NHS
Urgent Care 24
safe • caring • effective

PRIMARY CARE 24 (MERSEYSIDE) BOARD MEETING (OPEN)

DATE:	**29 November 2018**
TIME:	**10am**
VENUE:	**Conference Room**
DISTRIBUTION:	**All Board members & attendees**
BOARD MEMBERS:	STEVE HAWKINS (Chair), PAULA GREY, DR MARY RYAN, JAY CARR, KATHRYN FOREMAN, PAUL CUMMINS, HELEDD COOPER, PAUL KAVANAGH-FIELDS, DR. SANDRA OELBAUM
IN ATTENDANCE:	MARGARET SWINSON, COMPANY SECRETARY SUSAN WESTBURY, INTERIM AD OF HR

AGENDA

				Pages
1.	Chair's Welcome, apologies for absence and opening comments			Verbal
2.	New declarations of interest		MS	Verbal
3.	Patient Story: Extended Access		SS	Verbal
4.	Minutes of the meeting held on 3 October 2018			1 – 7
5.	Matters arising, action list progress and Corporate Risk Register			8 – 9
6.	**Chair and Non-Executives' Report**			
	6.1	Chair's Report	SH	No paper
7.	**Chief Executive**			
	7.1	Chief Executive's Report	MR	10 – 11
8.	**Performance**			
	8.1	Integrated Performance Report	Executive Team	12 – 35
9.	**Strategy**			
	9.1	Initial feedback from Executive Away day	MR	36 – 48
10.	**Governance**			
	10.1	Rules and trading name	MS	49
	10.2	CQC Update on Provider at Scale Pilot	MS	50 – 51

10.3	Policies for approval:		
	Policy for Policy Management	MS	52 – 94
	Anti-Fraud, Bribery and Corruption Strategy & Policy		95 – 111 112 – 121
	Gifts & Hospitality Policy		
11.	**Committee Reports**		
11.1	Quality & Workforce 21 November 2018	PG	122 – 123
11.2	Finance & Performance 21 November 2018	PC	124 – 125
12.	**Any other business**		

Confidential Items

Members of the Board are invited to move to confidential items of business.

Date and Time of Next Meeting

Date:	**31 January 2019**
Time:	**10am**
Venue:	**Urgent Care 24 Board Room**

NHS
Urgent Care 24
safe • caring • effective

Board Meeting:	Open Session	
Venue:	Conference Room, UC24	
Date:	3rd October 2018	
Time:	10.00am	
Attendees:	**Apologies:**	**Date of Next Meeting:**
Executives (EDs) Dr Mary Ryan (MR) – *Chief Executive V* Jay Carr (JC) – *Director of Service Delivery V* Sandra Oelbaum (SO) – *Interim Medical Director V* Heledd Cooper (HC) - *Director of Finance V* Alison Hughes (AH) - *Associate Director of HR* **Non-Executive Directors (NEDs)** Paul Cummins (PC) - V Paula Grey (PG) – *V Acting Chair* Kathryn Foreman (KF) - *V* **In attendance:** Margaret Swinson (MS) – *Company Secretary* Christine Day – *Notetaker* *V indicates a voting member of the Board*	Paul Kavanagh-Fields (PKF) – *Director of Nursing*	**29th November 2018**

Item		Action
1.	**Chair's Welcome, apologies for absence and opening comments** Paul Kavanagh-Fields, the new Director of Nursing was attending a Regional Directors of Nursing meeting and the Chair welcomed him in his absence. The Chair outlined the plan for the day starting with the Board, followed by a celebration leaving lunch for both Helena Leyden and Pat Higgins and ending with the Annual Members Meeting.	
2.	**New declarations of interest** There were no Declarations of Interest.	
3.	**Patient Story** Due to the time pressure of the Annual Members Meeting, no patient story was taken at this meeting.	
4.	**Minutes of the meeting held on the 7th June 2018** The minutes were agreed with one amendment to record that AH had attended the meeting until item 10 (Page 1).	

5.	**Matters arising and Action Log progress** **Action Point 1 – Review of Quality Report** It was agreed that the review would be linked to the wider discussions about governance, audit and performance reporting which would be delivered in the New Year. **Action Point 2 - CQC** On the agenda.	
6.	**Chair's and Non-Executives' Report** **6.1 Acting Chair's Report** The Acting Chair introduced the report prepared by Pat Higgins prior to her departure. **Item 3.1** requires the last sentence to be deleted. **Item 3.2:** PC had attended the Staff Council on Pat Higgins' behalf and provided a verbal update: • Uniforms and dress code had been the most controversial issues. • The Staff Council had been asked to create an environment where staff could contribute to the naming of the 3 new meeting rooms. • The Council also agreed to consider recycling options to ensure we are greener. • Health and Wellbeing had been discussed and Staff Council were asked to think about how this could be integrated into the daily work of staff. To this end, the Council were looking for volunteers to take the lead in various health promotion activities and events. **Item 3.3**: A meeting of the NEDs with the CEO had taken place and would be reported later in the meeting. **Board Recruitment:** • Paul Kavanagh-Fields had been appointed as Director of Nursing and commenced with UC24 on 2nd October. • Steve Hawkins had been appointed as Chair with effect from 4th October 2018 and would be welcomed at the next meeting.	
7.	**Chief Executive's Report** **7.1 Chief Executives Report** MR presented her report to the Board. She: • Noted the appointment of Paul Kavanagh-Fields; • Informed the Board Carol Rogers, Associate DON had been enrolled in an Aspiring Talent Programme with the Leadership Academy. • Wished Pat Higgins well in her retirement and welcomed the new Chair, Steve Hawkins; • Advised the Board that the vacant Medical Director post would be advertised in the coming weeks with a view to interviewing mid to late November; • Advised that following the most recent CQC inspection, the Asylum Service had been rated good in all domains which was a great result for the team and organisation and would be helpful given in the re-procurement process due to begin in early 2019; • Informed the Board that under the pilot Provider at Scale methodology CQC would be visiting UC24 on 9 October to undertake a 'well led' review prior to the individual inspections of 5 of the 7 Sefton Practices;	

	• Noted that CQC continued to be interested in Primary Care streaming and how they will inspect this and extended access services would be discussed at a meeting with CQC on 4 October; • Explained that the mobilisation of the 2 EA Services at St Helens and Liverpool had been challenging but that had gone live on 1 October as scheduled. There had been particular operational issues in relation to St Helens but these had been overcome. • Reported that UC24s efforts to partner with larger Liverpool GP groupings (Wagga and Brownlow) for Extended Access had been unsuccessful for different reasons. UC24 would continue to maintain good relationships with both. • Reported that the Liverpool Provider Alliance meetings had been cancelled over the summer, however the next meeting was due to take place on October 19th. UC24 continued to contribute to the Urgent Care Stream, especially paediatric urgent care led by Alder Hey. • Had attended the Kings Fund Integrated Health Summit which provided a useful overview. The Kings fund produced a report on Integrated Care Systems which was available on their website. There was a disappointingly low profile from the Social Enterprise / Voluntary Sector in the presentations though a higher profile in the audience. It was agreed that UC24 was in a unique place in terms of geography and scale of services as an organisation delivering Primary Care 365 days a year 24/7 across in hours general practice, extended access in 3 different areas, GP Streaming, intermediate care and OOH. KF commented that at a recent Liverpool Integrated Care Partnership meeting she had pointed out that the discussion had focussed on Trusts which reflected a narrow view of who are Health partners. The Board: • Noted the CEO Report.	
8.	**Performance** **8.1 Integrated Performance Report** **Out Of Hours**: JC reported a steady performance for July and August and drew attention to the fact there had been a lot of disruption during the last few weeks (office move, mobilisation, changes in personnel, new Staffing Model with different Service Managers). There were no major changes but he did point out Out Of Hours had performed really well considering Stacey Shields had been working on Extended Access. The Chair recommended extending thanks to everybody for working through a difficult time and their continued support. It was asked if a thank you could be given at this afternoons AMM as morale has been kept high with the outcome being great with more space, a bigger kitchen and more meeting rooms. **Asylum Practice:** JC reported a sustained increase in activity. **Finance** HC presented the Finance update, highlighting the following: • The end of month 5 position was a £158k deficit against a planned surplus of £18k, therefore reporting a variance against plan of £176k. The in-month position is reporting a deficit of £97k which is £80k behind plan. • Sefton Practices were reporting a YTD deficit of £302k (excluding overheads) which was £302k behind plan. The in-month position showed a deficit of £87k which is £87k behind plan. Year to date income from the Local Quality Contract and Enhanced Services was behind plan by £40k. Pay costs there were over	

	budget by £194k year to date, and in-month by £40k. The Board noted that the contract value has a residual gap of £86k year to date (full year £206k) on the basis of a fully staffed GP model. ● OOHs was reporting a YTD surplus of £200k (including overheads), which was £68k better than plan, and an in-month surplus of £8k, which was £6k behind the plan. Clinical pay was however overspent by £77k YTD and £11k in-month. Operational underspends are helping to offset the clinical pressure. ● Cash balances at month 5 were £1,360k. • Efficiency plans were in progress, but only had not yet released significant savings as many were phased towards the later part of the year. The programme included both cost savings and income generation. In light of new services and pressures, the programme had been revised. The revised efficiency plan will be reported at the next meeting. • HC explained that the new Sefton model needed to be articulated and costed to check for viability. This could not be discussed with Commissioners until there was internal clarity. The Chair thanked HC for her report and stated the Board were looking forward to working through the challenges. MR asked for it to be noted Simon Stevens had convened group to take forward the 10 year forward view. Amanda Doyle, Chief Officer at Blackpool CCG and an ex OoH GP, was leading on Primary Care and Urgent Care Aspects. MR had offered contribution from UC24 and had a place on the National Committee however it had not been possible to attend the first meeting due to short notice. **Quality** The Board noted the contents of the report and that PKF would present the next report. There were no particular issues to note. **Workforce** AH presented the report. **Statutory and Mandatory Training:** AH explained that any staff member who was not fully up to date with the 9 elements to Statutory and Mandatory Training would show as red on the system. The amount of completed training was therefore higher than the headline figure would suggest. This is being reviewed in order to provide a more accurate and meaningful report. **Appraisals**: Reporting of appraisal completion through RotaMaster continued to be inconsistent though appraisals were taking place. The HR managers were working to improve reporting levels. **Staff Turnover**: Turnover reflected the ongoing recruitment to the new Extended Access services, Sefton and Board positions. **GP Recruitment**: SO and the team continued to work hard on GP Recruitment and Retention and to work closely with the HR Team on the application process. The aim of this recruitment was to reduce locum sessions. The Board: • Noted the contents of the report and that the issues raised were being addressed appropriately.	
9.	**Strategy** **9.1** The Board noted that the Executive Team were due to meet to refresh the strategic plan which was now 18 months old. An initial report would be made to the November Board.	

10	**Risk Register** The Board reviewed the Corporate Risk Register non-confidential items assessed at over 15. There was one such risk, relating to the employment status of Associate GPs and locums and the financial impact should HMRC apply IR35 to this cohort of doctors. HC highlighted the following: • Public and private sector organisations were treated differently under the current rules in particular for private sector organisations, the individual not the organisation bore the responsibility for assessing whether they were an employee or not. UC24's status in this regard was unclear at present. • Should UC24 be treated as a public sector organisation and the staff be deemed employees, there would be implications for annual leave, sickness and overtime. • Regardless of the organisation's status, the onus was on UC24 to ensure staff were informed of their responsibilities and the tax impact of the different treatment. • HMRC would have the right to assess application of IR35 retrospectively, going back for 6 years. So far the approach taken by HMRC was not this punitive but the attitude of the organisation in making the appropriate assessment and being proactive in its approach was a factor in determining the HMRC response. This would also influence the HMRC attitude to fines and penalties which might be imposed. • With regard to agency GPs, one of the agencies used had started charging VAT in full on the invoice rather than just on the commission element. UC24 had arrangements with another agency whereby UC24 paid the GPs directly and accounted separately for the commission. • Work was being undertaken with Merco and an organisation they work with, Brooksons, to work through the IR35 implications and put the most efficient systems in place for the future. This work would tie in to a wider payroll review. HC advised the Board that there was no route for removing this risk but steps to mitigate and manage the risk appropriately were being undertaken. The Board: • Noted the report and asked to be kept updated of any developments.	
10.	**10.2 Rules, regulations and trading names Update** The Board was reminded that formal approval process for the new Rules would be undertaken at Annual Members Meeting and the Rules would then be submitted to the Financial Conduct Authority for approval. The application for change of name would also be submitted. The Board: • Noted the position and looked forward to receiving further information in due course. **10.3 CQC update** MS reported that the next stage meeting with CQC in reference to the Provider at Scale methodology pilot would take place on 4th October and that CQC would attend on 9th October to undertake an informal visit looking at aspects of the Well Led domain which would inform the individual practice visits, the first of which was on 16 October.	

	Seaforth and Litherland would not be inspected as part of this process as their registration process was not yet complete. Although questions had been raised in respect of the Extended Access service and Primary Care Streaming, MS assured the Board that the necessary regulated activities were registered with CQC with Stacey Shields as Registered Manager. The Chair informed the meeting she appreciated all support and ongoing work and wished good luck for the coming month. The Board: • Agreed to receive a further update in November.	
11.	**Committee Reports** **11.1 Quality & Workforce** PG presented the report, noting that most of the issues had been discussed earlier in the meeting. She drew attention to the work on Management of Change which had gone well in spite of a few challenges and thanked the team for all their work. The Committee had thanked Helena for all her work. The Board: • Was assured that the Committee was giving due scrutiny to the information presented to it • Noted the main issues from the meeting. **11.2 Finance and Performance Committee Report** PC reported that the main issues from the meeting had been discussed during the earlier parts of the agenda and emphasised the financial challenge in Sefton. The Board: • Was assured that the Committee was giving due scrutiny to the information presented to it • Noted the main issues from the meeting. **11.3 Audit Committee Report** KF reported on the Audit Committee meeting. The Committee had spent time discussing more focussed recommendation reporting for the future, particularly in light of the number of recommendations which had been outstanding for some time but which could be grouped into higher level recommendations. KF explained that HC had, at her invitation, prepared a presentation which outlined ways to develop and improve the Committee's work for the future she thanked HC for this work. The Board:	

	• Was assured that the committee is giving due scrutiny to the information presented to it • Noted the main issues from the meeting.	
12.	**Any Other Business** There being no other business, the meeting concluded.	

Date of next meeting: 29th November 2018

Time: **10am**

Venue: **UC24 Conference Room**

Open Section Action Points and Report back dates from UC24 Board Meeting 3 October 2018

Action No.	Board Meeting reference	Action Required:	Due From:	Required by:	Comments
1.	**26.7.18 Item 7.1**	Contact to be made with CQC with regard to sharing UC24 experience of Primary Care Streaming	MS	ASAP	MS emailed CQC to provide information and to raise the issue of whether any additional registration was required. This has been chased up and will be discussed (alongside any registration requirements for Extended Access as per Paper at item 4.5) on 4 October **Update following 4 October meeting on agenda**
2.	**3.10.18 Item 8.1**	Updated efficiency programme to be included in IPR	HC	November Board	In Appendix 11

Corporate Risk Register
29.11.18

Title	Ref	Local Risk Register	Handler	Description	Consequence (initial)	Likelihood (initial)	Rating (initial)	Controls	Consequence (current)	Likelihood (current)	Rating (current)	Gaps in controls	Level of assurance	Opened	Review date
Risk Type: Corporate Risk															
OOH	CR17	IUC	Dir SD	Fulfilmnent of GP rotas for all services not acheivable	Major	Possible	12	Robust rota management by IUC & PCS teams to enusre rotas filled Ongoing recruitment of GPs Focus on multidisiplinary working in all areas, where possible State back indemity will start April 2019 Review of all agency contracts to ensure they are robust	Major	Possible	12	Lack of GPs nationally continue to impact Continued agency usage risks last minute cancellations	Medium / High	27/04/2017	Reviewed 21/11/18
Finance	CR23	orporate ris	DoF	Potential impact of IR35 inclusion of Associate workforce could lead to significant financial pressure on UC24	Major	Possible	12	Staying close to lcal decision making for England / OOH providers	Major	Possible	12	HMRC have yet to make a decision on England though some nearby providers have been incorporated into IR35	Low	22.11.18	Reviewed 22/11/18
Corporate	CR31	orporate ris	CEO	Re-configuration of Urgent Care services across C&M could lead to loss of business and / or independence for UC24	Major	Possible	12	Present at Provider Alliance, which is likely to be delivery method of choice Continued relationship building with Merseycare Visiable in Urgent Care space	Major	Possible	12	No specification yet issued for new configuration	Medium	23.11.2018	Reviewed 23.11.2018

NHS
Urgent Care 24
safe • caring • effective

Title:	Meeting Date:	Agenda item no:
Chief Executive's report	29 November 2018	7.1
Prepared and presented by: Dr Mary Ryan	**Discussed by:**	
Link to UC24 Values: ✓ Providing quality patient services ✓ Being an excellent employer ✓ Working collaboration to achieve positive system change. **CQC Domain References** ✓ Safe ✓ Effective ✓ Caring ✓ Responsive ✓ Well-led	**Resource implications:** **Purpose of the report:** ☐ Assurance ☐ Decision ☐ Discussion ✓ Noting **Decisions to be taken:** The meeting is invited to: • note the Chief Executive's Report.	

