customers to tailor their engagement to access traditionally seldom heard groups.

4.4 Patients in Control

Provision of services to develop an equal partnership between clinicians, patients and carers in decisions which relate to an individual’s care or treatment to ensure that they receive services which are proactive, holistic, preventative and people-centred. The aim is to achieve a collaborative approach to care and treatment with active patient involvement and effective self-management support which takes account of peoples’ preferences through a culture of shared decision making. Services include but are not limited to:

- support to put in place systems that recognise people as active partners in health;
- support to enable patients to take an active part in the decision making process in relation to their own care; and
- support to promote the involvement of patients and carers in decisions which relate to their care or treatment including, but not limited to:
  - self management support;
  - shared decision making;
  - personalised care planning; and
  - personal health budgets.

5.0 Business Intelligence

5.1 Business Intelligence and Applications

Provision of business intelligence and applications that provide decision support, query and reporting such as KPIs, metrics, dashboards, risk stratification, monitoring and alert systems and workflow management systems. Services include but are not limited to:

- provision of applications that bring together data from a range of sources;
- presentation of data in a usable format for a customer;
- provision of regular reports to support performance monitoring and to enable decision making; and
- provision of data to support resource allocation and planning.

5.2 Business Analytics

Provision of analytical know-how and supporting analysis to answer key questions. Services include but are not limited to:

- predictive modelling;
- benefits case development;
- statistical analysis;
benchmarking; and
bespoke comparative analysis.

Lot 2A – Medicines Management and Optimisation

Provision of expert pharmaceutical support to CCGs/commissioners to develop and implement a strategy to deliver improved outcomes from medicines. Services include but are not limited to:
- engagement with patients and the public to better understand how local services can support patients to get more from their medicines;
- supporting an improved experience of medicine taking for patients;
- securing greater value for money from CCGs'/commissioners' medicines expenditure;
- improving medication safety including a demonstrable reduction in harm from medication errors;
- engaging across the system to improve the way that medicines are used and to reduce medication waste (engagement with community pharmacies, care homes, hospital trusts, the pharmaceutical Industry and others);
- effective use of a range of data sources to identify efficiencies and quality improvements in the way medicines are used locally;
- developing improvement plans on behalf of a customer;
- supporting customers to implement new national guidance and recommendations; and horizon scanning for, and identification of, new products.

LOT 2B

IFR and CHC / FNC

IFR

Provision of a robust system for the management of the Individual Funding Request process. Services include but are not limited to:
- clear and rigorous policies and procedures for IFRs;
- stakeholder engagement (including clinicians and patient groups) to ensure good local understanding of the policy and processes, including the appeals process and complaints procedure;
- recording and sharing of outcomes;
- periodic review of the process including learning from incidents and complaints;
- identification of new industry standards and monitoring of compliance with existing standards;
- analysis of data to identify trends; and
- use of NICE guidelines (or equivalent) and other national quality standards to support the IFR decision making process.

CHC

Provision of services to enable commissioners to support patients with Continuing Healthcare and Funded Nursing Care needs. Services include but are not limited to:
- comprehensive referral and assessment systems;
- systems which confirm and validate eligibility;
- assessing funding and options for placement;
- provider performance management;
- supporting customers to manage financial, clinical, quality and safety risks;
- supporting customers to develop person centred care; and
- supporting customers to manage quality and safety standards.
Appendix 3 – Overview of LPF process

- **Scoping**
  - Identification and consideration of how best to source commissioning support services, working with neighbours to identify any joint opportunities

- **Specification**
  - Development of a service specification to clearly state the full scope of services that will form part of the contract.

- **Preparing the Call-Off**
  - Completion of all the sections of the Draft Call-Off Order Form and Bidder Information Pack including relevant KPI's, service credits, payment terms and staff and asset transfer

- **Running the Call-Off**
  - Management of the Call-Off process including dealing with clarifications from suppliers

- **Evaluation and award**
  - Evaluation of each bidder’s Call-Off ITTs to identify which supplier has won the Call-Off contract
  - Standstill period and contract award to successful provider

- **Mobilisation**
  - If applicable: mobilisation of contract by new supplier and transfer of services from incumbent supplier

- **Ongoing contract management**
  - Ongoing contract management to ensure that required performance levels are met and to address issues early

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**ONE MONTH**

- **Scoping**
- **Describe what you are buying**
- **Tender development**
- **Contact the suppliers**

**TWO MONTHS**

- **Contract management**
- **Mobilisation**
- **Award contract**
- **Evaluation**

**FOUR TO SIX MONTHS**
NHS South Tees Clinical Commissioning Group  

Governing Body  

Agenda Item: 4.2  

Wednesday 29 July 2015

<table>
<thead>
<tr>
<th>Purpose of Paper</th>
<th>For information</th>
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<tbody>
<tr>
<td>Title</td>
<td>Report from the Primary Care Co-Commissioning Committee</td>
</tr>
<tr>
<td>Responsible</td>
<td>Mr David Brunskill, Lay Member &amp; Committee Chair</td>
</tr>
<tr>
<td>Author of the Report</td>
<td>Jacqui Keane, Governance and Risk Officer</td>
</tr>
</tbody>
</table>
| Recommendation(s) | The Governing Body are asked to:  
  a. note the business transacted by the Committee, and  
  b. consider and comment upon the format and content of this update report. |

**Summary**  
The Primary Care Co-Commissioning Committee is a formally constituted committee of the Governing Body and has powers delegated to it from the Governing Body in order that it may make decisions and approve actions in relation to the co-commissioning of primary care services in partnership with NHS England.

The CCG’s Constitution requires that a report is produced for the Governing Body outlining the workings of the Committee at least twice per year. This report provides a summary of business transacted by the Committee at its first two meetings, held in April and June 2015.

**Financial Implications**  
Financial implications relating to the decisions made by the Committee are provided in the report.

**Legal/Regulatory Implications**  
The Committee operates within the legal framework and Constitution of the CCG and NHS England with regard to joint commissioning arrangements.

**Assurance Framework/Risk Register Implications**  
There are no specific risks relating to the report. However, this will be kept under review as the review of the PMS/APMS contracts is progressed.

**Details of relationship to the NHS Constitution**  
Transparency and probity of decisions.

**Details of Patient and Public Involvement and/or Implications**  
Relevant patient and public involvement has been, or will be, sought in relation to the items under discussion.

**Has an Equality Analysis been completed?**  
Equality analyses will be completed as appropriate as schemes and strategies are developed.

**Attachments**  
Report from the Primary Care Co-Commissioning Committee.

**Please detail any Committees or Forums at which this paper has previously been tabled**  
Not in this format.
1. Introduction

The Primary Care Co-Commissioning Committee is a formally constituted committee of the Governing Body and has powers delegated to it from the Governing Body in order that it may make decisions and approve actions in relation to the co-commissioning of primary care services in partnership with NHS England.

The CCG’s Constitution requires that a report is produced for the Governing Body outlining the workings of the Committee at least twice per year. This report provides a summary of business transacted by the Committee at its first two meetings, held in April and June 2015.

2. Governance of the Committee

It is important that the Committee operates with high levels of transparency and probity and in line with the Terms of Reference approved by the Governing Body and NHS England and, as such, both meetings were held in public and included representation, in a non-voting capacity, from HealthWatch, Health & Wellbeing Boards and the Local Medical Committee. The Committee will meet on a bi-monthly basis and will be supported by an operational group.

In terms of membership, the Committee acknowledged the concerns of the CCG’s Lay Member for Audit at being a member of the Committee. However, it was confirmed that this was in line with national guidance and, at the request of the CCG, NHS England had taken legal advice and confirmed the appropriateness of the position. Notwithstanding this arrangement, the CCG is in the process of advertising for an additional lay member to join the Governing Body and a key element of the role will be membership of the Committee in order that the Lay Member for Audit may withdraw from its membership.

Although the Committee membership includes at least one Governing Body GP, this is a non-voting position.

Potential or actual conflicts of interest have been, and will continue to be, considered at each Committee and appropriate action will be taken should a conflict arise.

3. Key areas of discussion

The following summarises the key discussion areas from the April and June meetings:

a. Approval of Quality Engagement Scheme (QES) and Practice Enhanced Treatment Scheme (PES)

As requested by the Governing Body, the Committee considered the Quality Engagement Scheme in order to review and improve antibiotic prescribing practices to support work in reducing incidences of C.Diff at a non-recurring
cost of £150,000 for one year and the Practice Enhanced Treatment Scheme which relates to work transferred to primary care from secondary care at a cost of £1,094,968 (over 2 years). Both of these schemes were approved.

b. **Review of PMS and APMS Contracts**

NHS England provided the Committee with an update on the reviews of the PMS and APMS contracts for the Fulcrum, Haven, Resolution and Eston Grange Practices. This provided the Committee with a good level of understanding of the work undertaken by NHS England and it was agreed that further operational work relating to the review would be carried out between NHS England and the Co-Commissioning Operational Group. The outcome of the work is to be presented to the August meeting of the Primary Care Co-Commissioning Committee for decision prior to a final decision being made by NHS England.

c. **CQC visits to Practices**

The Committee were assured that, to-date, no concerns had been raised as a result of CQC visits to South Tees Practices. The Committee will receive a more in-depth briefing on the CQC process at a future meeting.

d. **Primary Care Strategy**

The Committee received an update on the development of the CCG’s strategic approach to primary care; recognising that it would build upon the engagement work undertaken as part of the Clear and Credible Plan development. As a result, the approach would focus on: integration; prevention; self-management and provision of 24/7 primary care services.

e. **General updates**

The Committee received routine updates on the contracting positions of the CCG and NHS England. There were no areas of concerns.

4. **Conclusion**

The role and business of the Primary Care Co-Commissioning Committee will evolve over the coming months. As part of this, NHS England will be working with the CCG to produce work plans which will be in line with the Terms of Reference for the committee and will be an important part of ensuring the effectiveness of the Committee.

The Governing Body are asked to:

a. note the business transacted by the Committee, and
b. consider and comment upon the format and content of this update report.

David Brunskill
Lay Member
Chair of Primary Care Co-Commissioning Committee

14.7.15
NHS South Tees Clinical Commissioning Group

Governing Body

Agenda Item: 4.3

Wednesday 29 July 2015

<table>
<thead>
<tr>
<th>Purpose of Paper</th>
<th>For Information</th>
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<tbody>
<tr>
<td>Title</td>
<td>Chief Officer Review of Objectives and Performance 2014/15</td>
</tr>
<tr>
<td>Responsible</td>
<td>Amanda Hume, Chief Officer</td>
</tr>
<tr>
<td>Author of the Report</td>
<td>Alex Sinclair, Head of Programmes and Delivery</td>
</tr>
<tr>
<td>Recommendation(s)</td>
<td>To note the content of the report</td>
</tr>
<tr>
<td>Summary</td>
<td>The report demonstrates performance against the seven CCG corporate objectives for 2014/2015, which focus on delivery of the CCG’s constitutional duties and strategic plan.</td>
</tr>
<tr>
<td>Financial Implications</td>
<td>None</td>
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<tr>
<td>Legal/Regulatory Implications</td>
<td>None</td>
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<tr>
<td>Assurance Framework/Risk Register Implications</td>
<td>None</td>
</tr>
<tr>
<td>Details of relationship to the NHS Constitution</td>
<td>The corporate objectives address requirements of the NHS constitution.</td>
</tr>
<tr>
<td>Details of Patient and Public Involvement and/or Implications</td>
<td>Not applicable</td>
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<tr>
<td>Has an Equality Analysis been completed?</td>
<td>Not applicable</td>
</tr>
<tr>
<td>Attachments</td>
<td>None</td>
</tr>
<tr>
<td>Please detail any Committees or Forums at which this paper has previously been tabled</td>
<td>None</td>
</tr>
</tbody>
</table>
1.0 Purpose of the report

This report demonstrates performance against the seven CCG corporate objectives for 2014/2015, which focus on delivery of the CCG’s constitutional duties and strategic plan.

2.0 Corporate Objective: To continue to demonstrate a measurable improvement in the quality and safety of the services we commission and the experiences of those who use them, encouraging transparency and openness.

Over the past 12 months we have seen strong performance against target across a range of quality indicators. Data from a wide range of sources is reviewed and monitored regularly to inform areas of challenge and further scrutiny or feed into commissioning intentions.

Performance of some key areas are highlighted below:

2.1 Referral to Treatment (RTT) access times

Our performance against the 18 week RTT targets have been consistently above the national standard through the year and year to date figures for RTT targets are shown below:

- Admitted pathways (94.22% vs 90% target)
- Non-admitted pathways (98.82% vs 95% target)
- Incomplete pathways (95.90% vs 92% target)

2.2 Cancer wait times

We have met all the standards for waiting times for cancer assessment and treatment this year, with year to date figures and targets for key indicators shown below:

- 2 week wait suspected cancer (95.34% vs 93% target)
- 31 day wait from diagnosis to definitive treatment (98.45% vs 96% target)
- 62 day wait from urgent referral to definitive treatment (89.25% vs 85% target)

2.3 Ambulance response times

Ambulance response times have been challenging throughout the year, with particular pressures in quarter 2 and quarter 3; however through continued work with other CCGs and North East Ambulance Services (NEAS), performance in quarter 4 has improved with 75.3% of
category A calls within 8 minutes (target 75%) and 95.0% of category A calls within 19 minutes (target 95%).

2.4 Friends and Family Test

At the end of quarter 4 (Jan- Mar 2015), the combined Friends and Family response rate was 32.3% and the combined percentage of patients who recommended the services was 92.7%. These figures are above the England average.

2.5 Healthcare Associated Infections

Healthcare Associated Infections (HCAI) have been an area of considerable challenge this year, specifically MRSA (5 cases vs 0 trajectory) and Clostridium difficile (112 cases vs 51 trajectory). The CCG continues to monitor the C. Difficile recovery plan at South Tees Foundation Trust and the CCG have an action plan in place relating to C.Difficile, which is scrutinised via governing body.

To support achievement of measureable improvement in the quality and safety of commissioned services there are other areas key areas of activity to note, as detailed below:

2.6 Assurance Visits and CQUIN

A programme of commissioner led assurance visits to commissioned services continues and includes a review of services and patient experience. Information from each of these quality assurance processes is used along with information from incidents and complaints to help drive improvement in care and service delivery. This is further supported by the Commissioning for Quality and Innovation (CQUIN) framework by building measures of quality and safety into commissioning specifications.

2.7 Safeguarding

In relation to safeguarding, we have an agreed a way forward with the safeguarding children GP with NHS England and we have appointed a designated safeguarding nurse.

2.8 Mental Health and Learning Disabilities

2014/15 has also seen an increased focus on improving commissioned services for mental health and learning disabilities. The CCG has been supported by interim dedicated support from North of England Mental Health Development Unit (NEMHDU) and we have identified and agreed executive leads for the mental health and learning disabilities work-stream. We have also led the mental health crisis concordat approach across Tees. This has seen significant progress in achieving commitments to share data and work together across all healthcare providers, police and social care in the interest of individuals in need. In addition 99% of people using mental health services in 2014/15 have care planned and managed using the care programme approach (CPA), which ensures collaborative assessment, planning, co-ordination and reviews of mental health and recovery. The Mental Health and Learning Disability work-stream have developed a mental health strategy and a learning disability strategy and have implemented the child and adolescent mental health services crisis pilot; supporting young people in crisis and aiming to reduce self-harm admissions.
2.9 Cancer

Working with partners we have been developing a Tees cancer strategy which sets out how we will do more to prevent cancer, detect it early and support those going through treatment and recovery. Development of patient held treatment summaries for people with cancer is on-going and a 24-hour professionals’ palliative advice line has been implemented.