1.0 Purpose

1.1 The purpose of this paper is to update the Board on the focus of the Chief Executive's work since the last meeting.

2.0 Matters for report

2.1 Board will recall that our last meeting coincided with our Annual Member's Meeting. This meeting was well attended and I thank everyone who attended. We agreed at the AMM some changes to the rules of the organisation and these are processing through the usual channels.

2.2 We also agreed formally at the AMM to adopt the new company name – Primary Care 24 and I am delighted to inform the Board that we have now gone live with this new name, including identifiers, email addresses and communications to key stakeholders.

2.3 In October, we hosted a 'well led' inspection from the CQC at Wavertree base. This went well and has informed the ongoing regulatory inspections of our 5 practices in South Sefton.

2.4 Those site inspections are revealing a mixed picture of achievement, as expected, and the Sefton team continue to work incredibly hard on ensuring each practice is fit for the CQC on arrival.

2.5 Inspections will be completed before Christmas and draft reports available in January, at which point we will release the results to practices for factual correction.

2.6 On October 1st, we went live with our 2 new 'extended access' services in Liverpool and St Helens. The mobilisation was trouble free and highly effectively led by Jay Carr and his team. These services are now up, running and delivering well.

2.7 Alison Hughes, Associate Director of HR, left the organisation in October. Since then, we have been availing of the services of Susan Westbury – Deputy Director of HR at Liverpool Women's Hospital – for 3 days / week. I am now in the process of reviewing our HR capacity and requirement and will brief Board on the options we can consider in the coming weeks.

2.8 Paul Kavanagh-Fields has now fully taken up post as the Director of Nursing and Steve Hawkins as Chair. We are hoping to appoint to our vacant Medical Director role on December 5th. We extend our thanks to Dr Sandra Oelbaum for her work while Interim MD.

2.9 The ongoing financial issues with Sefton practices have consumed much energy in the last month, but we are now underway with a recovery plan, alongside the generation of a full Transformation Plan with the NHS Transformation Unit. I will brief the Board further on this issue in Part 2.

3.0 Since our last meeting, I have met with Tony Leo (NHSE), Jan Leonard (SSCCG), Dwayne Johnson (Sefton LA), Fiona Lemmens (Liverpool CCG) and Jan Ledward (Liverpool CCG), outlining our plans for 2018/19 and reinforcing our commitment to contribute positively to the Urgent and Primary Care spaces whenever possible.

3.1 I have also attended a Primary Care resilience workshop in Lancaster. The facilitator was impressive and would be an excellent invitee to the 2019 'Start the Year' event.

3.2 Finally, the Executive Team undertook an 'away day' in November, which was very effective. I will report on this separately to the Board.

4.0 Recommendations

The meeting is invited to:

- note the Chief Executive's report.

NHS
Urgent Care 24
safe • caring • effective

Title: Integrated Performance Report	Meeting Date: 29th November 2018	Agenda item no: 8.1
Prepared and presented by: Presented by Dr Mary Ryan (CEO) Prepared by Executive Directors	**Discussed by:** Executive Directors	
Link to UC24 Values: ✓ Providing quality patient services ✓ Being an excellent employer ✓ Working collaboration to achieve positive system change. **CQC Domain References** ✓ Safe ✓ Effective ✓ Caring ✓ Responsive ✓ Well-led	**Resource implications:** **Purpose of the report:** ✓ Assurance ☐ Decision ☐ Discussion ✓ Noting **Decisions to be taken:** The meeting is invited to: • Note performance for September and October 2018 • To receive assurance that the necessary actions are being taken • Note that Extended Access would be reported in the January IPR.	

1.0 Purpose:

1.1 The purpose of this report is to update the Board with the performance across the organisation for the months of September and October 2018

1.2 The Extended Access services which commenced on 1 October 2018 will be incorporated into the report presented to the Board in January.

2.0 Report highlights:

2.1 Note the performance of the Integrated Urgent Care Service Delivery Unit

2.2 Note the performance in Primary and Community services.

3.0 Recommendations:

The meeting is invited to:

- Note performance for September and October 2018
- Receive assurance that the necessary actions are being taken
- Note that Extended Access would be reported to the Board in January.

Service Delivery	App. ref	Target	YTD (from Apr)	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Trend	November-18 Forecast	Exception Report Number
Integrated Urgent Care																		
OOH NQR 8 Calls answered in 60secs	1	95%	93.5%	95.4%	95.5%	93.3%	94.5%	92.3%	94.0%	95.4%	94.5%	94.5%	96.4%	90.3%	89.1%		93.3%	IUC001
OOH NQR 9 - Urgent DCA 20mins	1	95%	94.6%	95.9%	94.8%	94.5%	91.9%	92.4%	92.2%	95.0%	94.3%	94.6%	94.9%	97.4%	94.1%		94.9%	IUC002
OOH NQR 9 - Less Urgent DCA 60mins	1	95%	90.5%	90.6%	89.0%	78.1%	86.6%	76.7%	82.8%	92.2%	93.9%	88.5%	92.4%	93.8%	89.8%		87.6%	IUC003
OOH NQR 12 - Home Visits - Total	1	95%	93.4%	91.5%	85.9%	87.1%	91.6%	87.4%	93.8%	94.5%	94.0%	90.7%	92.9%	95.2%	92.5%		91.0%	IUC004
OOH NQR 12 - UCCs - Total	1	95%	99.6%	99.8%	99.1%	99.4%	99.7%	99.2%	99.2%	99.3%	99.8%	99.8%	99.9%	99.4%	99.5%		99.1%	
OOH activity	1	n/a	38,987	5,392	7,231	6,511	5,310	6,507	5,835	6,034	5,465	5,294	5,247	5,528	5,584		5,176	
Alder Hey Primary Care Streaming - appointment utilisation	2	50%	53.8%	66.9%	60.3%	61.1%	56.6%	70.0%	64.5%	56.2%	51.8%	52.9%	41.0%	52.3%	57.7%		50.3%	
Alder Hey Primary Care Streaming - average consultation length	2	15mins	15:09	16:17	16:16	15:20	15:08	14:46	14:55	15:48	14:43	15:16	14:14	15:00	16:09		15:07	IUC005
Alder Hey Primary Care Streaming - shift fulfilment rate	2	100%	56.1%	76.9%	78.7%	50.6%	57.7%	53.8%	45.2%	74.3%	55.1%	60.9%	46.2%	43.8%	67.1%		52.4%	IUC006
Aintree Primary Care Streaming - appointment utilisation	3	50%	37.6%	34.3%	31.1%	38.3%	43.4%	48.8%	38.7%	33.7%	35.5%	45.7%	36.9%	36.4%	36.3%		36.5%	IUC007
Aintree Primary Care Streaming - average consultation length	3	15mins	17:56	17:57	18:05	18:36	19:31	18:17	17:34	17:35	18:56	16:54	16:43	21:23	16:27		18:11	IUC008
Aintree Primary Care Streaming - shift fulfilment rate	3	100%	78.4%	95.4%	93.5%	86.0%	92.0%	95.5%	81.6%	83.5%	65.5%	70.4%	68.4%	87.5%	91.6%		82.5%	IUC009
RLUH Primary Care Streaming - appointment utilisation	4	50%	52.1%	73.0%	54.5%	45.5%	68.5%	57.9%	51.1%	46.4%	48.0%	57.0%	49.2%	58.8%	54.3%		54.1%	
RLUH Primary Care Streaming - average consultation length	4	15mins	19:24	15:33	16:57	17:56	16:19	16:52	19:06	20:43	19:37	18:59	19:23	17:57	20:05		19:08	IUC010
RLUH Primary Care Streaming - shift fulfilment rate	4	100%	81.4%	100.0%	93.2%	95.8%	83.4%	79.1%	82.0%	69.9%	78.4%	85.8%	76.9%	93.9%	83.1%		84.6%	IUC011
Knowsley Services - Home visits in 1, 2 and 6 hours	5	95%	99.5%	100.0%	100.0%	100.0%	99.3%	100.0%	100.0%	100.0%	100.0%	99.3%	100.0%	100.0%	97.1%		99%	
Knowsley Services - patients seen within 30 minutes of scheduled appt	5	95%	98.3%	98.1%	97.7%	98.3%	99.3%	98.2%	98.2%	98.5%	97.8%	99.0%	98.1%	97.8%	98.8%		98%	
Intermediate Care Service - consistent medical provision	6	90%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100%	
Liverpool Extended Access - utilisation rate of available appointments	7														42.9%		58%	
Liverpool Extended Access - DNA rate of booked appointments	7														9.3%		8%	
St Helens Extended Access - utilisation rate of available appointments	7														32.2%		47%	
St Helens Extended Access - DNA rate of booked appointments	7														6.3%		5%	
Primary and Community Services																		
Asylum practice - number of arrivals in month (EMIS reporting from Apr 2018)	8	n/a	2,868	451	386	367	316	372	348	298	361	453	457	418	533		469	
Finance																		
Budget variance (£000's)	9	0	-162	-56	-119	416	41	146	Month 1 not reported	-20	-19	-65	-80	-51	73		105	FIN001
Revenue surplus position (£000's) (Year end forecast)	9	129	-10	-15	-129	322	9	147	Month 1 not reported	2	-8	-54	-97	-47	194		-15	FIN001
Sefton practices LES/DES income	9	430	240	24	35	108	1	251	Month 1 not reported	66	8	61	4	38	62		40	
Total cash (£000's) (Year End forecast)	10	1,000	1,000	1,225	678	384	985	1,212	1,079	733	1,009	923	1,360	978	1,156		1,000	
Efficiency programme vs target	11	95%	100%	100%	100%	100%	100%	100%	Month 1 not reported	100%	100%	100%	100%	100%	100%		100%	
Better Payment Practice Code		95%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		100%	
Quality and Patient Safety																		
Friends and Family - likely / extremely likely to recommend (includes paper surveys at Knowsley in-hours services from June 2018)	12	85%	89.0%	87.3%	83.9%	85.9%	89.1%	86.8%	88.2%	88.1%	89.7%	89.4%	92.5%	89.4%	85.7%		87%	
Compliments received in month	12	n/a	20	1	2	6	1	0	1	2	1	1	3	2	10		5	
Complaints received in month	13	n/a	52	8	4	6	6	9	6	7	5	7	10	6	11		9	
Complaints not resolved within 25 working days	12		41	3	3	5	6	6	6	4	2	7	9	3	10		7	
Incidents recorded in month	12	n/a	511	60	79	73	59	77	84	61	63	79	72	66	86		75	
Safeguarding incidents recorded	12	n/a	9	4	5	1	0	1	1	0	2	0	1	1	4		2	
Workforce																		
Sickness rate	14	5% annually	Data not available	Reliable data not yet available from RotaMaster													Reliable data not yet available	
Staff turnover rate	14	20% annually	19.2%	29.4%	28.6%	26.4%	26.3%	26.3%	23.5%	21.8%	21.2%	20.0%	16.6%	15.2%	16.0%		16%	
Mandatory training compliance (employed staff only)	14	95%	87.2%	95.8%	97.2%	97.2%	85.3%	85.8%	85.9%	87.2%	86.8%	87.7%	86.3%	87.7%	88.9%		88%	
Appraisal compliance	14	95%	23.3%	92.1%	92.6%	89.3%	90.3%	87.6%	2.3%	3.8%	25.7%	31.9%	32.2%	33.8%	33.3%		35%	

Exception reference	Description	Commentary	Owner	Timescale to resolve (if applicable)
IUC001	Partial and non-compliance against NQR 8 - Calls answered within 60 secs	September performance impacted by 13% unfilled shifts throughout the month relating to sickness, annual leave and vacancies. Recruitment has now been completed. Slight deteroration in performance in October. Shift managers are monitoring and supporting operational staff on a shift by shift basis.	Head of Integrated Urgent Care	Nov-18
IUC002	Partial compliance against NQR 9 - Urgent DCA	GPs are being reminded to prioritise urgent DCA over less urgent. Weekend evening remain most challenged. The service was particularly impacted by late cancellation of GP's on 2 weekends. Some productivity issues identifed which are being dealt with via agencies.	Head of Integrated Urgent Care	
IUC003	Partial and non-compliance against NQR 9 - Less urgent DCA	Improved performance throughout September, deterioration in October issues as described in IUC002. NHS 111 Direct Booking was introduced on 30 October. Limited appointments available during initial phase but should alleviate pressure on DCA. Liverpool & St Helens Extended Access service now live allowing OOHs the option to direct book patients into this service.	Head of Integrated Urgent Care	Nov-18
IUC004	Full and partial compliance against NQR 12 - Home visits	Good performance in September. Slight deterioration in October impact of issues described in IUC002		Nov-18
IUC005	Full and partial compliance against Alder Hey Primary Care Streaming average consultation length	Slight deterioration in performance during October but comparable with same period last year. No specific trends identified.		
IUC006	Non-compliance against Alder Hey Primary Care Streaming shift fulfilment rate	.Improved performance in October as a result of a focus from Rota team. Alder Hey working more flexibly to support increased fulfilment rates.	Head of Integrated Urgent Care	Dec-18
IUC007	Non-compliance against Aintree Primary Care Streaming appointment utilisation	Appointment utilisation remains consistent. Aintree working with clinical staff to improve referral rates. Continuing issues for Aintree - limited engagement due to operational priorities.	Head of Integrated Urgent Care	Nov-18
IUC008	Non- and partial compliance against Aintree Primary Care Streaming average consultation length	Consultation length improved in October to best performance in 12 months.	Head of Integrated Urgent Care	Dec-18
IUC009	Non- and partial compliance against Aintree Primary Care Streaming shift fulfilment rate	September shift fulfilment increased by 20% as a result of introducing a more flexible workforce into the service in and out of hours. Improvement continued into October.	Head of Integrated Urgent Care	Dec-18
IUC010	Partial and non-compliance against The Royal Primary Care Streaming average consultation length	As for IUC008	Head of Integrated Urgent Care	Dec-18
IUC011	Partial and non-compliance against The Royal Primary Care Streaming shift fulfilment rate	Good performance in September with a significant increase in shift fulfilment as a result of implementing more flexibility. Reduction in October impacted by the resignation of a regular GP.	Head of Integrated Urgent Care	Nov-18
FIN001	Negative Variance against plan for year to date budget position.	The year to date position at the end of month 7 is a deficit of £11k, against a planned surplus of £143k, therefore reporting a variance against plan of £154k. Sefton Practices are reporting a YTD deficit of £404k (excluding any allocation of overheads). The in-month position is reporting a deficit of £70k. In relation to pay costs there is a £319k overspend year to date, in-month overspend £81k.	Head of Finance	Ongoing
WOR001	Non-compliance against UC24 staff mandatory training compliance	A review is planned of the calculation of mandatory training compliance as some modules are relevant to particular staff groups.	Ownership to be confirmed in relation to this specific issue	Not applicable
WOR002	Non-compliance against UC24 appraisal target	Current data is calculated by appraisals completed in financial year. The target figure is based upon compliance over 12 months. There are also some other concerns re data quality. These issues will be reviewed.	Associate Director of HR	Jan-19