2.10 Leadership

In terms of general leadership within the organisation, feedback from an independent governance review indicated a strong, well led organisation. In response to the feedback received, we have implemented some changes to roles and responsibilities of GP leads and members of the executive management team to improve / enhance the governance structure.

3.0 Corporate Objective: We will be more patient focused, improving outcomes through the development of a primary care strategy, promoting the role of general practice in the broader health and social care economy and ensuring our member practices are appropriately supported to maximise the benefits.

3.1 Primary Care Strategy

Significant engagement has taken place with member practices to seek their views and experiences to inform and shape the primary care strategy. In addition, the CCG has engaged with NHS England, NHS Property Services and patients and a draft strategy document has been shared with members including three priority areas ie: stabilise and strengthen general practice; deliver a ‘joined up’ NHS system, and improve patient engagement, control and responsibility. These three key areas have been developed in response to feedback from members that improvements are needed in morale, workload pressure, recruiting and attracting GPs fresh from training. Patients have fed back that improvements are needed in access and continuity of care.

3.2 Collaboration with HENE

Work has commenced in collaboration with Health Education North East (HENE) to strengthen our primary care infrastructure.

3.3 Primary Care Support Officers

The role of the Primary Care Support Officers (PCSO’s) has been reviewed following feedback from member practices. The new practice engagement and support officers will support CCG practices to improve quality in primary care. New job descriptions have been developed and recruitment is planned for June 2015.

3.4 Clinical Leads for Integration

Our two CCG clinical leads for integration have also been working closely with partners to improve communication, relationships and continuity between primary and secondary care with the common goal of optimising outcomes for the patients shared by these professional groups. Excellent progress has been made in terms of building relationships, facilitated by an integration event and establishment of a variety of communication channels.
3.5 Research and Innovation Strategy

We have published our first Research and Innovation strategy and have promoted research and innovation to transform local services with the establishment of a Primary Care Research and Innovation fund. We have supported five exciting new initiatives developed by local GPs and their teams to improve the care and treatment they give to their patients. These were in the areas of addiction, online GP consultations, digital patient information and advice and prehabilitation.

3.6 Educational Programme

The quality in primary care work-stream has co-ordinated the delivery of a comprehensive training programme to support the on-going professional development of primary care teams, which included sessions on obstetrics and gynaecology; neurology, paediatrics and cancer.

4.0 Corporate Objective: To build on existing relationships with member practices, the public and patients, ensuring greater engagement in commissioning decisions.

4.1 Clinical Leads

The involvement of primary care clinicians has always been central to the CCG’s values, and the organisation now has 19 clinical lead roles for areas including mental health, cancer, health inequalities, maternal and child health, education, research and development and integration.

4.2 Member engagement

Work continues to engage more effectively with local practice managers and management partners, learning from experiences and working with practices to understand their role and contribution to commissioning. The CCG ensures productive engagement with member practices via regular practice manager meetings and fortnightly member practice e-bulletins, including key information and opportunities to contribute to commissioning. In addition, engagement through locality meetings and clinical council of members continues to be an effective method of achieving two-way dialogue.

4.3 Practice Visits

A programme of practice visits continue to be undertaken throughout the year, by the Chief Officer and Chair, providing a valuable opportunity to speak with practice teams about commissioning and understand the most effective methods of working together to benefit local people. In response to feedback from practice visits, practices will be involved earlier in the commissioning cycle in 15/16, ensuring the methods of involvement are appropriate for the working patterns of our membership.

4.4 360 Stakeholder Survey

The CCG has recently been provided with the results of the CCG 360° Stakeholder Survey which delivers a broad range of feedback about the CCG’s key working relationships over the last 12 months. This has highlighted a number of positives in relation to collaborative working ie:

- Overall engagement with all stakeholders has improved year on year
- 60% stakeholders felt the CCG had taken on board suggestions
- 80% of stakeholders were very or fairly satisfied with the way the CCG has engaged
- 76% strongly/ tended to agree the CCG had listened to views
- 93% stated very / fairly good working relationship with the CCG

4.5 Audit of patient and public involvement

Work continues to engage with local people and an independent audit of CCG mechanisms for patient and public involvement identified significant assurance in this area.

4.6 Communication and Engagement Strategy

The CCGs communication and engagement strategy, which was approved in January 2015 at the Governing Body, is supported by mechanisms to ensure translation of the strategy into actions. We continued to reach out to our local people during 14/15 via annual campaigns, such as the ‘keep calm winter campaign’ and the flu campaign, the latter supporting an increase in uptake of vaccinations by healthcare workers compared to previous years. In addition to traditional methods of communication, we have increased our use of social media and are actively using ‘twitter’ to share key messages and stimulate discussion, ‘tweeting’ an overview from our weekly executive meeting. In addition, we continue to grow the membership of ‘My NHS’, with a current membership of 670 people.

4.7 Patient and Public Advisory Group

The CCG has established a Patient and Public Advisory Group (PPAG) to input into the CCG work programme and advise the CCG as a ‘critical friend’. The members will provide guidance and feedback to the CCG on the development and implementation of projects and will review and develop approaches to involving patients, lay members, staff and the public. We have recruited six core members from across Middlesbrough and Redcar and Cleveland and plan to hold 6 meetings throughout the year. An induction session is planned in June, and the first meeting will take place in July.

5.0 Corporate Objective: We will reduce waste and increase productivity to ensure that more of our resource is focused on direct patient care enabling delivery of our statutory obligation to deliver financial balance.

5.1 Financial Performance

Financially the CCG has performed well against its budgetary target achieving a 2.1% surplus and has successfully kept within prescribing budget.

5.2 Electronic Prescription Service

An electronic prescription service has been implemented in all practices across South Tees via the medicines management work-stream.

5.3 Antibiotic Formulary and Drug Approvals

The medicines management work-stream has also supported the implementation of a regional antibiotic formulary and a new robust drug approval process which meets constitutional requirements.
5.4 Community Innovations Fund

Throughout 2014/15 the CCG has applied excellent financial governance principles enabling the organisation to meet the health needs of local people delivered through commissioned services as well as releasing additional resources to support the Community Innovations Fund, doubling investment in community based service for local people this year to £400k with a dedicated fund of 200K supporting mental health initiatives. Projects funded included ‘Think with your Feet’ to reduce stigma and encouraging people through football to talk about mental health.

5.5 Emergency Admissions

There is confidence that plans and initiatives are continuing to drive productivity within the health system and whilst experiencing a 4% increase in planned activity, the CCG has delivered a 3.9% reduction in emergency admissions against the national trend of a 3.5% increase.

5.6 Quality Premium

We achieved 50% of our quality premium in 2013/14 and therefore received £684,775 to invest locally, which was classed as above average performance. We forecast that we may achieve some, but not all of the quality premium for 2014/15. This is because waiting times for A&E services have narrowly missed the national target by 0.06% and ambulance response times have not been reached over the winter, resulting in the year end position being under target. However we know that the cancer two week wait target and referral to treatment within 18 weeks, for a range of services measured by the quality premium, are exceeding national targets.

5.7 IMProVE reinvestment

Through the progression of the IMProVE (Integrated Management and Proactive Care for the Vulnerable and Elderly) project, the funding released from closure of Carter Bequest Hospital identified through the IMProVE programme as no longer fit for purpose, will support investment into community services, particularly an increase in therapy provision, further supporting the requirement to reduce waste by way of minimising void space.

5.8 Better Care Fund

The Better Care Fund will continue to drive the agenda in the years ahead; joint plans with local partner organisations will ensure greater integrated working to make best use of our collective local resources.

5.9 CCG Management Team

With a focus on productivity, we have strengthened the CCG management team with a number of additional key appointments. A Head of Programmes and Delivery and a Business Delivery and Operations Manager have been appointed with a focus on programme management, performance management and process improvement. They will also be managing the relationship with our commissioning support colleagues, holding them to account and ensuring delivery against our expectations.
6.0 Corporate Objective: To continue to develop and implement plans to increase the opportunities for greater use of ‘out of hospital care’.