IPR Narrative report - 2017/18 as at Month 6 (September)		
Service Delivery	Integrated Urgent Care	● UC24 IUC overall performance levels have improved, plans are in place to address under-performance.
		● ANPs are supporting telephone triage. The impact will be reveiwed after 3 months. We are recruiting to an ANP lead to support further recruitment to the non-medical workforce.
	Primary and Community Services	● Sefton practices: continued use of Agency GPs to support service delivery causing increased financial pressure within the service. Practice Managers have been instructed to review locum usage to reduce costs. Clinical utilisation has increased and DNA rates have reduced across the practice group.
		● GP "offer" developed and recruitment to non-medical clinical posts agreed and in process.
		● Increase in Asylum Service patients in July and August. Quality Impact Assessment commenced and due for completion in October 2018. Awaiting notification of CCG commissioning intentions expected in October 2018.
Finance		● The year to date position at the end of month 7 is a deficit of £11k, against a planned surplus of £143k, therefore reporting a variance against plan of £154k. The in-month position is reporting a surplus of £194k which is £73k ahead of plan. The 18/19 inflation uplift of 1.65% was applied to the OOH contracts, resulting in additional income of £70k year to date. The commencement of the Liverpool & St Helens Extended Access contracts has contributed £128k & £21k respectively to the in-month surplus. ● Sefton Practices are reporting a YTD deficit of £404k (excluding any allocation of overheads). The in-month position is reporting a deficit of £70k. Income from the Local Quality Contract and Enhanced Services is behind plan by £12k YTD. NHS England increased the global sum to £88.96 per weighted patient and was back-dated to April - this provided additional income of £15k. Income from 17/18 yet to be claimed by the practices is estimated to be £60-£70k and is at risk due to the length of time being taken. Excluding income received which relates to the 17/18 year, the Sefton YTD loss stands at £516k. In relation to pay costs there is a £319k overspend year to date, in-month overspend £81k. The pay budget has been prepared on a fully salaried staffing assumption to facilitate budget monitoring by the practice managers and SDU leads. In this best case scenario, the contract value has a residual gap of £120k year to date (full year £206k). ● OOHs is reporting a YTD surplus of £339k (including overheads), which is £138k better than plan. The in-month position reported a surplus of £119k, which was £76k ahead of the plan. Clinical pay overspend was £145k YTD, in-month there was a £23k overspend. As noted above, the in-month position has benefited from additional income of £70k in relation to the inflation uplift applied to the OOH contracts. There has also been an increase in primary care streaming activity generating additional income of £20k this month. Pressures in the GP workforce continue to result in significant agency requirements. Operational underspends are helping to offset the clinical pressure. ● Cash balances at month 7 were £1,156k. ● Achieving the efficiency target is reliant on generation of income from new business. The Liverpool & St Helens Extended Access Services commenced in October and have made a significant contribution to the UC24 financial position.
Quality		● At the end of October 2018 there were 23 open complaints in Datix
		● There were 2 compliments received in September 2018 and 10 received in October 2018
Workforce		● A review of terms and conditions of service is due to commence for completion in Q4 18/19
		● Consideration to be given to the development of a comprehensive Workforce / Org Development strategy and plan

Appendices

App 1 OOH reporting template

National and Local Quality Requirements reporting template

Reporting time period: Monday 01/10/18 18:30 to Thursday 01/11/18 07:59 Halton, Knowsley and Liverpool CCG

Ref	NQR / LQR	Target description	Total volume	Compliant	Patient choice	Non-compliant	% compliance
1	NQR 2	Case details sent by 8am	5584	5552	2	30	99.5%
2	NQR 8	<0.1% calls engaged	1759	1759		0	0.0%
3	NQR 8	<5% calls abandoned after 30 seconds	1759	1712		47	2.7%
4	NQR 8	Calls answered <60 seconds	1669	1487		182	89.1%
5	NQR 9	Cases passed to 999 <3 minutes (Target =100%)	0	0	0	0	
6	NQR 9	Urgent cases DCA <20 minutes	905	796	56	53	94.1%
7	NQR 9	All other cases DCA <60 minutes	3116	2612	187	317	89.8%
8	LQR 1	NHS 111 6 hour priority <6 hours	1101	1005	26	70	93.6%
9	LQR 2	Repeat prescription requests <6 hours	26	26	0	0	100.0%
a		*Total cases received requiring assessment (5)+(6)+(7)+(8)+(9)*	*5148*				
b		*Total cases requiring action (6)+(7)+(8)+(9)*	*5148*				
		Following priority determined by Definitive Clinical Assessment (DCA)					
10	NQR 12	UCC Emergency <1 hour	1	0	0	1	0.0%
11	NQR 12	UCC Urgent <2 hours	373	364	4	5	98.7%
12	NQR 12	UCC Less urgent <6 hours	1391	1384	4	3	99.8%
c	*Total*	*Urgent Care Centre cases*	*1765*	*1748*	*8*	*9*	*99.5%*
13	LQR 3	Telephone Advice Emergency <1 hour	20	17	1	2	90.0%
14	LQR 3	Telephone Advice Urgent <2 hours	339	330	5	4	98.8%
15	LQR 3	Telephone Advice Less Urgent <6 hours	2738	2603	65	70	97.4%
d	*Total*	*Telephone Advice cases*	*3097*	*2950*	*71*	*76*	*97.5%*
16	NQR 12	Home visit Emergency <1 hour	0	0	0	0	
17	NQR 12	Home visit Urgent <2 hours	249	232	0	17	93.2%
18	NQR 12	Home visit Less urgent <6 hours	444	409	0	35	92.1%
e	*Total*	*Home Visit cases*	*693*	*641*	*0*	*52*	*92.5%*
f		*Total telephone and face-to-face consultations (c)+(d)+(e)*	*5555*	*5339*	*79*	*137*	

Information section

No Definitive Clinical Assessment (DCA)		
19	Cases not requiring DCA; triaged by other clinician	338
20	Patient episode continued, service provided	95
21	Patient episode ended, no service provided	3
Repeat prescription cases outcomes		
22	Repeat prescription requests (6 hour advice)	26
23	Repeat prescription requests forwarded to UCC	0
24	Repeat prescription requests forwarded for visit	0
Final case-type totals		
25	*Total Ambulance cases*	*0*
26	*Total Telephone Advice cases*	*3097*
27	*Total UCC attendances*	*1765*
28	*Total Home Visits*	*693*
29	*Total Repeat prescription requests*	*26*
g	*Total cases completed (=a+19+20+21)*	5584
Referrals to secondary care		
30	Hospital referred (referred for admission / advised A&E)	546
Compliance levels		
31	**Fully compliant (95-100%) - except ref 2 & 5**	
32	**Partially compliant (90-94.9%) - except ref 2 & 5**	
33	**Non-compliant (89.9% and under) - except ref 2 & 5**	

Comments:

Urgent Care Centres				
Emergency	1 hour total	Pat. choice	Compliant	% result
Aintree	0	0	0	
Garston	0	0	0	
Huyton	0	0	0	
Kirkby	0	0	0	
Old Swan	1	0	0	0.0%
Runcorn	0	0	0	
The Royal	0	0	0	
Widnes	0	0	0	
Total	1	0	0	0.0%
Urgent	2 hour total	Pat. choice	Compliant	% result
Aintree	15	0	15	100.0%
Garston	49	0	49	100.0%
Huyton	44	0	44	100.0%
Kirkby	6	0	6	100.0%
Old Swan	127	3	121	97.6%
Runcorn	116	0	114	98.3%
The Royal	12	1	11	100.0%
Widnes	4	0	4	100.0%
Total	373	4	364	98.7%
Less urgent	6 hour total	Pat. choice	Compliant	% result
Aintree	113	0	113	100.0%
Garston	148	1	147	100.0%
Huyton	134	0	134	100.0%
Kirkby	57	0	57	100.0%
Old Swan	566	2	562	99.6%
Runcorn	267	1	265	99.6%
The Royal	85	0	85	100.0%
Widnes	21	0	21	100.0%
Total	1391	4	1384	99.8%
Grand total	1765	8	1748	

Template property of Liverpool CCG

Source: Adastra/Business Intelligence Team

Author: Performance Improvement Analyst (CS)

App 2 Alder Hey

Month	Potential slots available	Blocked slots	Un-covered slots	Actual appts available	Appts booked	Slots not used	% of appts used	Avg appts per hour	Ref for admission/A &E	% ref for admission/ A&E	Slots deducted for shift fulfilment	Shift fulfilment (includes un-filled shifts)
Nov-17	930	342	215	715	478	237	66.9%		54	11.3%	0	76.9%
Dec-17	961	291	203	758	457	301	60.3%		22	4.8%	2	78.7%
Jan-18	961	519	475	486	297	189	61.1%	2.35	19	6.4%	0	50.6%
Feb-18	868		356	512	290	222	56.6%	2.27	23	7.9%	11	57.7%
Mar-18	961		441	520	364	156	70.0%	2.70	23	6.3%	3	53.8%
Apr-18	930		510	420	271	149	64.5%	2.51	16	5.9%	0	45.2%
May-18	961		247	714	401	313	56.2%	2.18	25	6.2%	0	74.3%
Jun-18	930		418	512	265	247	51.8%	2.00	14	5.3%	0	55.1%
Jul-18	961		375	586	310	276	52.9%	2.05	22	7.1%	0	61.0%
Aug-18	961		517	444	182	262	41.0%	1.60	8	4.4%	0	46.2%
Sep-18	930		523	407	213	194	52.3%	2.19	15	7.0%	0	43.8%
Oct-18	961		316	645	372	273	57.7%	2.37	24	6.5%	0	67.1%

Month	Average consultation length (minutes) per month
Nov-17	16:17
Dec-17	16:16
Jan-18	15:20
Feb-18	15:08
Mar-18	14:46
Apr-18	14:55
May-18	15:48
Jun-18	14:43
Jul-18	15:16
Aug-18	14:14
Sep-18	15:00
Oct-18	16:09

Source: Adastra/Business Intelligence Team
Author: Performance Improvement Analyst (CS)

App 3 Aintree Includes any additional weekday daytime cover provided

Month	Potential slots available	Un-covered slots	Actual appts available	Appts booked	Slots not used	% of appts used	Avg appts per hour	Ref for admission/A &E	% ref for admission/A &E	Slots deducted for shift fulfilment	Shift fulfilment (includes un-filled shifts)
Nov-17	324	15	309	106	203	34.3%		16	15.1%	0	95.4%
Dec-17	402	26	376	117	259	31.1%		18	15.4%	0	93.5%
Jan-18	456	62	394	151	243	38.3%	0.89	25	16.6%	2	86.0%
Feb-18	1032	82	950	412	538	43.4%	1.32	60	14.6%	1	92.0%
Mar-18	1122	50	1072	523	549	48.8%	1.46	87	16.6%	1	95.5%
Apr-18	1080	199	881	341	540	38.7%	1.22	56	16.4%	0	81.6%
May-18	1122	185	937	316	621	33.7%	1.03	41	13.0%	0	83.5%
Jun-18	1098	379	719	255	464	35.5%	1.08	27	10.6%	0	65.5%
Jul-18	1140	365	775	354	421	45.7%	1.35	45	12.7%	0	68.0%
Aug-18	1140	360	780	288	492	36.9%	1.09	43	14.9%	0	68.4%
Sep-18	1080	135	945	344	601	36.4%	1.16	43	12.5%	0	87.5%
Oct-18	1158	97	1061	385	676	36.3%	1.24	50	13.0%	0	91.6%

Month	Average consultation length (minutes) per month
Nov-17	17:57
Dec-17	18:05
Jan-18	18:36
Feb-18	19:31
Mar-18	18:17
Apr-18	17:34
May-18	17:35
Jun-18	18:56
Jul-18	16:54
Aug-18	16:43
Sep-18	21:23
Oct-18	16:27

Source: Adastra/Business Intelligence Team
Author: Performance Improvement Analyst (CS)

App 4 RLUH Includes any additional weekday daytime cover provided

Month	Potential slots available	Un-covered slots	Actual appts available	Appts booked	Slots not used	% of appts used	Avg appts per hour	Ref for admission/A&E	% ref for admission/A&E	Slots deducted for shift fulfilment	Shift fulfilment (includes un-filled shifts)
Nov-17	574	0	574	419	155	73.0%		23	5.5%	0	100.0%
Dec-17	704	44	660	360	300	54.5%		34	9.4%	4	93.2%
Jan-18	1085	46	1039	473	566	45.5%	1.57	35	7.4%	0	95.8%
Feb-18	703	116	587	402	185	68.5%	1.70	48	11.9%	1	83.4%
Mar-18	916	191	725	420	305	57.9%	1.70	44	10.5%	0	79.1%
Apr-18	880	158	722	369	353	51.1%	1.53	54	14.6%	0	82.0%
May-18	904	272	632	293	339	46.4%	1.40	28	9.6%	0	69.9%
Jun-18	856	185	671	322	349	48.0%	1.43	43	13.4%	0	78.4%
Jul-18	874	132	742	423	319	57.0%	1.71	42	9.9%	0	84.9%
Aug-18	830	192	638	314	324	49.2%	1.45	44	14.0%	0	76.9%
Sep-18	824	50	774	455	319	58.8%	1.84	54	11.9%	0	93.9%
Oct-18	892	151	741	402	339	54.3%	1.72	42	10.4%	0	83.1%

Month	Average consultation length (minutes) per month
Nov-17	15:33
Dec-17	16:57
Jan-18	17:56
Feb-18	16:19
Mar-18	16:52
Apr-18	19:06
May-18	20:43
Jun-18	19:37
Jul-18	18:59
Aug-18	19:23
Sep-18	17:57
Oct-18	20:05

Source: Adastra/Business Intelligence Team
Author: Performance Improvement Analyst (CS)

App 5 Knowsley PCS

Key Performance Indicators (monthly) – October 2018 Telephone Triage and Home visiting Service, and Bookable GP appointments							
	Indicator Number	Description	Target	Total volume	Met KPI	Patient choice	% result
Quality	1	Patient experience of the service to be collected weekly and reported monthly	85% satisfied	35	34		97.1% (compliance calculated using responses of Extremely Likely and Likely)
	2	Clinical audit of 3% of clinical consultations	As per OOH contract				
	3	Number of complaints received		0			
	4	Number of compliments received		0			
	5	Number of incidents reported		2			
	6	Number of post event messages sent from Adastra within 24 hours	100%	240	240	0	100.0%
Triage	7a	Number of cases triaged via Pathfinder referral in 20 minutes (Halton & Knowsley)	95%	49	43	0	87.8%
	7b	Number of cases triaged via CAS referrals in 20 minutes (Halton & Knowsley)	95%	26	18	4	84.6%
	7c	Number of cases triaged via CAS referral in 60 minutes (Halton & Knowsley)	95%	5	5	0	100.0%
	7d	Number of cases triaged via surgery referral in 60 minutes	95%	0	0	0	
Home visits	8a	Number of patients visited within 1 hour of triage end (Pathfinder & CAS referrals) (Halton & Knowsley)	95%	0	0	0	
	8b	Number of patients visited within 2 hours of triage end (Pathfinder & CAS referrals) (Halton & Knowsley)	95%	0	0	0	
	8c	Number of patients visited within 6 hours of triage end (Pathfinder & CAS referrals) (Halton & Knowsley)	95%	12	11	0	91.7%
	8d	Number of patients visited within 6 hours of request by surgery (Knowsley surgeries)	95%	158	154	0	97.5%
Appointments	9a	Number of patients seen on day of scheduled appointment (Knowsley surgeries) on weekdays	95%	1762	1552	210	100.0%
	9b	Number of patients seen on day of scheduled appointment (Knowsley surgeries) on weekends	95%	146	100	46	100.0%
	9c	Number of patients seen on day of scheduled appointment (Walk-in Centres (all CCGs), Pathfinder & CAS – Halton & Knowsley)	95%	20	20	0	100.0%
	10a	Number of patients seen within 30 minutes of scheduled appointment time (Knowsley surgeries) on weekdays	95%	1552	1501	13	97.6%
	10b	Number of patients seen within 30 minutes of scheduled appointment time (Knowsley surgeries) on weekends	95%	100	100	0	100.0%
	10c	Number of patients seen within 30 minutes of scheduled appointment time (Walk-in Centres)	95%	2	2	0	100.0%
	10d	Number of patients seen within 30 minutes of scheduled appointment time (Pathfinder referrals – Halton & Knowsley)	95%	4	4	0	100.0%
	10e	Number of patients seen within 30 minutes of scheduled appointment time (CAS referrals – Halton & Knowsley)	95%	14	13	1	100.0%
Doctor advice (stand-downs)	11a	Number of cases completed as Doctor Advice (i.e. face-to-face consultation was planned but did not take place) from Pathfinder & CAS referrals in 1 hour (Halton & Knowsley)	95%	0	0	0	
	11b	Number of cases completed as Doctor Advice (i.e. face-to-face consultation was planned but did not take place) from Pathfinder & CAS referrals in 2 hours (Halton & Knowsley)	95%	0	0	0	
	11c	Number of cases completed as Doctor Advice (i.e. face-to-face consultation was planned but did not take place) from Pathfinder & CAS referrals in 6 hours (Halton & Knowsley)	95%	1	1	0	100.0%

The following KPIs are no longer reported as of November 2017 (from 2015 Service Specification):

2) Practice experience of the service to be collected by Commissioner and reported following review.
7) Number of eligible patients admitted to Intermediate Care step-up beds.
9) Number of available appointments utilised.
10) Number of appointments refused by the service

Source: Adastra/EMIS/Business Intelligence team
Author: Performance Improvement Analyst (CS)

App 6 Intermediate Care

Month	Total Time (hours)	Allocated Time (hours)	Unallocated Time (hours)	% hours filled
November 2017 – Knowsley GP	172	172	0	
November 2017 – Knowsley GP Standby	26	26	0	
				100.0%
December 2017 – Knowsley GP	163.75	163.75	0	
December 2017 – Knowsley GP Standby	25.25	25.25	0	
				100.0%
January 2018 – Knowsley GP	182.5	182.5	0	
January 2018 – Knowsley GP Standby	24.5	24.5	0	
				100.0%
February 2018 – Knowsley GP	148.5	148.5	0	
February 2018 – Knowsley GP Standby	31.5	31.5	0	
				100.0%
March 2018 – Knowsley GP	160.25	160.25	0	
March 2018 – Knowsley GP Standby	36	36	0	
				100.0%
April 2018 – Knowsley GP	160.25	160.25	0	
April 2018 – Knowsley GP Standby	24.75	24.75	0	
				100.0%
May 2018 – Knowsley GP	168	168	0	
May 2018 – Knowsley GP Standby	39	39	0	
				100.0%
June 2018 – Knowsley GP	165	165	0	
June 2018 – Knowsley GP Standby	25.5	25.5	0	
				100.0%
July 2018 – Knowsley GP	172	172	0	
July 2018 – Knowsley GP Standby	27	27	0	
				100.0%
August 2018 – Knowsley GP	187.5	187.5	0	
August 2018 – Knowsley GP Standby	19.5	19.5	0	
				100.0%
September 2018 – Knowsley GP	158.5	158.5	0	
September 2018 – Knowsley GP Standby	21.5	21.5	0	
				100.0%
October 2018 – Knowsley GP	180.5	180.5	0	
October 2018 – Knowsley GP Standby	26.5	26.5	0	
				100.0%
November 2018 – Knowsley GP	155	155	0	
November 2018 – Knowsley GP Standby	43	43	0	
				100.0%

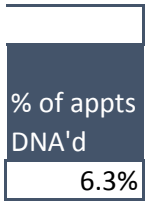
Source: RotaMaster
Author: Business Intelligence Lead

App 7 **Extended Access**

Liverpool Extended Access					
Month	Appts available	Appts booked	Appts DNA'd (incl 'tel not answered')	% of appts booked	% of appts DNA'd
Oct-18	3850	1650	153	42.9%	9.3%

St Helens Extended Access				
Month	Appts available	Appts booked	Appts DNA'd	% of appts booked
Oct-18	645	208	13	32.2%

Source: RotaMaster / EMIS / Adastra
Author: Business Intelligence Lead


% of appts DNA'd
6.3%

App 8 Asylum practice

	Current year			Previous year			EMIS results
Month	Arrivals (current year)	Health Assessments done in month (current year) - from Mar 2018 for arrivals in month	GP Appts (current year)	Arrivals (previous year)	Health Assessments done in month (previous year)	GP Appts (previous year)	Arrivals (EMIS report)
Nov 17	451	345	67	443	314	60	
Dec 17	386	144	30	450	221	69	
Jan 18	367	227	47	331	250	77	
Feb 18	316	290	45	356	239	66	
Mar 18	372	250	33	344	316	94	
Apr 18	338	206	47	248	189	65	348
May 18	284	192	52	360	241	63	298
June 18	359	208	42	371	265	56	361
July 18	460	258	44	403	109	58	453
Aug 18	450	307	53	309	299	27	457
Sep 18	403	177	61	314	318	52	418
Oct 18	517	243	Not reported	341	231	52	533

Source: UC24 Asylum practice Practice Manager / EMIS

Author: Business Intelligence Lead/Associate Director of Service Delivery

App 9 Finance Position

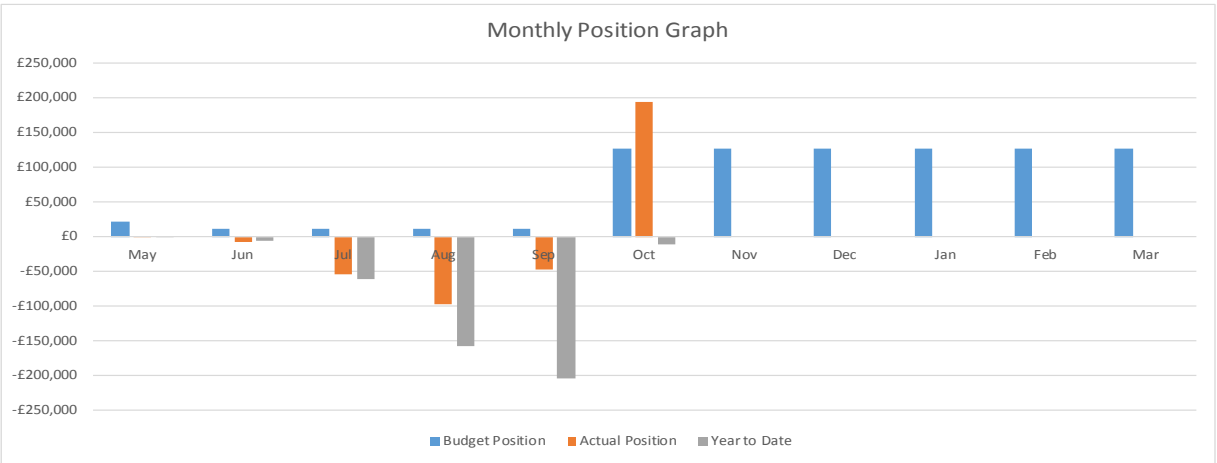
Service Line Reports as at 31 October 2018								
SDU	Type	Annual Budget	YTD Budget	YTD Actuals	YTD Variance	Period Budget	Period Actuals	Period Variance
IUC	Income	(10,994,973)	(5,720,941)	(5,894,688)	173,747	(1,054,807)	(1,214,131)	159,325
IUC	Pay	6,992,230	3,731,973	3,725,077	6,897	652,051	668,898	(16,847)
IUC	Non Pay	195,154	59,191	53,074	6,117	27,193	18,162	9,031
IUC	Overheads	2,497,953	1,478,717	1,449,872	28,845	215,497	224,839	(9,343)
IUC Total		**(1,309,637)**	**(451,059)**	**(666,665)**	**215,606**	**(160,066)**	**(302,232)**	**142,166**
Primary & Community Services	Income	(2,925,698)	(1,706,657)	(1,774,609)	67,952	(243,808)	(283,299)	39,491
Primary & Community Services	Pay	2,744,916	1,601,201	1,884,227	(283,026)	228,743	307,771	(79,028)
Primary & Community Services	Non Pay	109,645	63,957	234,207	(170,250)	9,138	39,180	(30,043)
Primary & Community Services	Overheads	552,611	349,404	333,451	15,953	45,084	44,814	270
Primary & Community Services Total		**481,474**	**307,905**	**677,275**	**(369,371)**	**39,156**	**108,466**	**(69,310)**
Grand Total (Surplus) / Deficit		**(828,162)**	**(143,155)**	**10,610**	**(153,765)**	**(120,910)**	**(193,766)**	**72,856**

Management Accounts as at 31 October 2018								
SDU	Type	Annual Budget	YTD Budget	YTD Actuals	YTD Variance	Period Budget	Period Actuals	Period Variance
IUC	Income	(10,994,973)	(5,720,941)	(5,894,688)	173,747	(1,054,807)	(1,214,131)	159,325
IUC	Pay	6,992,230	3,731,973	3,725,077	6,897	652,051	668,898	(16,847)
IUC	Non Pay	195,154	59,191	53,074	6,117	27,193	18,162	9,031
IUC Total		**(3,807,589)**	**(1,929,777)**	**(2,116,537)**	**186,761**	**(375,563)**	**(527,071)**	**151,509**
Primary & Community Services	Income	(2,925,698)	(1,706,657)	(1,774,609)	67,952	(243,808)	(283,299)	39,491
Primary & Community Services	Pay	2,744,916	1,601,201	1,884,227	(283,026)	228,743	307,771	(79,028)
Primary & Community Services	Non Pay	109,645	63,957	234,207	(170,250)	9,138	39,180	(30,043)
Primary & Community Services Total		**(71,137)**	**(41,499)**	**343,825**	**(385,324)**	**(5,928)**	**63,652**	**(69,580)**
Corporate Support	Income	(27,672)	(16,142)	(21,970)	5,828	(2,306)	(3,544)	1,238
Corporate Support	Pay	2,082,055	1,211,398	1,208,939	2,459	174,133	180,866	(6,733)
Corporate Support	Non Pay	996,181	632,865	596,354	36,511	88,754	92,332	(3,578)
Corporate Support Total		**3,050,564**	**1,828,121**	**1,783,323**	**44,798**	**260,580**	**269,653**	**(9,073)**
Grand Total		**(828,162)**	**(143,155)**	**10,610**	**(153,765)**	**(120,910)**	**(193,766)**	**72,856**

Sefton Practices							
	Annual Budget	YTD Budget	YTD Actuals	YTD Variance	Period Budget	Period Actuals	Period Variance
Base Contract	(1,701,804)	(992,719)	(1,014,948)	22,229	(141,817)	(157,510)	15,693
QOF	(227,724)	(132,839)	(103,759)	(29,080)	(18,977)	(15,071)	(3,906)
LQC income (SSCCG)	(334,128)	(194,908)	(202,381)	7,473	(27,844)	(58,070)	30,226
CQRS income (NHSE)	(96,288)	(56,168)	(36,873)	(19,295)	(8,024)	(4,033)	(3,991)
NHSE APMS Contract KPIs	(98,334)	(57,362)	(59,752)	2,390	(8,195)	(8,794)	600
NHSE Reslience Funding	0	0	0	0	0	0	0
NHSE Set Up Fees	0	0	0	0	0	0	0
NHSE Additional Funding	0	0	0	0	0	0	0
Prior Year Income	0	0	(98,502)	98,502	0	(7,424)	7,424
Jospice income	(49,920)	(29,120)	(24,960)	(4,160)	(4,160)	0	(4,160)
Sundry income	(52,004)	(30,336)	(20,229)	(10,107)	(4,334)	(1,939)	(2,395)
Total Income	**(2,560,202)**	**(1,493,451)**	**(1,561,403)**	**67,952**	**(213,350)**	**(252,841)**	**39,491**
Pay	2,498,772	1,457,617	1,776,789	(319,172)	208,231	289,278	(81,047)
Non Pay	267,372	155,967	188,584	(32,617)	22,281	33,872	(11,591)
Contract Gap	(205,927)	(120,127)	0	(120,127)	(17,160)	0	(17,160)
(Positive)/Negative Contribution to Overheads	**15**	**6**	**403,970**	**(403,964)**	**2**	**70,309**	**(70,307)**

Position Graph

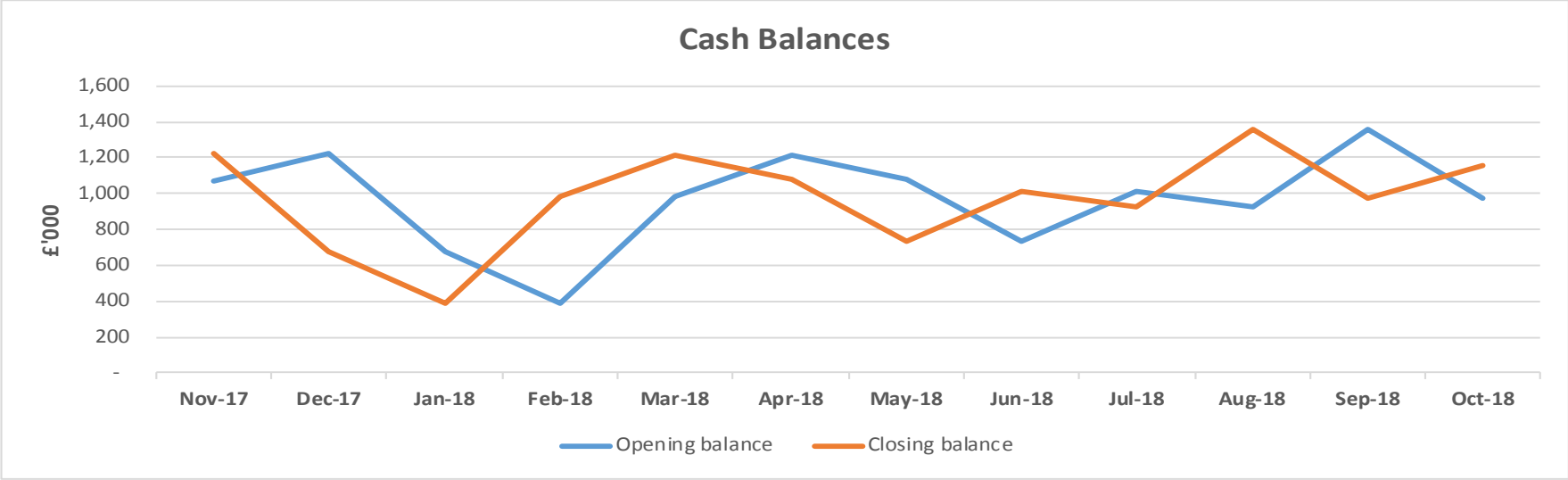
The below graph plots out the year to date actual positions, along with the planned position.