6.1 IMProVE

We have further progressed the IMProVE programme (Integrated Management and Proactive Care for the Vulnerable and Elderly) completing a formal 13 week consultation on the 31st of July 2014. A two year programme of work is now well underway to implement the programme which will deliver the objective of delivering more services closer to home.

6.2 Community Stroke

Within the IMProVE programme we have achieved the implementation of a community stroke team delivering stroke rehabilitation for up to 40% of stroke patients within their own home. This coincided with the centralisation of stroke rehabilitation and the development of a centre of excellence at Redcar Primary Care Hospital. Patients now have access to single room accommodation and improved therapy facilities, including a hydrotherapy pool and two gymnasiums. The staff to patient ratio has now increased, reducing the waiting time for therapy and enabling staff to spend more time with patients. Beds at Carter Bequest Hospital, our oldest community estate which previously housed stroke beds has now been closed with services transferring to other community estate.

6.3 Outpatient and Day Treatment Services

The IMProVE programme has also developed a plan detailing potential out-patient and day treatment services which could safely be delivered in community venues. It is anticipated that medical day treatments to be delivered in Redcar Primary Care Hospital will include simple chemotherapy and intravenous therapy treatments. A regional pilot for administering Parkinson disease treatments is also to be accommodated at the hospital, commencing in September, 2015.

6.4 Theatre Utilisation

Theatre utilisation in Redcar Primary Care Hospital continues to improve for delivery of minor surgery clinics and diagnostic procedures.

6.5 Practice Enhanced Treatment Service

In order to further support increased provision of care closer to home it was recognised that the movement of care out of a hospital setting would not only require greater investment and capacity in community based service but there would also be implications for Primary Care. As part of the CCGs response to this, work was undertaken to further develop the Practice Enhanced Treatment Service (PETS) which directly supported practices to respond to the increasing demands of work transferred from a secondary to primary care setting.
6.6 Rationalisation of work-streams

To improve development of pathways of care between acute and community settings, we have merged two work-streams to function as the new ‘Care Closer to Home’ work-stream, to ensure synergistic benefits and improved communications.

6.7 Patient Pathway Redesign

Revised patient pathways for dermatology and musculoskeletal services have been implemented to ensure patients are seen by the right person at the right time, alongside new ways of working to reduce general anaesthetic procedures, reduced hospital stays for women experiencing miscarriage and improvements to rapid response and district nursing services.

7.0 Corporate Objective: We will maximise healthy life expectancy and independent living in our community by establishing innovative and integrated health and social care services which promote prevention, eliminate waste and duplication, and are planned around the needs of the individual.

7.1 Integration Programme Board

An integration programme board (IPB) has been established with chief executives of local health and social care organisations, chaired by the CCG Chief Officer, to lay the foundations for establishing and commissioning an integrated health and social care system across Middlesbrough, Redcar and Cleveland. The CCG officer has formally committed to taking forward the integration agenda with a focus on making more effective use of system resources. A jointly appointed Integration Project Manager is now in post and is supporting the IPB in taking forward work across organisations, including projects already agreed and identified through the Better Care Fund.

7.2 Single Point of Access

An outline business case for development of a Single Point of Access for health and social care has been produced with the Integration Programme Board agreeing to progress using funding from the Better Care Fund. Other Better Care Fund plans include a front of house team in A&E, ‘time to think’ beds, support for care homes and a number of schemes to support carers.

7.3 111 Directory of Services

To facilitate access to service information, the Health Inequalities work-stream has increased the number of services populated on the 111 Directory of Service (DoS) with plans to increase the use of DoS in Primary Care which could support social prescribing.

7.4 Deep End Project

The deep end project was established as part of the Quality in Primary Care work-stream and brings together GPs working with people living in some of our most deprived communities. This group has produced innovative approaches to increasing screening uptake in areas such as cancer in the most deprived areas of the locality. The group has also made suggestions as to
how the social prescribing model could more effectively be used by practices serving deprived
groups and how the ‘Troubled Families’ agenda may fit with such practices. Further work
includes enabling communities to engage in self- care through support with learning language
skills.

7.5 Back Pain Pathway

A new combined physical and psychological standardised back pain pathway is due for launch
in July 2015.

7.6 Dementia Service

A service commenced in January 2015 to improve dementia services and the use of dementia
support services among people from black, Asian and minority ethnic (BME) communities.

8.0 Corporate Objective: To improve opportunities for planned care through the
development and implementation of an urgent care strategy that will enable our
population to access the right care at the right time.

8.1 Urgent Care Strategy

Close partnership working throughout 2014/15 has informed the development of a draft strategy
for urgent care across South Tees. This has been closely intertwined with the programme of
improving health and social care for the vulnerable and elderly IMPROVE, bringing care closer to
home. An overarching theme in the strategy is to streamline and simplify access to urgent care
services, so that patients can get the right care, in the right place, first time. The aim is to reduce
pressure on secondary care services by commissioning a simple, accessible, high quality urgent
care system that shifts the provision of some care from A&E to more appropriate settings in
primary care, the community, or Urgent Care Centres.

8.2 Urgent Care Schemes

Work has progressed to pilot and implement key schemes over the winter period to make the
system more resilient and encourage the effective use of health services. This has included
supporting a seasonal ailment scheme with pharmacies, implementing regionally co-ordinated
public awareness campaigns, working jointly with local authorities to improve the process of
discharging patients from hospital into domiciliary care and commissioning a GP service in A&E.

8.3 Additional Ambulances

Throughout the winter period pressures continued to build in relation to the Ambulance service,
and its ability to meet the 75%, 8 minute response standard. This meant that for some parts of
our population ambulances were slower to respond than in others. In direct response to this,
and in light of pressures associated with the Bed Bureau at James Cook University Hospital, the
CCG undertook to commission a service piloting the use of South Tees CCG dedicated
ambulances. These vehicles are staffed by paramedics and provide a direct response to urgent
GP ambulance requests. Early feedback from the pilot has shown a positive impact in
supporting improvements in the response rate across South Tees and in improving the flow of
patients through the James Cook University Hospital. The pilot has been extended to run for a
full twelve month period throughout 15/16 to enable a comprehensive evaluation.
8.4 Urgent Care Pilot Scheme

In 2014/15 we created an Urgent Care Pilot Scheme for GP practices with input from practice managers and clinicians. We provided resource up front to the 46 participating practices to allow them to develop plans to reduce or avoid non-elective admissions and A&E attendances, then measured their progress against a target to reduce overall urgent care spending by £5 per patient. Practices are to receive a full or partial ‘attainment’ payment based on the proportion of the reduction target they achieved. This scheme directly contributed to the 3.9% reduction in Urgent Care related activity in 14/15 compared to the previous year.

8.5 STAR Scheme

The CCG supported the South Tees Access and Response (STAR) scheme, which was a successful bid by our member practices for 2.9M funding from the Prime Ministers Challenge fund, which will gain momentum in 2015/2016.

9.0 Summary

Significant progress has been made during 2014 / 2015 to deliver against the corporate objectives and ultimately deliver services that meet the needs of our local population.

Key to the continued success of the CCG will be close working relations with key partners alongside listening to the public in order to deliver innovative and transformational approaches to the commissioning and delivery of services to meet the needs of the local population.

To support delivery of our corporate objectives during 2015/16, the CCG will be adopting a new programme management approach alongside a business planning process to ensure work plans are aligned to the corporate objectives, and are also effectively monitored and managed.

The remuneration committee is asked to receive this report and note for information.