Source: E-Financials
Author: Head of Finance

App 10 Cash Position

	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18
Opening balance	1,069	1,225	678	384	985	1,212	1,079	733	1,009	923	1,360	978
Closing balance	1,225	678	384	985	1,212	1,079	733	1,009	923	1,360	978	1,156



Source: Bank Statements
Author: Head of Finance

App 11 Efficiency Position

Efficiency Plans Summary

	Revised Annual Plan	Year to Date		
		Original Plan	Revised Plan	Actual
1. Clinical Workforce	£ 65,500	£ 32,500	£ 10,917	£ -
2. New Income Generation	£ 125,000	£ 40,833	£ 20,833	£ 117,933
3. Stand Alone Schemes	£ 72,806	£ 29,468	£ 22,635	£ 21,968
Total	**£ 263,306**	**£ 102,802**	**£ 54,385**	**£ 139,901**

Source: Efficiency Monitoring Tool
Author: Head of Finance

App 12 Quality and Patient Safety

Friends & Family Test

"How likely are you to recommend our service to friends and family if they needed similar care or treatment?"				
	Aug-18	**Sep-18**	**Oct-18**	**Nov-18 MTD (to 22nd)**
Extremely Likely	75.0%	69.1%	66.2%	64.2%
Likely	17.5%	20.3%	19.6%	22.3%
Neither Likely or Unlikely	3.4%	3.6%	5.5%	5.7%
Unlikely	2.2%	2.5%	1.9%	3.0%
Extremely Unlikely	1.6%	2.9%	5.5%	4.1%
Don't know	0.4%	1.6%	1.3%	0.7%

Source: Synapta
Author: Business Intelligence Lead

Compliments

SDU/Dept/Area	Primary & Community Services			Out Of Hours (incl Alder Hey)	Internal
	Asylum	Daytime Services (incl EAS)	GP Practices		
Sep-18	0	1	0	1	0
Oct-18	0	0	6	4	0

Source: Datix
Author: Governance Administrator (SD)

Incidents

SDU/Dept/Area	Primary & Community Services			Out Of Hours (incl Alder Hey)	Internal
	Asylum	Daytime Services (incl EAS)	GP Practices		
Sep-18	0	0	4	53	9
Oct-18	3	29	6	18	32

Source: Datix
Author: Governance Administrator (SD)

Complaints not resolved within 25 days

During the month of September 2018 there were 3 complaints that were not closed within the 25 working day timeframe.
During the month of October 2018 there was 1 complaint closed within the 25 working day timeframe; 1 exceeded the 25 working day timeframe and 9 complaints are not due to be closed within the month of October because of the date the complaint was received.

Source: Datix
Author: Governance Administrator (SD)

Safeguarding reports

Total number of incidents reported during September was 66; of these, 1 was a safeguarding referral.
Total number of incidents reported during October was 86; of these, 4 were reported as safeguarding incidents and of those 4, 1 was a safeguarding referral.

Source: Datix
Author: Governance Administrator (SD)

App 13 Complaints received

Date Received	Service	Description	Action Taken	Commissioner	Grade	Outcome	Closed
27.09.2018	PCS - Maghull Practice	Confidentiality Breach	Under review	NHS England	Not graded	Under review	Ongoing
26.09.2018	PCS – Litherland Practice	Care & Treatment	Under review	NHS England	Not graded	Under review	Ongoing
14.09.2018	PCS - Netherton Practice	Care & Treatment	Under review	NHS England	Moderate	Under review	Ongoing
12.09.2018	PCS – Thornton Practice	Appointment access	Under review	NHS England	Moderate	Under review	Ongoing
05.09.2018	OOH	Care & Treatment	Under review	Liverpool	Not graded	Under review	Ongoing
02.09.2018	OOH	Care & Treatment	Review undertaken	Liverpool	Moderate	Partially Upheld	Closed
08.10.2018	OOH	Care & Treatment	Under Review	Liverpool	Not graded	Under Review	Ongoing
11.10.2018	PCS Seaforth Practice	Attitude & Behaviour and treatment	Under Review	NHS England	Not graded	Under Review	Ongoing
16.10.2018	PCS Seaforth Practice	Care & Treatment	Review Undertaken	NHS England	Low	Partially Upheld	Closed
18.10.2018	OOH GP	Care & Treatment	Under Review	Liverpool	Not graded	Under Review	Ongoing
19.10.2018	PCS Thornton Practice	Care & Treatment	Under Review	NHS England	Moderate	Under Review	Ongoing
19.10.2018	PCS Thornton Practice	Care & Treatment	Under Review	NHS England	Not graded	Under Review	Ongoing
20.10.2018	OOH GP	Attitude & Behaviour	Under Review	Knowsley	Not graded	Under Review	Ongoing
24.10.2018	PCS - Litherland Practice	Care & Treatment	Under Review	NHS England	Moderate	Under Review	Ongoing
30.10.2018	OOH GP	Care & Treatment	Under Review	Halton	Moderate	Under Review	Ongoing
30.10.2018	PCS Litherland Practice	Administrative Processes	Under Review	NHS England	Not graded	Under Review	Ongoing
31.10.2018	St Helens EAS	Attitude & Behaviour and Care & Treatment	Under Review	St Helens	Not graded	Under Review	Ongoing

Source: Datix
Author: Governance Administrator (SD)

App 14 Workforce

Staff Turnover

UC24	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18
Start of Month Staff Numbers	232	232	233	231	235	240	240	242	241	237	240	239
Starters	3	5	2	6	7	2	5	2	3	4	3	7
Leavers	3	4	4	2	2	2	3	3	7	1	4	3
TUPE												
Staff in probation period	41	42	36	36	34	25	27	24	25	23	19	24
Staff due to receive appraisal	191	190	197	195	201	215	213	218	216	214	221	215
End of Month Staff Numbers	232	233	231	235	240	240	242	241	237	240	239	243
Turnover Rate	1.29%	1.72%	1.72%	0.86%	0.84%	0.83%	1.24%	1.24%	2.93%	0.42%	1.67%	1.24%
Annualised rate	15.5%	20.6%	20.7%	10.3%	10.1%	10.0%	14.9%	14.9%	35.1%	5.0%	20.0%	14.9%
Rolling Annualised rate	29.4%	28.6%	26.4%	26.3%	26.3%	23.5%	21.8%	21.2%	20.0%	16.6%	15.2%	16.0%

Source: Rotamaster
Author: HR Manager

Appraisal compliance (figures re-calculated Sep 2018 to count 'staff requiring appraisal' rather than 'total staff'

Appraisals completed in date	176	176	176	176	176	5	8	56	69	69	72	73
Total staff requiring appraisal	191	190	197	195	201	215	213	218	216	214	213	219
	92.1%	92.6%	89.3%	90.3%	87.6%	2.3%	3.8%	25.7%	31.9%	32.2%	33.8%	33.3%

Source: Rotamaster
Author: HR Manager

Mandatory training compliance

Courses due to be completed by end of working month	1624	1624	1631	1617	1645	1680	1680	1694	1687	1659	1680	1673
Courses completed by end of working month	1556	1578	1585	1379	1412	1443	1465	1470	1480	1432	1473	1488
	95.8%	97.2%	97.2%	85.3%	85.8%	85.9%	87.2%	86.8%	87.7%	86.3%	87.7%	88.9%

Source: Rotamaster/E-learning portal
Author: Interim Training Manager

Service Delivery	App. ref	Target	YTD (from Apr)	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Trend	Nov-18 Forecast	Exception Report Number
Sefton GP practices - cover of Clinical Sessions (GP & ANPs)	2.1	100%	95.4%			101.0%	106.0%	101.0%	96.0%	96.8%	93.0%	93.4%	95.0%	98.9%	95.0%		96%	PCS001
Sefton GP practices - Salaried/Associate cover of clinical sessions	2.1	70%	32.9%			45.0%	43.0%	36.0%	47.0%	42.3%	39.4%	26.2%	21.4%	28.7%	25.5%		25%	PCS002
Sefton GP practices - Agency Cover (GP & ANP) cover of clinical sessions	2.1	30%	64.7%			55.0%	57.0%	66.0%	53.0%	58.7%	60.6%	67.2%	73.6%	70.3%	69.5%		71%	PCS002
Sefton GP practices - appointment utilisation	2.2	>90%	81.8%	70.1%	62.0%	59.3%	71.6%	73.2%	81.0%	83.2%	78.7%	79.2%	82.1%	83.2%	85.3%		84%	PCS003
Sefton GP practices - appointment DNA rate	2.2	<5%	5.5%	5.7%	5.1%	3.8%	4.9%	6.2%	6.3%	5.6%	5.2%	6.4%	5.1%	4.5%	5.1%		5%	PCS003

Exception reference	Description	Commentary	Owner	Timescale to resolve (if applicable)
PCS001	Sefton GP practices - cover of Clinical Sessions (GP & ANPs)	Consistent overall performance at 95% . Unfilled sessions due to late cancellation of locum GPs.	Associate Director of Service Delivery	Jan-18
PCS002	Sefton GP Practices - % of salaried vs agency cover	Slight increase in as a result of annual leave cover and sick leave of a salaried GP. Two practices remain entirely reliant upon locums. An Associate GP commenced on 1 October 2018.	Associate Director of Service Delivery	Jan-18
PCS003	Sefton GP Practices appointment utilisation and 'did not attend' rate	Overall utilisation rate improved in September and October. Overall DNA rates fluctuating between 4.5 and 5%. GP DNA ratesins consistent at 4% with a variance in performance at Practice level between 2% and 12%. The Interim Primary Care Manager is working across all Practices to review processes and support Practice Managers to implement new arrangements.	Associate Director of Service Delivery	Jan-18

App 2.1 **Sefton GP practices**

Salaried v Agency utilisations

Practice	Weekly Contracted Clinical Sessions - (Based on Surgery Size)	Planned September sessions	Actual Salaried/ Associate GP sessions	Actual GP Agency Sessions	Actual Salaried ANP sessions	Actual Agency ANP sessions	Totals	Salaried GP utilisation of clinical sessions	Agency GP utilisation of clinical sessions	Salaried ANP utilisation of clinical sessions	Agency ANP utilisation of clinical sessions	Total Coverage	Total salaried cover (GPs & ANPs)	Total Agency cover (GPs & ANPs)	Comments
Crosby	14 sessions	56	8	46	0	6	60	14%	82%	0%	11%	107%	14%	93%	
Maghull	15 sessions	60	0	55	0	13	68	0%	92%	0%	22%	113%	0%	113%	
Crossways	14 sessions	52	31	12	0	0	43	60%	23%	0%	0%	83%	60%	23%	
Litherland	14 sessions	60	34	22	0	0	56	57%	37%	0%	0%	93%	57%	37%	
Seaforth	10 sessions	40	8	32	0	0	40	20%	80%	0%	0%	100%	20%	80%	1 = GP Joint injection clinic for Sefton Practice patients
Thornton	16 sessions	64	28	16	0	17	61	44%	25%	0%	27%	95%	44%	52%	
Netherton	12 sessions	48	0	46	0	2	48	0%	96%	0%	4%	100%	0%	100%	
Totals	**95**	**380**	**109**	**229**	**0**	**38**	**376**	**28.7%**	**60.3%**	**0.0%**	**10.0%**	**98.9%**	**28.7%**	**70.3%**	

Additional service - joint injection clinic 12 appointments, 12 attended, no DNA's (Seaforth)

Practice	Weekly Contracted Clinical Sessions - (Based on Surgery Size)	Planned October sessions	Actual Salaried/ Associate GP sessions	Actual GP Agency Sessions	Actual Salaried ANP sessions	Actual Agency ANP sessions	Totals	Salaried GP utilisation of clinical sessions	Agency GP utilisation of clinical sessions	Salaried ANP utilisation of clinical sessions	Agency ANP utilisation of clinical sessions	Total Coverage	Total salaried cover (GPs & ANPs)	Total Agency cover (GPs & ANPs)	Comments
Crosby	14 sessions	64	8	48	0	8	64	13%	75%	0%	13%	100%	13%	88%	
Maghull	15 sessions	69	0	59	0	13	72	0%	86%	0%	19%	104%	0%	104%	
Crossways	13 sessions	60	33	17	0	0	50	55%	28%	0%	0%	83%	55%	28%	
Litherland	14 sessions	64	30	34	0	0	64	47%	53%	0%	0%	100%	47%	53%	
Seaforth	10 sessions	46	32	14	0	0	46	70%	30%	0%	0%	100%	70%	30%	
Thornton	16 sessions	66	5	37	0	16	58	8%	56%	0%	24%	88%	8%	80%	
Netherton	12 sessions	54	0	44	0	4	48	0%	81%	0%	7%	89%	0%	89%	
Totals	**95**	**423**	**108**	**253**	**0**	**41**	**402**	**25.5%**	**59.8%**	**0.0%**	**9.7%**	**95.0%**	**25.5%**	**69.5%**	

Source: Sefton practices Practice Managers

Author: Associate Director of Service Delivery

App 2.2 Sefton GP practices

Nov-17									
attended		885	1137		1048			3070	70.1% appt utilisation
DNA		46	108		96			250	5.7% DNA rate
total		1298	1670		1413			4381	

Dec-17									
attended		770	974		807			2551	62.0% appt utilisation
DNA		40	116		55			211	5.1% DNA rate
total		1231	1501		1385			4117	

Jan-18									
attended		489	1179	1169	976			3813	59.3% appt utilisation
DNA		48	93	34	67			242	3.8% DNA rate
total		1595	1697	1820	1318			6430	

Feb-18									
attended		844	978	990	793			3605	71.6% appt utilisation
DNA		28	94	34	89			245	4.9% DNA rate
total		1219	1358	1362	1098			5037	

Mar-18									
attended		1038	1018	1058	961	653	1092	5820	73.2% appt utilisation
DNA		88	100	60	63	112	71	494	6.2% DNA rate
total		1620	1364	1530	1220	872	1342	7948	

Apr-18	Available Appointments	Appointments Booked	DNAs	Appointments Attended	% of available appointments booked	% DNA	Overall Utilisation
Thornton	1020	993	47	946	97.4%	4.6%	92.7%
Maghull	1292	1153	35	1118	89.2%	2.7%	86.5%
Crossways	1148	936	27	909	81.5%	2.4%	79.2%
Crosby	1069	900	73	827	84.2%	6.8%	77.4%
Netherton	867	773	59	714	89.2%	6.8%	82.4%
Seaforth	874	720	83	637	82.4%	9.5%	72.9%
Litherland	1259	1034	89	945	82.1%	7.1%	75.1%
Totals	7529	6509	413	6096	86.5%	6.3%	81.0%

May-18	Available Appointments	Appointments Booked	DNAs	Appointments Attended	% of available appointments booked	% DNA	Overall Utilisation
Thornton	933	902	36	866	96.7%	4.0%	92.8%
Maghull	1285	1215	48	1167	94.6%	4.0%	90.8%
Crossways	1221	915	31	884	74.9%	3.4%	72.4%
Crosby	1162	1020	61	951	87.8%	6.0%	81.8%
Netherton	829	759	25	731	91.6%	3.3%	88.2%
Seaforth	871	814	97	686	93.5%	11.9%	78.8%
Litherland	1093	962	73	869	88.0%	7.6%	79.5%
Totals	7394	6587	371	6154	89.1%	5.6%	83.2%

Jun-18	Available Appts	Appts Booked	DNAs	Appts Attended	% of available appointments booked	% DNA	Overall Utilisation
Thornton	998	966	41	925	96.8%	4.2%	92.7%
Maghull	1083	965	32	933	89.1%	3.3%	86.1%
Crossways	1389	832	15	817	59.9%	1.8%	58.8%
Crosby	987	862	36	826	87.3%	4.2%	83.7%
Netherton	725	645	43	602	89.0%	6.7%	83.0%
Seaforth	882	768	90	678	87.1%	11.7%	76.9%
Litherland	1264	1045	62	983	82.7%	5.9%	77.8%
Totals	7328	6083	319	5764	83.0%	5.2%	78.7%

Jul-18	Available Appts	Appts Booked	DNAs	Appts Attended	% of available appointments booked	% DNA	Overall Utilisation
Thornton	858	842	57	785	98.1%	6.8%	91.5%
Maghull	1172	1073	35	1038	91.6%	3.3%	88.6%
Crossways	1316	833	24	809	63.3%	2.9%	61.5%
Crosby	1014	896	50	843	88.4%	5.6%	83.1%
Netherton	1078	955	99	856	88.6%	10.4%	79.4%
Seaforth	803	727	77	650	90.5%	10.6%	80.9%
Litherland	1179	960	61	899	81.4%	6.4%	76.3%
Totals	7420	6286	403	5880	84.7%	6.4%	79.2%