10 June 2015
NHS South Tees Clinical Commissioning Group

Governing Body

Agenda Item: 5.1

Wednesday 29 July 2015

<table>
<thead>
<tr>
<th>Purpose of Paper</th>
<th>For Information</th>
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<tbody>
<tr>
<td>Title</td>
<td>Confirmed Minutes of Previous Board Meetings</td>
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| Responsible              | Mr Peter Race, Lay Member  
Mrs Amanda Hume, Chief Officer                                      |
| Author of the Report     | Minute Taker at meetings                                                        |
| Recommendation(s)        | The Governing Body is asked to note the following confirmed minutes:            |
|                          | • Audit Committee Minutes held on 21 April 2015                                  |
|                          | • Redcar & Cleveland Health & Wellbeing Board held on 1 April 2015               |
| Summary                  | Not applicable to this paper                                                     |
| Financial Implications   | Not applicable to this paper                                                     |
| Legal/Regulatory Implications |                                                   |
| Assurance Framework/Risk Register Implications | Not applicable to this paper |
| Details of relationship to the NHS Constitution | Not applicable to this paper |
| Details of Patient and Public Involvement and/or Implications | Not applicable to this paper |
| Has an Equality Analysis been completed? | No |
| Attachments              | • Audit Committee Minutes  
• Redcar & Cleveland Health & Wellbeing Board Minutes |
| Please detail any Committees or Forums at which this paper has previously been tabled | • Audit Committee  
• Redcar & Cleveland Health & Wellbeing Board |
Minutes of the NHS South Tees Clinical Commissioning Group
Audit Committee

Held on Tuesday 21 April 2015 at 9.30am
In the Board Room at South Tees CCG at North Ormesby Health Village

Present:
Mr Peter Race MBE Chair
Mr David Brunskill PPI Lay Member – GB Member
Mr John Drury Secondary Care Doctor – GB Member

In Attendance:
Dr Janet Walker Chair – Governing Body
Mr Simon Gregory Chief Finance Officer
Mr John Whitehouse Director of Audit, Audit North
Mr Nick Rayner Deloitte – External Audit
Mr Paul Thompson Deloitte – External Audit
Miss Yvonne Gibson Senior Finance Manager – North of England Commissioning
Mrs Liane Cotterill Support (NECS) Senior Governance Manager – North of England Commissioning
Mrs Aimee Tunney Support (NECS) Governance & Assurance Officer – North of England
Mrs Sandra Edwards Commissioning Support (NECS) Governance Officer, North of England Commissioning Support (NECS) – Minute Taker

AC/11/15 Apologies for Absence

Apologies were received from Paul Hewitson, Deloitte (External Audit).

AC/12/15 Declarations of Interest

There were no declarations of interest in relation to items on the Agenda.

AC/13/15 Unconfirmed Minutes of the previous meeting held on 4 February 2015

The Minutes of the previous meeting held on 4 February 2015 were accepted as a true record.
AC/14/15  Matters Arising and Action Log

14.1  Matters Arising

There were no matters arising from the previous meeting.

14.2  Action Log

14.2.1  AC/77/14 – Mr Thompson advised that External Audit would report back in May once the financial accounts were finalised and it was agreed this action could be closed.

14.2.2  AC/01/15 – Mr Gregory stated he would bring any necessary deep dive topics to future Committees but there were no deep dive topics for this Committee to consider. This action could now be closed.

14.2.3  AC/02/15 – Mr Gregory explained that the PBR tariff issue had moved on and the Governing Body had received updated prices for the current financial year. This action could be closed.

AC/15/15  Draft Annual Accounts

15.1  Yvonne Gibson presented the draft annual accounts on a page-by-page basis. She pointed out that the set of accounts compared the current (2014-15) and previous year (2013-14) and the comprehensive net expenditure for the year was well within the CCG allocation.

15.2  Comprehensive Net Expenditure

Regarding the balance sheet there are no fixed assets and current assets are debtors. Last year’s figure of £1,655,000 was high but this year the figure is £615,000 which is more appropriate. There were some ‘one off’ high values last year but this year things have gone through on time. The current cash balance of £78,000 indicates a good year for cash management.

15.3  Statement of Financial Position

The current liabilities were £20,548,000 with some accruals on contracts of 10 months. Mr Gregory highlighted Primary Care medicines which cannot be paid until receipt of final performance data.

15.4  Statement of Changes in Taxpayer’s Equity

This indicates the share capital of the CCG. Last year £6,782,000 was spent with net funding of £392,142,000, giving a balance at 31 March 2015 of £19,848,000.

15.5  Statement of Cash Flows

This year there is a debtor/creditor balance which indicates cash flow has
improved. CHC were provided with £13,000 in new claims. At the end of March 2014 there was a cash balance of £78,000. The CCG spent less cash than last year due to NHSE/PCT cash position but this year there is a normal level of cash.

15.6

**Notes to Financial Statements**

15.6.1 Miss Gibson advised that these were standard notes required to be included and tailored to the CCG. She highlighted the pooled budget with Middlesbrough Council for the equipment store (note 1.6). The CCG’s contribution in 2013-14 was £167,000 and the CCG was waiting to find out the joint contribution when Middlesbrough Council has completed their accounts. Middlesbrough Council is fully aware of the CCG deadlines.

15.6.2 The CCG is required by NHSE to put a balance towards the risk pool for CHC claims (note 1.24). In 2014-15 the CCG paid net £565,000 which was reclaimed from NHSE. There is an additional £900,000 which has been ring-fenced.

15.7

**Other Operating Revenue**

There was a decrease to the 2013-14 risk share agreement with HaST who have paid directly. There was also a risk share with Leeds which ended in 2013-14. The Chair asked if the CCG should be looking to use this facility in the future. Mr Gregory replied that risk share made sense for the future and probably benefitted the CCG. He reminded the Committee that the CCG had pulled out of risk sharing with Leeds and Newcastle last year as that had become less appropriate.

15.8

**Employee Benefits and Staff Numbers**

There had been an increase in salary costs due to an increase in staff. Confirmed staff sickness figures would be available in May 2015.

15.9

**Pension Costs**

Mr Gregory had contacted NHS England regarding these notes which should reflect the changes to the NHS pension scheme which has changed from ‘final salary’ to ‘career average’. Currently, these notes are very similar to last year. Mr Gregory pointed out that NHSE’s response was not helpful and Mr Thompson offered to look at suitable wording.  

**Action: AC/03/15 – Mr Thompson**

15.10

**Operating Costs**

Mr Gregory highlighted some of the lines as follows:-

15.10.1 **Services from other CCGs and NHS England**

Mr Gregory pointed out that in the first year money went directly from NHSE to NECS but this year the GPIT funding had been routed through the CCG.
15.10.2 **Services from Foundation Trusts**
The CCG spent a little less with TEWV this year but, despite the contract with South Tees, tariffs came down so performance was above plan. This figure also includes Internal Audit.

15.10.3 **Purchase of Health care from non-NHS Bodies**
The spend on NHS Bodies increased by £11m due to a reclassification, so all payments to primary care, opticians, etc, were now included on this line.

15.10.4 **Primary Care**
More had been spent on primary care across the board. £1.2m more was spent on the first part of BCF as well as CHC packages. Last year the funding was broken down into what was actually spent between private hospitals and the local authority and this will be indicated again. Mrs Hume suggested that in this breakdown it should be noted that more was spent on establishment which also included new furniture.

15.10.5 **Premises**
In respect of property, £175,000 was spent on rooms whilst the remainder was void costs. This year it was £3.5m and £5.8m last year. The main reason for the change was the first year the CCG worked on the original plan but this year there has been more control over costs resulting in a net improvement of £2m for property costs.

15.10.6 **Prescribing Costs**
Prescribing costs were almost the same as the previous year due to a combination of issues. Pharmacies are up on non-NHS contract. The bulk of the £317,000 spend was on advice from GPs, £154,000 compared to £128,000 on Workstream advice and work on the Improve project of £23,000. The CCG also sought advice on building up the Commissioning Health contract of £28,000. Mrs Hume pointed out that the CCG was also raising awareness of the North East Mental Health Development Unit (NEMHDU).

15.11 **Better Payment Practice Code**
It was noted that NHS payables had increased on the previous year due to NCAS.