Aug-18	Available Appointments	Appointments Booked	DNAs	Appointments Attended	% of available appointments booked	% DNA	Overall Utilisation
Thornton	959	912	52	860	95.1%	5.7%	89.7%
Maghull	982	905	27	878	92.2%	3.0%	89.4%
Crossways	1227	909	20	889	74.1%	2.2%	72.5%
Crosby	1054	903	24	879	85.7%	2.7%	83.4%
Netherton	959	815	43	772	85.0%	5.3%	80.5%
Seaforth	677	625	91	534	92.3%	14.6%	78.9%
Litherland	789	681	34	647	86.3%	5.0%	82.0%
Totals	6647	5750	291	5459	86.5%	5.1%	82.1%

Sep-18	Available Appointments	Appointments Booked	DNAs	Appointments Attended	% of available appointments booked	% DNA	Overall Utilisation
Thornton	*Not supplied*	*Not supplied*	*Not supplied*	*Not supplied*	-	-	-
Maghull	720	703	9	694	97.6%	1.3%	96.4%
Crossways	707	584	13	571	82.6%	2.2%	80.8%
Crosby	768	651	36	610	84.8%	5.5%	79.4%
Netherton	734	659	26	633	89.8%	3.9%	86.2%
Seaforth	686	528	63	465	77.0%	11.9%	67.8%
Litherland	836	757	28	729	90.6%	3.7%	87.2%
Totals	4451	3882	175	3702	87.2%	4.5%	83.2%

Oct-18	Available Appointments	Appointments Booked	DNAs	Appointments Attended	% of available appointments booked	% DNA	Overall Utilisation
Thornton	1013	966	59	907	95.4%	6.1%	89.5%
Maghull	1546	1508	22	1486	97.5%	1.5%	96.1%
Crossways	929	763	13	750	82.1%	1.7%	80.7%
Crosby	1391	1196	51	1143	86.0%	4.3%	82.2%
Netherton	995	890	70	820	89.4%	7.9%	82.4%
Seaforth	986	935	98	837	94.8%	10.5%	84.9%
Litherland	1610	1355	75	1280	84.2%	5.5%	79.5%
Totals	8470	7613	388	7223	89.9%	5.1%	85.3%

Source: Sefton practices Practice Managers
Author: Associate Director of Service Delivery

NHS
Urgent Care 24
safe • caring • effective

Title:	Meeting Date:	Agenda item no:
Executive Team Away Day	29 November 2018	9.1
Prepared and presented by: Dr Mary Ryan	**Discussed by:**	
Link to UC24 Values: ✓ Providing quality patient services ✓ Being an excellent employer ✓ Working collaboration to achieve positive system change. **CQC Domain References** ✓ Safe ✓ Effective ✓ Caring ✓ Responsive ✓ Well-led	**Resource implications:** **Purpose of the report:** ☐ Assurance ☐ Decision ☐ Discussion ✓ Noting **Decisions to be taken:** The meeting is invited: • To note the discussions held on 8 November.	

1.0 Purpose

1.1 The purpose of this paper is to update the Board the Executive Team away day held on 8 November to focus on building knowledge of each other, strengthening new relationships and refreshing the strategic plan.

2.0 Summary Notes

2.1 Summary notes are attached

3.0 Recommendations

The meeting is invited to:

- note the Chief Executive's report.

UC24 EXECUTIVE AWAY DAY

NOVEMBER 8TH 2018

SUMMARY NOTES

Questions generated & topics emerging from initial discussion:

UNDERSTANDING THE BUSINESS:

Do we understand our own capacity?

Do we understand our terms & conditions and are they realistic?

How did UC24 get to where it is now?

Is it working well (processes etc.)?

Do we really understand what we are?

RISK & GOVERNANCE:

What is our attitude to risk?

What does governance mean to us?

What about corporate governance?

Do we really act like a Social Enterprise?

Processes & Procedures need an overhaul

HOUSEKEEPING:

We have some 'free floating' / important roles with no owner

The office / our environment

There is concern about the IG Toolkit

TEAM / LEADERSHIP:

Are we (as a group) behaving like leaders?

How do we communicate with each other?

How do with communicate with others?

Do we have shared values and vision?

Do we all understand the challenges?

Do some of our teams need a full re-organisation?

Do we respect each other's opinions?

Do we all share the same view of our jobs?

DEVELOPMENT:

How will we work with the new Chair?

Some of our teams are under skilled

How do we look for new business?

Do we understand the role of our NEDs?

Mission statement refresh:

To deliver the best quality healthcare to the population we serve, by being the employer of choice in 24 hour Primary Care

Next Steps:

1. Agree Objectives with Board
2. Create full Strategic Business Plan for 2019-2021
3. Each exec to develop actions plans from the agreed strategies and oversee operationalising with their teams
4. Review 3 monthly to ensure focus and progress in all areas
5. All team and individual objectives to map to corporate in 2019/20 PDP & appraisal round

OBJECTIVES FOR 2018 – 2020

---

1. **Over the next 12 months, we will consolidate our business and demonstrate success in each service line**

2. **Over the next 6 months we will review and re-shape our organisational governance process and structures, to reflect our current business and demands**

3. **We will be the employer we wish to be at all levels of the organisation**

4. **We will develop our corporate functions from transactional to transformational**

5. **We will engage the organisation with digital offers and solutions**

6. **We will engage with sectors outside health to scope business opportunities, while remaining open to health based opportunities**

7. **We will communicate at all levels effectively, positively and regularly**

STRATEGIES UNDERLYING THESE OBJECTIVES

With lead executives

---

1. Over the next 12 months, we will consolidate our business and demonstrate success in each service line

Success will be measured across several areas:

Finance – is each service breaking even, contributing to overheads and making some surplus?	Heledd Cooper
Safety – are we sure services are safe? Incidents? Complaints? Are we meeting regulatory requirements?	Paul Kavanagh-Fields Sandra Oelbaum
Are we being ranked highly in this domain in CQC inspections?	Paul Kavanagh-Fields Sandra Oelbaum
Effective – Do we deal with patients effectively, answer their questions, minimise inappropriate use of secondary care services. Are our patients experiencing better outcomes?	Paul Kavanagh-Fields Sandra Oelbaum

2. Over the next 6 months we will review and re-shape our organisational governance process and structures, to reflect our current business and demands

How we collect risks, manage them and collate them into a single risk register will be reviewed.	Paul Kavanagh-Fields
Building on this, governance will be strengthened and a Board Assurance Framework will be constructed to assure the Board that we are sighted on risks and they are being managed.	Paul Kavanagh-Fields
Any out of date or absent policies will be identified and reviewed via a new 'managing policies' process, which will be described and embedded in the organisation.	Margaret Swinson

3. We will be the employer we wish to be at all levels of the organisation

We will evaluate any new or replacement post before recruiting.	Heledd Cooper
We will overhaul and review induction at all levels in the organisation as a priority	Heledd Cooper (via HR)
We will recruit & retain a salaried GP workforce	Sandra Oelbaum
We will review the previous work on terms & conditions and complete it, ensuring that all managers understand our offer to all clinical and non-clinical staff	Heledd Cooper (via HR)
We will articulate our training offer clearly and embed it as part of an overarching Organisational Development Strategy	Heledd Cooper (via HR) Paul Kavanagh-Fields

We will build a Research Strategy, working with the NIHR Clinical Research Network, North-West	Sandra Oelbaum
We will develop a fully worked up workforce plan for all our services for the next 2 years and beyond	Heledd Cooper (via HR)
We will develop a plan that ensures our staff can stay healthy – both physically and mentally.	Heledd Cooper (via HR)

4. We will develop our corporate functions from transactional to transformational

Concentrating this year on

Payroll	Heledd Cooper
IMT	Jay Carr
Human Resources	Heledd Cooper (via HR)
Health & Safety	Paul Kavanagh-Fields

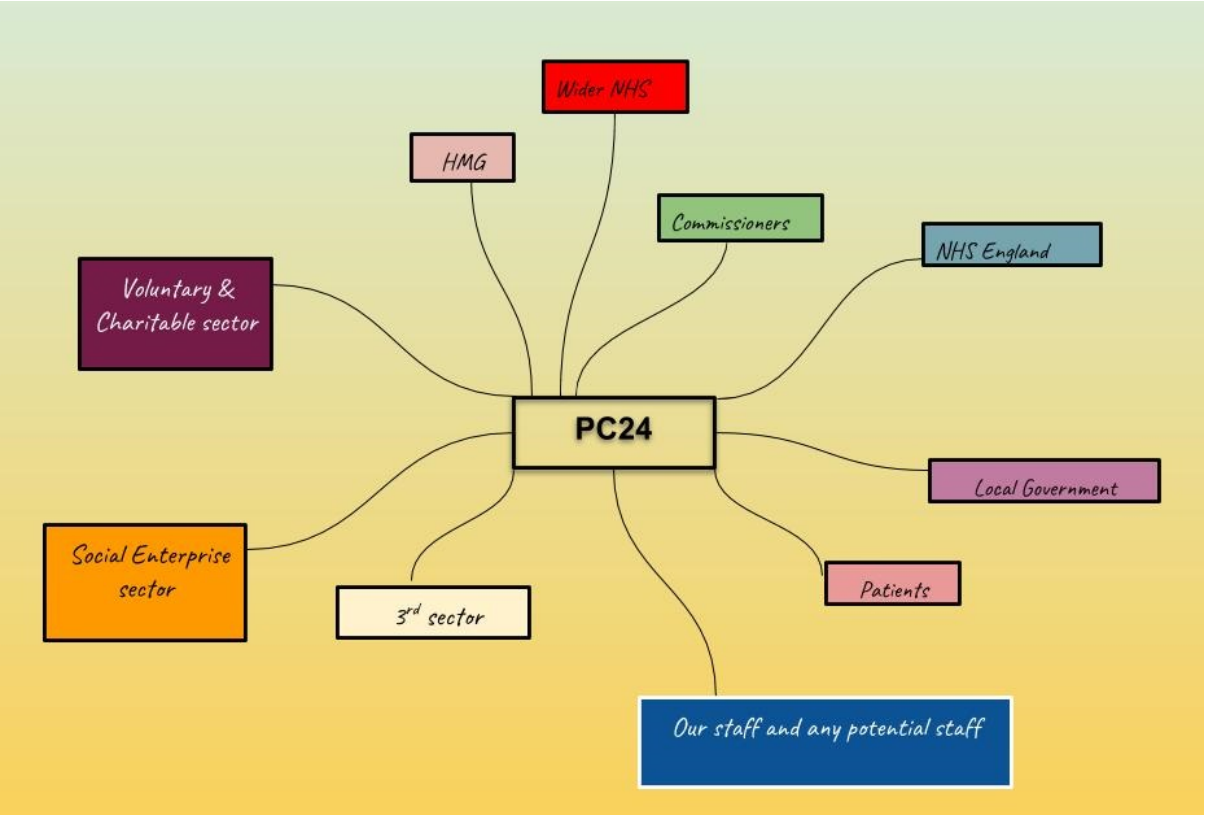
5. We will engage the organisation with digital offers and solutions

We will actively plan to research, understand and engage with e-health, video consultation and other aspects of technology as applied to our primary care work.	Jay Carr
We will consider the appointment of a subject matter expert in this area.	Jay Carr

6. We will engage with sectors outside health to scope business opportunities, while remaining open to health based opportunities

Chiefly via the CEO, but supported by Executive colleagues, we will explore other areas of business for the organisation.	All
We will use the **Business Model Canvas** to rapidly assess all opportunities (including health based opportunities) before investing time and energy in new areas.	All

7. We will communicate at all levels effectively, positively and regularly



NHS
Urgent Care 24
safe • caring • effective

Title: Rules and Trading Name	**Meeting Date:** 29 November 2018	**Agenda item no:** 10.1
Prepared and presented by: Company Secretary	**Discussed by:**	
Link to UC24 Values: ✓ Providing quality patient services ✓ Being an excellent employer ✓ Working collaboration to achieve positive system change. **CQC Domain References** ✓ Safe ☐ Effective ☐ Caring ☐ Responsive ✓ Well-led	**Resource implications:** **Purpose of the report:** ☐ Assurance ☐ Decision ☐ Discussion ✓ Noting **Decisions to be taken:** The meeting is invited to: • Note the agreement of the FCA to the change of name • Note the update with regard to the Rules.	

1.0 Purpose:

1.1 To inform the Board formally of the change of name of the organisation

1.2 To update the Board with regard to the amendment of the Rules.

2.0 Change of Name

2.1 The Financial Conduct Authority have approved the change of name. An implementation plan is now being rolled out but the new name is legally active and, a search for Urgent Care 24 on the authority's website brings up the organisation under its new name.

3.0 Rules:

3.1 The Rules have been submitted to the Financial Conduct Authority. A response was received on 19 November which raised some minor issues requiring amendment or clarification. These included the need to re-submit the Rules with the change of name implemented. These changes are now being processed.

4.0 Recommendations:

The meeting is invited to:

- Note the agreement of the FCA to the change of name
- Note the update with regard to the Rules.

NHS
Urgent Care 24
safe • caring • effective

Title: CQC Update	Meeting Date: 29 November 2018	Agenda item no: 10.2
Prepared and presented by: Margaret Swinson	**Discussed by:**	
Link to UC24 Values: ✓ Providing quality patient services ☐ Being an excellent employer ✓ Working collaboration to achieve positive system change. **CQC Domain References** ✓ Safe ☐ Effective ☐ Caring ☐ Responsive ✓ Well-led	**Resource implications:** **Purpose of the report:** ✓ Assurance ☐ Decision ☐ Discussion ✓ Noting **Decisions to be taken:** The meeting is invited to: • Note the ongoing work on the Provider at Scale pilot • Be assured that the appropriate registrations are in place for Extended Access and Primary Care Streaming.	

1.0 Purpose:

1.1 The purpose of the paper is to update the Board on the Provider at Scale Pilot inspection work with CQC and to update the board on CQC's position regarding Primary Care Streaming and Extended Access following the meeting on 4 October 2018.

2.0 Developments in relation to Provider at Scale inspections

2.1 CQC met with UC24 as planned on 4 October prior to the start of the inspection programme for the quarter and subsequently on 9 November, part way through the inspection schedule to provide feedback and discuss how the process was going.

2.2 The pilot was based around the use of a number of slightly different inspection processes which would be evaluated in early 2019. The mechanism at UC24 comprised a day at Headquarters looking at a set agenda which it was hoped would inform the practice visits in respect of the well-led domain but which was not officially an inspection visit. This took place on 9 October and has been followed by fortnightly visits to 5 practices: Thornton, Maghull and Crosby with Crossways and Netherton still to be undertaken.

2.3 At the 9 November a number of areas of feedback were offered by UC24 the key ones being:

- Fortnightly visits put a constant pressure on the team at HQ in terms of provision of pre-inspection packs and general visit preparation.

- The process made it difficult to judge how much HQ presence was needed on the actual practice visit days particularly for SO as the Primary Care lead GP and for the SDU leadership. Attendance at the feedback sessions had been particularly important but, with the visit frequency, a challenge for diary management.

- It would have been helpful to have a day of official inspection at HQ prior to the visits as this would have ensured a number of areas, in particular HR, were fully complete.

2.4 CQC concurred with the comments. A further meeting for feedback would be scheduled after the completion of the site visits.

3.0 Extended Access and Primary Care Streaming

3.1 At the meeting on 4 October, the registration position of Extended Access and Primary Care Streaming was discussed. These matters had been raised with CQC at an earlier stage following comments from CQC regarding patient safety risks at a UHUK meeting in relation to Primary Care Streaming and a question from St Helens in relation to the registration of their Extended Access service.

3.2 All the required regulated activity registrations to cover the provision of these services were already in place under Stacey Shields, as Registered Manager for Integrated Urgent Care and services were under the management of the Shift manager based at HQ and, therefore, operated similarly to the Out of Hours service which had HQ as a registered location only, with the sites not being registered as separate locations. Whilst all services are detailed in the Statement of Purpose individual services, per se, were not registerable, unless managed separately or from a specific location as is the case with the Asylum and the individual GP Practices.

3.3 CQC advised that there was a lack of consistency nationwide in respect to registrations. In some areas new providers were registering all sites but the general trend was towards the UC24 position. UC24 was therefore advised that no further registration was required. UC24 would be notified if this position changed.

4.0 Recommendations:

The meeting is invited to:

- Note the ongoing work on the Provider at Scale pilot

- Be assured that the appropriate registrations are in place for Extended Access and Primary Care Streaming.

NHS
Urgent Care 24
safe • caring • effective

Title:	Meeting Date:	Agenda item no:
Policies for approval	29 November 2018	10.3

Prepared & presented by:	Discussed by:
Margaret Swinson	**Executive Team, Committees**

Link to UC24 Values:	Resource implications:
✓ Providing quality patient services ✓ Being an excellent employer ✓ Working collaboration to achieve positive system change. **CQC Domain References** ✓ Safe ✓ Effective ✓ Caring ✓ Responsive ✓ Well-led	**Purpose of the report:** ☐ Assurance ✓ Decision ☐ Discussion ☐ Noting
	Decisions to be taken: The meeting is invited to approve the: • Policy for Policy Management • Anti-Fraud, Bribery and Corruption Strategy and Policy • Gifts and Hospitality Policy

1.0 Purpose:

1.1 The purpose of this paper is to present the Policy for Policy Management, the Anti-Fraud, Bribery and Corruption Strategy and Policy and the Gifts and Hospitality Policy to the Board for approval, all three having been recommended to the Board by the relevant Committees.

1.2 The policies will be brought in line with the new branding as required before being uploaded to the intranet.

2.0 Recommendation

The meeting is invited to approve the:

- Policy for Policy Management
- Anti-Fraud, Bribery and Corruption Strategy and Policy
- Gifts and Hospitality Policy

Policy For Policy Management

Version	V3
Supersedes:	V2 Urgent Care 24 Ratification, Governance and Implementation of Policies.
Date Ratified by Board:	24th November 2016
Reference Number:	UC24POL43
Title & Department of originator:	Governance
Title of responsible committee/department:	Quality & Workforce Committee
Effective Date:	24th November 2016
Next Review date:	1 year review due to new version of policy. November 2019 (or when there is a change in policy).
Target audience:	All staff with responsibility for writing and revising policy / procedure.
Impact Assessment Date:	26.10.2016
Summary	This document sets out the policy by which all policy documents of Urgent Care 24 will be prepared, approved and implemented.

Version	Date	Control Reason	Title of Accountable Person for this Version
V1.4	Oct 2016	Archived.	Governance Manager
V2.0	Oct 2016	Significant restructuring of the original policy for policy management, to incorporate Equality Impact assessment, Privacy Impact Statement and guidance, Training needs analysis and implementation plan	Associate Director of Quality & Patient Safety
V3.0	Nov 2018	Update following review of policy process & for GDPR	Company Secretary

Reference Documents	Electronic Locations (Controlled Copy)	Location for Hard Copies
Equality Act 2010. Health & Social Care Act 2012. Data Protection Act 2018. UC24 Equality and Health Inequalities Analysis Guidance Notes. UC24 Equality and Health Inequalities Screening Tool. Privacy Impact Assessment Compliance Checklist	Urgent Care 24 Intranet/Policy Documents & Guidance/Governance & Risk/	Policy File, Wavertree Headquarters

Consultation: Committees / Groups / Individual	Date
Quality & Patient Safety Policy Group	19.10.16
Executive Team	November 2018

CONTENTS **Page**

Appendices

1 PURPOSE

1.1 This is the policy for policy management throughout Urgent Care 24. Good policy management underpins all clinical and non–clinical processes within Urgent Care 24 to ensure they are consistent, effective and safe.

1.2 For the purpose of sound governance processes, it is important that such policies and standard operating procedures are appropriately authenticated and regularly updated. This is in order that they form a reliable and valid source of good practice.

1.3 This policy is designed to:

- Implement a coordinated and uniformed approach to policy development and management to ensure there is standardised corporate style and format.
- Ensure that UC24 through its policies adheres to legal requirements, considers equality and diversity principles and complies with the data protection principles in the Data Protection Act (DPA) 2018.
- Provide clarity and consent to the process of policy preparation, approval implementation and review
- Promote consultation to ensure that polices are well researched, evidenced based and reflect the view of the stakeholders
- Ensure all policies are accessible to all relevant staff and are up to date
- Ensure registers and archives of all policies are maintained.

2 SCOPE

2.1 This is a policy that applies to all employees, including clinical and medical staff within Urgent Care 24 who have a responsibility for writing or revising policy / procedures

2.2 This policy should be read in conjunction with the Procedure for the Development of Policies.

2.3 For the purpose of this policy, the word policy refers to policies and standard operating procedures.

3 RESPONSIBILITIES

3.1 All employees have a responsibility to adhere to the terms and conditions of this policy

3.2 Managers, Heads of Departments and Clinicians who are specified as the responsible people within the policy must ensure the correct procedure is carried out.

3.3 Any queries on the application or interpretation of this policy must be discussed with the Company Secretary prior to any action taking place.

3.4 This policy will be reviewed within one year, thereafter, on a three yearly basis and updated as appropriate.

3.5 Outlined below are the specific responsibilities in relation to policy production, development and implementation.

3.5.1 **The UC24 Board –** each must have an Owner. Following the UC24 Governance arrangements for policy approval as described in Appendix 8, the Board will be presented with policies for approval, including those reviewed by the author in line with good practice and the requirements of the Essential Standards of Quality and Safety (March 2010).

3.5.2 **Executive/Associate Directors/Service Delivery Unit Heads & the Medical Director** are responsible for identifying the need for a new policy and for identifying the Owner of the policy.

3.5.3 **The Policy Owner** is a named person for the processes of preparing, consulting on and reviewing policies. The Owner will:

- On behalf of the Leadership Team, oversee the process for approving and ratifying their policy
- Develop/update policy documents, taking account of other organisational policy documents, commissioning requirements, statutory requirements and relevant evidence-based practice and guidance.
- Consult as appropriate with service users / carers, staff and other stakeholders in the development / review of the document in line with the structure in **Appendix 8**.
- Attend the Policy Group to discuss their policy document
- Prepare the appropriate cover sheet and checklist prior to presentation of the policy to the Leadership Team, including a plan for implementation, training needs analysis and communication plan.
- Provide copies of the policy document to the Governance Team once it has been approved and issued.
- Oversee the monitoring of the implementation plan.
- Undertake the impact assessment for the policy, using the Equality and Health Inequalities Screening Tool. **Appendix 1**.
- Liaise with the Governance Team throughput the policy development stages to seek advice were necessary.

3.5.4 **The Governance Team** have the following responsibilities:

- Producing an indexed list of documents developed
- Maintaining, monitoring and overseeing the index of policies
- Notifying policy owners of policy review dates at least 2 months before expiry and forwarding the policy in editable form for review
- Ensure the archiving system is maintained and accessible when required
- Supporting the work of the Policy Group
- Providing “expert” advice when requested

3.5.5 **Line Managers, Heads of Departments and Lead GPs** will be instrumental in disseminating and implementing the policies. They must ensure that, as part of the induction process, all new employees and clinicians are shown how to access Urgent Care 24’s policy documents. They are responsible for ensuring staff have read and understood the policies relevant to their role and that staff training needs on implementation of new and updated policy documents are identified.

3.5.6 They will also monitor working practices via their day to day supervisory role and the staff appraisal system, to ensure these practices are consistent with Urgent Care 24's policies.

3.5.7 They are responsible for ensuring staff are released to attend training as required to enable policies to be successfully implemented.

3.5.8 **All employees and clinicians** have a responsibility to ensure that they are aware of the policies which are relevant to their area of work, and that they act in accordance with these at all times.

3.5.9 **Policy group -** has its membership drawn from across the organisation and is chaired by the Company Secretary. It oversees the policy document approval process and will

- Review, all new policies in line with the procedure set out in Appendix 8.
- Receive new policies from policy owners with the aim of provision of detailed scrutiny and overview, comments before the policy is sent to Leadership Team for consideration.
- Monitor the policy index to ensure that appropriate notice is given to Policy Owners of policy renewal dates

3.5.10 **Policy Author** – the member (s) of staff responsible for writing, the policy document in accordance with the *Policy on Policy Management* and its supporting documents. This may be the Policy Owner.

4 DEFINITIONS

4.1 An **Urgent Care 24 policy** reflects the "rules" governing the implementation of the organisation's processes. It governs or binds employees across the organisation. Examples may include the following; information security policy, incident reporting policy or complaints policy.

4.2 An **Urgent Care 24 standard operating procedure** is a rigid statement of practice allowing little or no flexibility or variation. It details guidance on how a particular

risk should be carried out, a step by step guide which someone not familiar with the work can follow. Examples include the following; administration, operational and clinical standard operating procedures.

5 WRITING A POLICY OR PROCEDURE

5.1 The overall aim is for the design of a policy or procedure to be simple, consistent and easy to use. The requirements of writing a good policy or procedure can be found in (**Appendix 2**).

5.2 A policy or procedure must contain all the essential components and, where appropriate, additional components included. The template defines the style to which the policy should comply and identifies those issues which should be addressed (**Appendix 3**).

5.3 The content of each policy should demonstrably comply with all relevant legal and statutory requirements. These include referencing in the policy, the relevant Essential Standards of Quality and Safety, other national guidance and policy in force at the time of writing or review. In doing so, the document owner must assure themselves and the organisation that they possess adequate and up-to-date knowledge on the subject matter or they have access to this knowledge.

5.4 All policies and standard operating procedures must follow the corporate design as detailed in **Appendix 4 & 5.**

6 THE CONSULTATION AND APPROVAL PROCESS

6.1 The Leadership Team will oversee the production and implementation of the policies of Urgent Care 24. Heads of Department and Service Delivery Units will be responsible for the production and implementation of standard operating procedures. In exceptional circumstances, for example, where the proposed policy aims to change drastically a component of service delivery and/or organisational practice, the Leadership Team will be informed and approval sought.

6.2.1 The UC24 Policy Group will have responsibility for seeking assurance that a policy has been developed, consulted on and has an achievable implementation plan in place to meet the needs of the organisation prior to approval of the policy.

6.3 Heads of Department and Lead GPs are responsible for the production, review and dissemination of all policies. Consultation will take place between the Heads of Departments or Lead GPs and relevant staff, with the final approved policy being sent to the officer assigned to co-ordinating these procedures.

6.4 The document owner will, with the support of the relevant Head of Service Delivery Unit/Department or Lead GP, assign tasks regarding the review or creation of policies to staff who have (or have access to) the necessary skills and knowledge to undertake the work.

6.5 Where policies are identified for review, the review work should be discussed with the document owner before the forecast review date. A member of the Governance Team will notify the policy owner of the expected review date within two months prior to review date.

6.6 ***The policy owner will then within a specified period,*** ensure the policy is revised as necessary in liaison with interested parties from inside and outside Urgent Care 24 as appropriate. The interested parties may include, for example, professionals contracted to work with the organisation. Where appropriate, formal "local" approval from the relevant committee(s) should be obtained

6.7 The updated policy will be presented to the Policy Group with the required checklist including the detailed implementation plan and ensuring that the document complies with the style and content requirements.

6.8 The Policy Group will determine whether the policy is ready to be presented to the Leadership Team with the appropriate coversheet and checklist having considered:

- a summary of the key points of the document

- the process used in developing the document to demonstrate that it was robust, identification of the people involved and consulted, experts used, literature reviewed
- implications for the organisation, such as the changes in ways of working, staff training and additional resources might be required
- implementation plan and people responsible for implementation

6.9 The Leadership Team will then consider the policy for initial approval and either agree that it is ready to be presented to the relevant committee or request further re-drafting from the Policy Owner.

6.10 When the policy is fit for purpose it will be submitted to the relevant committee of the Board for review and commendation to the full Board for approval.

7 RATIFICATION, PUBLICATION AND DISSEMINATION OF POLICY

7.1 All corporate policies will be approved by the Board. It is then the responsibility of the policy owner, to ensure that implementation plan is completed, including an appropriate training programme, that the policy is disseminated and that senior staff are aware of the implications of the policy and can advise staff accordingly.

7.2 The Company Secretary will be responsible for ensuring policies are considered by the appropriate committees of the Board.

7.3 Line Managers, Heads of Departments and senior staff play a key role in the effective dissemination and implementation of all policies. They must:

- Ensure that staff are made aware of any policies which are relevant to carrying out their duties in a safe and acceptable manner

- Direct new staff towards those documents that are relevant to their role at the local induction, ensure that they have read and understood the documents and to keep a signed record

- Ensure that, where required staff are in receipt of any training or update to assist in the introduction of amended or new policies and standard operating procedures.

8 REVIEWING POLICIES

8.1 New policies will be current and reviewed after one year, thereafter at the discretion of the policy owner they will be reviewed no later than three yearly or as required when a change policy is required in order to meet organisational need, address risk or comply with legislation.

8.2 Where documents are approaching their agreed review date, the assigned member of the Governance Team will notify the owner at least two months before the scheduled review date. The owner will determine if the degree of revision required to update the policy and procedure is minor or major.

8.3 These provisions do not preclude the early review of a policy in light of e.g. changing practice or national guidance etc. Where such a need is identified, the policy owner should be informed, and the process managed as outlined above.

8.4 Whenever a policy and procedure is reviewed, the document history detailed on the front page of the policy document (**Appendix 4 & 5**) must be updated accordingly.

8.5 Whenever a policy is to be developed or reviewed, the policy owner will need to complete an Equalities and Health Inequalities Screening which will help assess whether a full Equalities and Health Inequalities Analysis will need completing. A policy cannot be accepted by the Policy Group without the completion of an Equalities and Health Inequalities Screening.

8.6 Whenever a policy is to be developed or reviewed, the policy writer will need to assess if any personal information is identified within the document. If so, a Privacy Impact Assessment will need to be completed. The policy document will need to state that a Privacy Impact Assessment has been considered and whether

it is needed or not. If the policy document needs a Privacy Impact Assessment, this will need to be submitted to the Policy Group with the policy.

9 IMPLEMENTATION

9.1 This Policy will be implemented via the policy owner with the support of the Service Managers and any relevant Committees.

9.2 The policy owner will outline the plan for implementation in conjunction with the production of the policy (**Appendix 6**). Training needs should be assessed and identified. Where additional resources may be required, this information should be attached with a full breakdown of financial resources required.

9.3 **Dissemination.** Once this policy has been approved, it will be uploaded to the staff intranet, this will be supported by a message through UC24's newsletter, NEWS24 by the Governance Team.

9.4 **Monitoring Compliance.** Monitoring compliance should be included in the policy. Targets for this policy are:

Element	Lead	Tool	Frequency	Reporting arrangements
100% of policies in date	Company Secretary (supported by Governance Team)	Audit of the policies on the intranet register	Quarterly	Through the Audit Committee

9.5 **Review of arrangements.** All policies must be reviewed by their authors at least every three years, or as and when a change is required or new evidence becomes available. All new polices, must be reviewed within 12 months of issue to ensure the effectiveness of implementation.

9.6 **Control and archiving arrangements.** All staff employed in UC24 must ensure that they are working with the most up to date version of the policy, obtained from

the intranet. The Governance Team are responsible for ensuring the most up to date version is in place.

10 LOCATION OF POLICIES

10.1 All policies can be found on Urgent Care 24's Intranet. It is the responsibility of the Policy Owner to ensure that the revised policy has been forwarded to the Governance Team with the instruction to upload the policy to the intranet.

11 EQUALITY & DIVERSITY

UC24 is committed to an environment that promotes equality and embraces diversity in its performance as an employer and service provider. It will adhere to legal and performance requirements and will mainstream equality and diversity principles through its policies, procedures and processes. This policy has been implemented with due regard to this commitment. To ensure that the implementation of this policy does not have an adverse impact in response to the requirements of the Equality Act 2010 this policy has been screened for relevance during the policy development process and a full equality impact analysis conducted where necessary. UC24 will take remedial action when necessary to address any unexpected or unwarranted disparities and monitor practice to ensure that this policy is fairly implemented.

12 PERSONAL INFORMATION

UC24 is committed to the protection of personal information in the development of its policies. All policies must comply with the data protection principles in the Data Protection Act 2018. All individuals with responsibility for reviewing/writing policies should consider Privacy Impact Assessment compliance. Appendix 7.