15.12 **Operating Leases**
This covered leases with Property Services and it was suggested a note should be included to cover the void issue.

15.13 **Trade and Other Receivables**
These have reduced to £616,000 which is the correct level. Other information will be completed in time for the final accounts.
15.14 **Cash and Cash Equivalents**
This indicates the breakdown of cash and the net change.

15.15 **Creditors (Trade and Other Payables)**
These figures included another reclassification under accruals. In 2013-14 this was £8,324,000 whilst this year it is £17,743,000 due to the reclassification. A note will be included to explain this factor.

15.16 **Provision**
The £13,000 for CHC is shown in this line.

15.17 **Financial Instruments**
This table gives a breakdown of receivables and comparisons.

15.18 **Pooled Budgets**
The CCG has a pooled Budget with the following Councils: Middlesbrough, Redcar & Cleveland, Stockton, Hartlepool and HaST CCG. In 2013-14 income was £719,000; expenditure -£514,000. Further information would be available in the final accounts.

15.19 **Intra-Government and Other Balances**
This is a breakdown of balances with other sector bodies.

15.20 **Related Party Transactions**
This information would be completed by the end of the week indicating payments to related parties and the amount due. The CCG highlighted to Deloitte the fact that some members of NECS sit on SMT and relevant values need to be taken into account when producing the final accounts.

15.21 **Financial Performance Targets**
The South Tees CCG performance was £395,208 for 2014-15 within the target of £403,519

15.22 The Chair thanked Mrs Gibson for her work in compiling the draft Annual Accounts.

**The Audit Committee ACCEPTED the draft accounts, acknowledging the final accounts would be presented to the Audit Committee in May.**

15.23 Mr Thompson pointed out that it was only by looking at the end of the accounts was it seen that the CCG had had a good year and wondered whether there was a way of showing this in the accounts as, currently, the position could be misinterpreted. He suggesting something be included to indicate the CCG had performed well against annual target. Mrs Hume agreed that it was useful point to include.

15.24 Mr Brunskill suggested a brief summary to be listed on the Contents
Mr Thompson suggested a narrative note giving highlights and referring to the actual ‘notes’.

**AC/17/15 Draft Annual Governance Statement**

17.1 Mr Gregory explained that this Statement followed the same format as the previous year, and would be modified to include the wording of Deloitte and the Head of Internal Audit Opinion. The draft Statement would be submitted on Friday 24 April 2015.

17.2 Mr Gregory gave a brief synopsis of the headings in the report which explained the internal workings of the CCG. The Constitution had been updated twice during the year and themes looked at during the year were listed.

17.3 There had been a significant external assessment of Governance which had provided good feedback. The role of GPs on the Governing Body was looked at with the suggestion that one GP has more of a Governance role rather than being involved in executive decisions.

17.4 Committee attendance and topics for discussion were listed, together with the time spent discussing specific topics relating to Audit, Quality and Performance. These timings were based on the official agenda timings rather than actual timings and may need to be changed.

17.5 The Risk Management Framework had been refined this year with the process having changed.

17.6 GP Safeguarding was seen as a risk but there were more mitigations and a better process this year. Mr Gregory highlighted that although the risk was on the South Tees CCG patch this was not within the CCG’s control.

17.7 There was an issue on how well the CHC Team performed and whether it could manage all the different issues and targets. The balance was to keep on top of restitution and transfers from hospital in Winter. Mr Gregory pointed out that CHC Assessors were vulnerable to being recruited by the Benefits Agency where salaries were higher.

17.8 Regarding outlining the internal control framework – last year the CCG had been given text on legacy balance transfer so this needed to be included. The item on Information Governance needed to be updated citing business critical models and how to assess. However, there are sufficient controls in the system for providers giving assurance that everything is working.

17.9 Mr Gregory pointed out that last year there was more duplication in the report but this year Governance allows cross-referencing which made the
Mr Gregory advised that Risks with a rating above 16 had been included, however it looked confusing with two C.Difficile risks so these may be merged for the purposes of the Annual Report.

With regard to Winter activity pressures the risk may be reduced for the Annual Report because this year it seemed to work as a normal environment issue.

The QIPP Plan has delivered this year with the second half year seeing reductions in emergency admissions, though there had been increases at the beginning of the year. Over the year the end result is -3.5% on the previous year which is bucking the national trend. Nevertheless, it had been hoped to achieve more than that, which is disappointing. £600,000 has been allocated to QIPP for 2015-16.

Professional requested services are on target but may not be included in the final report.

The CCG looked to be at risk because of the STHFT financial position so should probably be included in the report.

BCF was in last year’s report and so should be included again this year with more detail added.

There has been heightened scrutiny of Involvement Activities with improvements being made in the decision-making process by engaging with the public. However, there is a risk when managing this and a discussion is required as to whether this risk should be included in the management report.

Mr Thompson asked how the conclusion (page 89 of Annual Report) reflected with regard to effectiveness. Mr Gregory replied that the report referred to it as a separate issue but it could possibly be mentioned in the summary. Mr Thompson responded that the heading implied it was a ‘conclusion’ and questioned how the two could link together. Mr Gregory explained that the CCG had been working with the manual in putting the Annual Report together.

Mr Gregory concluded that the Governance Statement was still a work in progress.

The section on the Remuneration Report was discussed, particularly to make the pension information readily understandable to the public. The Chair felt that as a result of recent discussion it would be prudent to clarify the situation to avoid confusion.
Mrs Hume was concerned that the ‘payment’ section showed distorted increases because of the inclusion of sessional GPs. It was suggested there could be a better link to the staffing complement of 20 wte, as currently there was the potential for misinterpretation.

Mr Brunskill pointed out that from a lay person’s viewpoint remuneration should be really clear, indicating staffing numbers, earnings and only have some detail because confusion could arise when using comparatives. Mr Gregory said it was necessary to show all the significant payments to GPs for work done. Mr Brunskill felt that the public may look through the information to see whether those employed by the CCG were merely attending meetings. Mr Thompson said he agreed with Mr Brunskill.

The Audit Committee ACCEPTED the Draft Annual Governance Statement.

Draft Internal Audit Plan 2015-16

Mr Whitehouse summarised the issues for the CCG to consider – Co-commissioning, Safeguarding, Better Care Fund including the increase in importance and the Government arrangements around it), CHC (looking at issues to be addressed in the following year), re-procurement of the NECS Service and Government procurement associated with that.

Mr Whitehouse wondered whether the issues raised required the Audit Committee to have a special meeting. The Chair replied that a lot of progress is made in those meetings and there was already an agenda item to cover these points in a pre-arranged meeting with Mr Gregory. Mr Gregory advised that the partnership with Governance was working to ensure that Section 35 ‘stacked up’.

Mr Whitehouse pointed out that he had spoken with Mr Gregory about the potential increase of Internal Audit fees, suggesting they could give substantial help in risk identification and profiling by taking on further work. This could be discussed in the aforementioned meeting.

The Audit Committee AGREED the Draft Internal Audit Plan for 2015-16 as a work in progress and delegating final approval to the Management meeting.

External Audit Update

Mr Rayner advised that a full audit would be held the following week, mainly looking at VFM. Questions would be sent to Mr Gregory and there were currently some risk assessment points.
19.2 The main issue was the impact of CHC which had limited assurance and how that affected the CCG spending of public money.

**The Audit Committee NOTED the External Audit Update.**

**AC/20/15 Annual Cycle of Business**

The Chair explained that the Audit Committee worked with Internal Audit endeavouring to ensure that all the items were covered; however, at their last meeting Mr Whitehouse had mentioned that a number of ‘deep dives’ were required on specific areas which would be built into the Annual Cycle of Business.

**The Audit Committee APPROVED the Annual Cycle of Business for the forthcoming year.**

*Liane Cotterill and Nick Rayner left the meeting.*

**AC/21/15 Chief Finance Officer’s Report**

21.1 Mr Gregory pointed out that, again, no special payments were required to be made whilst Aged Debtors was at a normal rate.

21.2 The Seal had been used on four occasions for Partnership Agreements (Section 256 of the NHS Act 2006):

- Transfer of funding from NHS South Tees CCG to the Corporate Directorate of Redcar & Cleveland Borough Council regarding:
  - Revenue Grant Agreement relating to Resilience Services – value £203,750. Sealed on 12 March 2015
  - Revenue Grant relating to LD and Mental Health Services. Value £347,006. Sealed on 12 March 2015
- Transfer of funding from NHS South Tees CCG to the Corporate Directorate of Middlesbrough Borough Council regarding:

21.3 The above would no longer be part of Section 256 Agreements but would become part of the Better Care Fund pooled budget.

21.4 The report detailed the timetable for the upload of the final signed off accounts and all is on target to meet the deadline.
The Audit Committee NOTED the Chief Finance Officer’s Report.

AC/22/15 Assurance Framework

22.1 Mr Gregory pointed out that this topic had been covered earlier in the Agenda under the Draft Annual Governance Statement.

22.2 Mrs Hume said that the STFT financial position was not a significant risk to the CCG but it was incongruous that this was scrutinised by Monitor and there was a need to reflect how to report this appropriately.

22.3 Mr Gregory advised that the 4-hour wait was in jeopardy again though the Trust could habitually fail but keep clear of Monitor. Mrs Hume advised that she had a monthly conference call with Monitor who had cancelled the last call because they had no major areas of concern and so there was a need to reflect on how to frame that risk more appropriately.

22.4 It was pointed out that risk 836 (Implementation of the Better Care Fund) should be ‘red’ rather than ‘amber’.

The Audit Committee NOTED the Assurance Framework

AC/23/15 Draft Annual Internal Audit Report (including Head of Internal Audit Opinion)

23.1 The Head of Internal Audit Opinion (HIAO) contributes to the assurances available to the Accountable Officer and Governing Body underpinning the effectiveness of the CCG’s system of internal control. The report takes into account audits competed during 2014-15 and associated assurance levels, also considering the third party arrangements in place with the North of England Commissioning Support Unit (NECS) and Shared Business Services (SBS).

23.2 The overall opinion is that Significant Assurance can be given that there is a generally sound system of internal control designed to meet the CCG’s objectives and that controls are generally being applied consistently. However, some weakness in the design and consistent application of controls put the achievement of particular objectives at risk. Nevertheless, the opinion may be impacted by the service auditor reports which had not yet been issued.

23.3 Mr Whitehouse explained that some work had been delayed because of operational reasons but was compliant with standards. Work had been undertaken to support the CCG throughout the year and it was important to continue supporting the CCG in developing the Assurance Framework and Risk Management processes by ‘supporting’ rather than ‘giving an
23.4 One piece of work currently unfinished related to the Business Continuity Plan (BCP) which would be covered by a third party assurance piece of work and there was one limited assurance piece of work around health care. This would not impact negatively on the HIAO but was required to be mentioned in the Annual Report.

23.5 One issue was third party assurance but it is important to note that NECS spend more on third party assurance than any other CSU in the country.

23.6 The CCG received a Service Auditor Report (SAR) from NECS from 1 April 2014-30 September 2014; covering 123 control relating to 39 control objectives in Payroll, Business Intelligence, Information Governance, Finance, IT and Quality, in relation to those services provided to the CCG. There were five exceptions noted in the control environment relating to Payroll, Finance Training, Management Accounts, Finance and routine reports. The report provided reasonable assurance that the specified control objectives would be achieved if the described controls operated effectively throughout the year. The Deloitte opinion was a qualified one, on account of these five exceptions. A further report would be due in May but Audit North had not yet seen this.

23.7 Mr Whitehouse pointed out there were other third party assurance reports unseen, particularly from SBS who run the ledger for NHS England; and one on the payroll system although that only involved 20 people.

23.8 Appendix 1 gave a summary of the work undertaken which contributed to the annual opinion. Some had not been assigned assurance levels because Audit North felt it was more important to work alongside and support the CCG. However, many topics had been given a ‘significant’ assurance rating. CHC received a ‘limited’ assurance rating and Data Quality received a ‘significant’ assurance rating.

23.9 NHS Protect issued a revised Anti-Fraud manual in July 2014 which had been adopted in trying to address fraud appropriately. The CCG is required to complete the Self Review Tool in June 2015 which covers up to March 2015, however, it is based on guidance as yet unseen. Audit North had taken part in national fraud activity and passed on information about Counter Fraud to both the CCG and NECS.

23.10 Mr Gregory stated he had not yet seen the IG Toolkit. Dr Walker advised that it was due presently as there had been some delay because the system was fragile at the year end. Mr Gregory pointed out that SAR would have to wait in case there were significant issues. Mr Thompson offered to check on this though the deadline would be tight for completing everything.

Action AC/04/15 - Mr Thompson
23.11 **Audit Handbook**

Mr Whitehouse advised that a new handbook had been produced in 2014-15 for which he will circulate a brief note.

The Audit Committee NOTED the Draft Annual Internal Audit Report (including Head of Internal Audit Opinion)

**AC/24/15 Any Other Business**

*Auditor Panels – Draft Guidance to help Health Bodies meet their Statutory Duties*

24.1 Mr Gregory explained that at some point in future the CCG would be able to appoint its own auditors and so there was a requirement to set up an Auditor Panel by April 2016 for that process. He noted that the Chair had some experience of this through South Tees Foundation Trust.

24.2 The Chair advised that he had reported back to the non-Executive Directors of the trust that a robust process was in place and financial benefits had been achieved, although open competition didn’t guarantee a reduction in price and so it was a risk.

24.3 The Chair further advised that in a free market it would be expected that prices would fall, however, 2017-18 would show a difference in prices. The Chair pointed out that in a free market it would be expected that prices would come down.

The Audit Committee NOTED Mr Gregory’s comments on the Auditor Panel process.

**AC/25/15 Date and Time of Next Committee**

The next Audit Committee (to discuss the Full Annual Accounts only) will be held on **Wednesday 27 May 2015 at 1.00pm at The Resource Centre, Meath Street, Middlesbrough, TS1 4RX** (prior to the Governing Body Meeting).

The meeting closed at 11.15

Signed: _______________________________ Date: _______________________

Peter Race MBE
Chair of the Audit Committee.
HEALTH AND WELLBEING BOARD

A meeting of the Health and Wellbeing Board of Redcar & Cleveland Borough Council was held on 1 April 2015 at the Redcar Leisure & Community Heart.

PRESENT

Councillor Lanigan (Chair) - Redcar & Cleveland Borough Council;
Councillor Ovens, Councillor Mason,
Mark Adams, Barbara Shaw, Paul Edmondson
Jones and Amanda Skelton – Redcar &
Cleveland Borough Council;
Ian Holtby – Redcar & Cleveland Healthwatch;
Amanda Hume – South Tees CCG;
John Pearson – Doorways VSF Chair;
John Feeney – Cleveland Fire Brigade;
Ian Coates – Cleveland Police;
Julia Bracknell – Children’s Trust;
Iain Sim – Coast and Country Housing;
Ian Hayton – Cleveland Fire Authority;
David Brown – Tees, Esk & Wear Valley;
Peter Clark – DWP Jobcentre Plus;
Mandy Headland – South Tees Foundation Trust.

IN ATTENDANCE

Councillor Halton.

OFFICIALS

Lucy Donaghue.

APOLOGIES FOR ABSENCE were submitted on behalf of:
Dr Janet Walker – South Tees CCG;
Martin Barkley – Tees, Esk & Wear Valleys Foundation Trust;
Tricia Hart – South Tees Hospitals NHS Trust;
Dr Ali Tahmessebi – South Tees Clinical Commissioning Group;

DECLARATIONS OF INTEREST

Councillor Ovens declared a non-pecuniary interest in agenda item 6, the Mental Health Crisis Care Concordat, as a family member worked at Roseberry Park, and as a member of the Fire Authority.

MINUTES

RESOLVED that the minutes of the meeting held on 07 January be approved and signed by the Chair.
19. APPROACH TO HEALTH INEQUALITIES – LOCAL RESPONSE TO “DUE NORTH”

The Director of Public Health presented a report outlining the background to the Due North Inquiry, the outcomes of the discussions at the Health & Wellbeing Board Development Session held on 25 February 2015 and a timetable to enable Redcar and Cleveland Health and Wellbeing Board to be confident about undertaking a formal LGA Peer Review in 2016.

Members discussed the item and made the following comments and asked the following questions:

- Elected Members in the Authority should be kept up to date of the work undertaken by the Health & Wellbeing Board.
- Members supported the view that a Peer Review should be carried out to look at the work undertaken by the Health & Wellbeing Board. The Peer Reviews acted as a critical friend and provided advice that could be learnt from.
- The membership of the Health & Wellbeing Board had only recently been reviewed. There was still one appointment that needed to be made.
- Targeting the right people was vital, it was important to look at the needs of the population and where targets were resources.

RESOLVED that:

1. The report be noted.

2. The Health & Wellbeing Board note the outcomes of the Board Development Session and agree to take a dual approach in focussing joint attention on a series of small carefully identified local geographical areas while giving children the best start in life and, that this should be done in collaboration with leading organisations like Durham University and Joseph Rowntree Foundation.

3. That there be a small Time Limited Working Group established, under the chairmanship of the Director of Public Health, to work with all partners and external organisations to develop a formal proposal on this approach with clear associated costs, defined actions and good outcome measures. The Group should report to every meeting of the H&WB Executive and bring the full proposal back to the next Board.

4. That the Director of Public Health work with all Members of the Board and partner organisations to carry out a stocktake of the extent to which we are engaging with (and benefitting from) all the elements of the LGA Improvement Programme, such as the
mentoring, knowledge management, leadership programmes.

5. That the Director of Public Health works with all Members of the Board and partner organisations to complete the self-assessment tool to enable the Board to assess its effectiveness and to determine what opportunities there may be for improvement or change. This should also involve an element of benchmarking against other Health & Wellbeing Boards.

6. That the Director of Public Health register the Board for a formal Peer Review in early 2016 and, in the meantime, explore how we might conduct a slimmed down mock peer review in the summer or early autumn.

7. That the Director of Public Health ensure that the stocktake and self-assessment is carried out over the next few months in order that a full report on these can be brought to the next Health & Wellbeing Board along with a progress report on both the mock Peer Review and the application for a formal LGA Peer Review.

20. INTEGRATION PROGRAMME BOARD UPDATE

The Chief Officer of South Tees CCG gave an update which provided details on the Integration Programme Board and how partners could work better together to benefit individual citizens in the area – NOTED.

21. MENTAL HEALTH CRISIS CARE CONCORDAT

The Chief Officer of South Tees CCG gave a presentation which provided details of the information sharing that had taken place regarding 30 individuals that had mental health issues, and which partners they were known to.

Members discussed the item and made the following comments and asked the following questions:

- The Police had a large amount of dealings with some of these individuals. Putting these individuals in Police cells were not always the best way to resolve these issues but sometimes the only option. The work of the Concordat would hopefully give the Police more options in the future.
- The 24 hour assessment centre would further reduce the pressure on the crisis teams.
- There was no issue around the number of beds available for adults at the current time.
- There were discussions across Tees about the young people in custody.
- Processes in A&E were being reviewed.
Coast and Country Housing may have some data that could be shared to give a complete picture.
10% of children were experiencing emotional and mental health issues across Teesside.

RESOLVED that:

1. The report be noted.
2. That future updates be brought to the Health & Wellbeing Board.

22. JOINT STRATEGIC NEEDS ASSESSMENT

The Assistant Director of Public Health presented a report outlining the approach to refreshing the Joint Strategic Needs Assessment (JSNA) and discussed how the Redcar and Cleveland Health & Wellbeing Board could ensure that the JSNA was central to their decision making.

Members discussed the item and made the following comments and asked the following questions:

- The JSNA was a statutory requirement.
- St Helens had produced a very comprehensive JSNA based on the priorities of the Health & Wellbeing Board and would be happy to share their work with Redcar and Cleveland Borough Council.
- Mark Reilly had done a piece of work around the JSNA and showed some really interactive ways to present the data. That could be shared with the Board Members for a better understanding.
- The North East Veterans Strategy formed part of the JSNA.

RESOLVED that:

1. The report be noted.
2. The Health & Wellbeing Board note the process for refreshing the JSNA.
3. The refreshed JSNA be brought back to a future meeting of the Health & Wellbeing Board for consideration.

23. SECURING QUALITY IN HOSPITAL SERVICES

The Chief Officer of South Tees CCG gave a presentation which provided details on routine and specialist hospital care services at County Durham and Darlington NHS Foundation Trust, North Tees and Hartlepool NHS Foundation Trust and South Tees Hospitals NHS Foundation Trust, in five clinical areas:

- Acute Paediatrics, Maternity and Neonatology (Children, Maternity,
very small/ill babies);
• Acute medicine;
• Acute surgery;
• Intensive care; and
• End of Life.

Over 700 standards were agreed across these service areas and an initial assessment was carried out to determine the extent to which the standards were being met across the three Foundation Trusts.

This first phase of the project was completed in March 2013 and the leadership for the work was picked up by the five Clinical Commissioning Groups across Durham and Tees, with Darlington CCG leading the Programme on behalf of the five CCGs.

Members discussed the item and made the following comments and asked the following questions:

• There was a shortage in specialists.
• There were huge funding issues that needed to be addressed.
• The future of healthcare required careful consideration.
• The needs of the population needed to be the focus.
• There had been interviews undertaken with 1,000 members of the public. Once the information had been collated it would be shared with the Members of the Health & Wellbeing Board.
• The Health and Wellbeing Board Members see the budget forecasts for the in hospital services.

RESOLVED that:

1. The report be noted.
2. That the budget forecasts for the in hospital services be circulated to Members of the Health & Wellbeing Board.

24. PHARMACEUTICAL NEEDS ASSESSMENT

The Director of Public Health presented a report requesting approval for publication of the Redcar and Cleveland Health & Wellbeing Board Pharmaceutical Needs Assessment 2015. It was a statutory document which had to be published by 1 April 2015.

Members of the public did not know what services were available to them. It was important that information was circulated to the residents advising them of pharmacy opening hours and what services were being offered. Members were advised that a leaflet was being produced that would provide this information and would be distributed to all residents.
RESOLVED that:

1. The report be noted.

2. That the pharmacy opening hours and services be promoted to the residents in the Borough.

3. That authority continues to be delegated to the Director of Public Health, to approve, as required:
   - publication of minor errata/ service updates as on-going notifications that fall short of formal Supplementary Statements to the PNA (for example changes of ownership, minor relocations of pharmacies, minor adjustments to opening hours and service contracts that do not impact on need)
   - any response on behalf of the Redcar and Cleveland HWB to NHS England (42 day) consultation on applications to provide new or amended pharmaceutical services, based on the PNA

4. That the Health and Wellbeing Board acknowledge the responsibility of the Board for maintenance of the PNA including the need to assess on-going changes which might impact on pharmaceutical need and the assessment thereof and respond by initiating early review or publishing a Supplementary Statement to the 2015 PNA as required. To continue delegation of authority to DPH to make initial assessment with respect to potential Supplementary Statement or need for full review. Approval of Supplementary Statements will be undertaken by HWB Executive as required, likely to be quarterly.

25. HEALTHWATCH UPDATE

The Chair of Redcar and Cleveland HealthWatch gave an update on the Enter and View Visits carried out at the James Cook University Hospital and the recommendations made for areas of improvement – NOTED.

26. DATE AND TIME OF NEXT MEETING

The Chair advised the future meeting dates would be agreed following the elections. These would be circulated to the Board Members once known – NOTED.