This policy complies with the Data Protection Act 2018, therefore no Privacy Impact Assessment is necessary.

13 TRAINING NEEDS ANALYSIS

Training Programme	Course Length	Frequency	Delivery Method	Staff Group	Recording Attendance	Strategic & Operational Responsibility
Level 1 Equality & diversity Mandatory Training		On appointment then 3 yearly	E-Learning	All staff	Attendance is recorded on the Training database	
Awareness Raising of the Equalities and Health Inequalities Guidance notes		On appointment	Face to face / self-study	100% of staff who have a responsibility to review or write policies.	n/a	
Awareness Raising of the Privacy Impact Assessment Guidance notes		On appointment	Face to face / self-study	100% of staff who have a responsibility to review or write policies.	n/a	

Appendix 1 Equality and Health Inequalities Screening Tool

Equalities and Health Inequalities – Screening Tool

Version number: V1

First published: November 2016

To be read in conjunction with Equalities and Health Inequalities Analysis Guidance, Quality & Patient Safety Team, Urgent Care 24, 2016.

Prepared by: Quality & Patient Safety Team.

1 Introduction

The purpose of this Screening Tool is to help you decide whether or not you need to undertake an Equality and Health Inequalities Analysis (EHIA) for your project, policy or piece of work. It is your responsibility to take this decision once you have worked through the Screening Tool. Once completed, the Head of your SDU or the Quality & Patient Safety Team will need to sign off the Screening Tool and approve your decision i.e. to either undertake an EHIA or not to undertake an EHIA.

The Quality and Patient Safety Team can offer support where needed. It is advisable to contact us as early as possible so that we are aware of your project.

When completing the Screening Tool, consider the nine protected characteristics and how your work would benefit one or more of these groups. The nine protected characteristics are as follows:

1. Age
2. Disability
3. Gender reassignment
4. Marriage and civil partnership
5. Pregnancy and maternity
6. Race
7. Religion and belief
8. Sex
9. Sexual orientation

A number of groups of people who are not usually provided for by healthcare services and includes people who are homeless, rough sleepers, vulnerable migrants, sex workers, Gypsies and Travellers, Female Genital Mutilation (FGM), human trafficking and people in recovery. Urgent Care 24 will also consider these groups when completing the Screening Tool:

The **guidance** which accompanies this tool will support you to ensure you are completing this document properly. It can be found at: http://extranet.urgentcare24.co.uk/

2 Equality and Health Inequalities: Screening Tool

A	**General information**		
A1	Title: What is the title of the activity, project or programme?		
A2.	What are the intended outcomes of this work? Please outline why this work is being undertaken and the objectives.		
A3.	Who will be affected by this project, programme or work? Please identify whether the project will affect staff, patients, service users, partner organisations or others.		
B	**The Public Sector Equality Duty**		
B1	Could the initiative help to reduce unlawful discrimination or prevent any other conduct prohibited by the Equality Act 2010? If yes, for which of the nine protected characteristics (see above)?		
	Yes	No	Do not know
	Summary response and your reasons:		
B2	Could the initiative undermine steps to reduce unlawful discrimination or prevent any other conduct prohibited by the Equality Act 2010? If yes, for which of the nine protected characteristics? If yes, for which of the nine protected characteristics?		

	Yes	No	Do not know
	Summary response and your reasons:		
B3	Could the initiative help to advance equality of opportunity? If yes, for which of the nine protected characteristics?		
	Yes	No	Do not know
	Summary response and your reasons:		
B4	Could the initiative undermine the advancement of equality of opportunity? If yes, for which of the nine protected characteristics?		
	Yes	No	Do not know
	Summary response and your reasons:		
B5	Could the initiative help to foster good relations between groups who share protected characteristics? If yes, for which of the nine protected characteristics?		
	Yes	No	Do not know
	Summary reasons:		
B6	Could the initiative undermine the fostering of good relations between groups who share protected characteristics? If yes, for which of the nine protected characteristics?		
	Yes	No	Do not know
	Summary response and your reasons**:**		
C	**The duty to have regard to reduce health inequalities**		
C1	Will the initiative contribute to the duties to reduce health inequalities?		
	Could the initiative reduce inequalities in access to health care for any groups which face health inequalities? If yes for which groups?		
	Yes	No	Do not know
	Summary response and your reasons:		
C2	Could the initiative reduce inequalities in health outcomes for any groups which face health inequalities? If yes, for which groups?		
	Yes	No	Do not know
	Summary response and your reasons:		
D	Will a full Equality and Health Inequalities Analysis (EHIA) be completed?		
D1	Will a full EHIA be completed? Bearing in mind your previous responses, have you decided that an EHIA should be completed? Please see notes. [1] Please place an X below in the correct box below. Please then complete part E of this form.		
	Yes	Cannot decide	No

[1] Yes: If the answers to the previous questions show the PSED or the duties to reduce health inequalities are engaged/in play a full EHIA will normally be produced. No: If the PSED and/or the duties to reduce health inequalities are not engaged/in play then you normally will not need to produce a full EHIA.

E	Action required and next steps
E1	If a full EHIA is planned: Please state when the EHIA will be completed and by whom. Name: Date:
E2	If no decision is possible at this stage: If it is not possible to state whether an EHIA will be completed, please summarise your reasons below and clearly state what additional information or work is required, when that work will be undertaken and when a decision about whether an EHIA will be completed will be made. Summary reasons: Additional information required: When will it be possible to make a decision about an EHIA?
E3	If no EHIA is recommended: If your recommendation or decision is that an EHIA is not required then please summarise the rationale for this decision below. Summary reasons:

F	*Record Keeping*		
Lead originator:		Date:	
Director signing off screening:		Date:	
Directorate:		Date:	
Screening published:		Date:	

Appendix 2

Characteristics of good policies or procedures

The overall aim for any document is for the design to be simple, consistent and easy to use.

Policies should:

- Be written in clear, concise and simple language
- Address what is the rule rather than how to implement the rule
- Be readily available to the community and their authority should be clear
- Indicate designated "experts" who can interpret policies and resolve problems
- Represent a consistent, logical framework for action

Standard Operating Procedures should:

- Be clear how the procedure helps Urgent Care 24 achieve its aims and objectives
- Be developed with the procedure users (the organisations' employees) in mind. Well developed and thought out standard operating procedures provide benefits to the procedure user
- Involve procedure users in their development to engender a sense of ownership
- Be understandable and written is such a way that what needs to be done can be easily followed by procedure users

Writing Style

- Concise with a minimum of verbiage
- Factual - accuracy should be double checked
- Should not provide information that may be quickly outdated (e.g. names)
- If an acronym is used, it should be spelled out the first time
- Not excessively technical, must be simple enough to be understood by a new member of staff

Design and Layout of Policy/Procedure/Guideline Documents

- Use Arial 12 point text
- The format is justified with spacing of 1.5
- Number the paragraph and pages
- Generous use of white space

- Presentation is structured so that the reader can quickly focus on the aspect of policy/procedure relevant to the decision in hand
- Use headings to indicate key points. Headings need to be consistent, e.g. location on each page, type size, bold etc.
- Contain a "cover sheet" indicating name and reference number of policy/procedure, date of ratification, owner details, date of review/update, and next forecast review date reference to associated relevant Essential Standards and other legislation and guidance in the policy.

Appendix 3

Components of a Policy

The document ***must*** contain the following components:

Cover Sheet

This must include name and reference number of policy, date of ratification, owner details, date of review/update. Any changes should be documented on the cover page, outlining the main change/s.

1.0 PURPOSE

A concise statement of the rationale for the document, including where necessary reference to external regulations or other relevant guidance This policy is ……

(Font: Arial, Size 12, number each section and subsection)

2.0 SCOPE OF THE POLICY

Exactly who the document applies to and the consequences for non-compliance if necessary this section makes explicit if this is a corporate or specific document

3.0 RESPONSIBILITIES

This should describe the responsibilities and duties of both management and employees. It should include any particular responsibilities or functions that a particular post or department may have, relevant to the document or its implementation

4.0 DEFINITIONS

Definition of terms where required

5.0 POLICY PROCEDURES

Reference to detailed procedures that are recommended in order to carry out the intent of the document This will be the main part of the

document, generally divided into sections and describe in detail what has to be done in order to comply with the document's intent, aims and objectives

6.0 GETTING HELP

The specific office or person to contact for interpretations, resolution of problems and other special situations.

7.0 RELATED POLICIES

Information about related policies, procedures or guidelines this should include a complete reference and ensure that any documents cited are readily available

8.0 MONITORING COMPLIANCE

Please refer to section 9.4 in this document.

9.0 INFORMATION, INSTRUCTION AND TRAINING

This section should detail what information, instruction, training and supervision is necessary for both employees and managers in order to meet the policy requirements. It should detail when, how often and by whom the above items should be given. The requirement for training records should be indicated

10.0 EQUALITY AND HEALTH INEQUALITIES

UC24 is committed to an environment that promotes equality and embraces diversity in its performance as an employer and service provider. It will adhere to legal and performance requirements and will mainstream equality and diversity principles through its policies, procedures and processes. This policy has been implemented with due regard to this commitment. To ensure that the implementation of

this policy does not have an adverse impact in response to the requirements of the Equality Act 2010 this policy has been screened for relevance during the policy development process and a full equality impact analysis conducted where necessary. UC24 will take remedial action when necessary to address any unexpected or unwarranted disparities and monitor practice to ensure that this policy is fairly implemented.

11.0 MAIN REFERENCES

Below is a list of the relevant statutory provisions which influence Urgent Care 24's operation in relation to the policy/procedure:

- Equality Act 2010.
- Health & Social Care Act 2012.
- Data Protection Act 1998.

Appendix 4 Corporate Design Template for Policies (front sheet)

Name of Policy

Version	
Supersedes:	
Date Ratified by Board:	
Reference Number:	
Title & Department of originator:	

Title of responsible committee/department:	
Effective Date:	
Next Review date:	
Target audience:	
Impact Assessment Date:	
Summary	

Version	**Date**	**Control Reason**	**Title of Accountable Person for this Version**
Reference Documents		Electronic Locations (Controlled Copy)	Location for Hard Copies
Consultation: Committees / Groups / Individual			Date

Appendix 5 Corporate Design Template for Standard Operating Procedure

Title			**Doc. No.**	
Scope				
Purpose				

Guidelines	

PROCEDURE		RESPONSIBILITY
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		
11		
12		
13		

STANDARD OPERATING PROCEDURE DOCUMENT (SOP)

Title		Doc. No.	

Version	
Supersedes	
Approving Managers/Committee	
Date Ratified	
Department of Originator	
Responsible Executive Director	
Responsible Manager/Support	
Date Issued	

Next Review Date	
Target Audience	

Version	Date	Control Reason	Accountable Person for this Version

Reference documents	Electronic Locations	Locations for Hard Copies
	Urgent Care 24 Intranet / Corporate Policies/ Current SOPS/ ……	Standard Operating Procedures File in the Call Centre.

Document Status: This is a controlled document.
Whilst this document may be printed, the electronic version maintained on the UC24 Intranet is the controlled copy. Any printed copies of the document are not controlled.

Appendix 6 Policy Implementation Plan

Question	Response	Additional resources If so identify	Timescale
Who does the policy affect	All staff who have a responsibility to write policy, including clinical and medical staffing.	Nil	4 weeks
What additional Standard Operating Procedures or forms	As outlines in the appendices	Nil	As above

need to be included in the policy			
What is the proposed date of implementation	December 2018	Nil	As above
Is training required	Refer to TNA embedded in document.	Nil	
If so what training is required (attach separate training outline)	Refer to TNA embedded in document.	Nil	
Who will facilitate the training	Quality & Patient Safety Team and Human Resources	Nil	
What audit processes have been identified	Refer to Monitoring and Compliance within the document.	Nil	

Appendix 7 Privacy Impact Assessment Template

Data Protection Act 2018

PRIVACY IMPACT ASSESSMENT (PIA)

Compliance Checklist

Privacy

Privacy has become a much larger consideration for business and government in recent years. New information technologies have increased public concerns about intrusion into their privacy.

Beyond the recognition of privacy as a human right, specific laws have been introduced to deal with particular areas of concern. Much of the legislative attention to date has been focused on information about people that is collected, stored, used and disclosed by organisations. The handling of personal data is regulated by the Data Protection Act 2018, which the Information Commissioner's Office oversees.

Privacy impact assessment

Privacy Impact Assessment (PIA) is a process which enables organisations to anticipate and address the likely impacts of new initiatives, foresee problems, and negotiate solutions. Risks can be managed through the gathering and sharing of information with stakeholders. Systems can be designed to avoid unnecessary privacy intrusion, and features can be built in from the outset that reduces privacy intrusion.

This Privacy Impact Assessment (PIA) aims to assist Urgent Care 24 when proposing change to investigate whether the personal information aspects of their project comply with the data protection principles in the Data Protection Act (DPA).

The checklist has been designed for use by any employee proposing change. The Quality & Patient Safety Team should be consulted about the completion of this checklist.

It should be noted that many terms used in the **principles** have meanings specific to the **Data Protection Act**, and it would be prudent to refer to the Act for definition for those terms. Another useful reference is the specific guidance on the Information Commissioner’s website **https://ico.org.uk/**

A) BASIC INFORMATION - New or existing Project, System, Technology or Legislation

1 Lead Directorate and project name	
Directorate	
Department	
Project	

2 Contact position and/or name, telephone number and e-mail address. (This should be the name of the individual most qualified to respond to the PIA questions)	
Name	
Title	
Phone Number	
E-Mail	

3 Description of the programme / system / technology / legislation (initiative) being assessed.
If this is a change to an existing project, system, technology or legislation, describe the current system or programme and the proposed changes. *(N.B. if the initiative does **not** collect, use or disclose personal data* - see definition and statement below).*

4 Purpose / objectives of the initiative (if statutory, provide citation/reference).	
Purpose	

5 What are the potential privacy impacts of this proposal?

IF THERE IS NO PERSONAL DATA INVOLVED,
GO TO SECTION C DPA COMPLIANCE - CONCLUSIONS (on the last page)

***IMPORTANT NOTE:**
'Personal data' means data which relate to a living individual who can be identified:

(a) from those data, or
(b) from those data and other information which is in the possession of, or is likely to come into the possession of, the data controller, and includes any expression of opinion about the individual and any indication of the intentions of the data controller or any other person in respect of the individual.

(Data Protection Act 2018)

B) DATA PROTECTION PRINCIPLES (DPPs) (General Data Protection Regulations (GDPR))

PRINCIPLE 1 **LAWFUL AND FAIR PROCESSING**	
Personal data shall be processed fairly and lawfully and, in particular, shall not be processed unless – (a) at least one of the conditions in Chapter 2 GDPR is met, and (b) in the case of sensitive personal data, at least one of the additional conditions is also met	
1.1 Preliminary	
What type of personal data are you processing?	Personal Confidential Data of the deceased and of the living
1.2 Conditions relevant for purposes of the first principle: processing of any personal data	
Describe the purposes for which you will be processing personal data.	
List which of the grounds you will be relying on as providing a legitimate basis for processing personal data.	
1.3 Conditions relevant for purposes of the first principle: processing of any *sensitive* personal data	
If this project does not involve the processing of sensitive personal data, please go to section 1.4	
Identify the categories of *sensitive personal data* that you will be processing.	
Identified *the purposes* for which you will be processing *sensitive personal data*.	
Identify which of the grounds you will be relying on as providing a legitimate basis for processing *sensitive personal data*?	
1.4 Obtaining consent	
Are you relying on the individual to provide consent to the processing as grounds for lawful and fair processing?	Delete as appropriate Yes No
If yes, when and how will that consent be obtained?	.
For the processing of *sensitive personal data*, are you relying on *explicit* consent?	Delete as appropriate Yes No

If yes, when and how will that consent be obtained?	
1.5 Lawful processing	
How is compliance with the Human Rights Act being assessed?	Via this PIA Review and the Data Sharing Agreement - Information is limited to a need to know and informed consent is provided to ensure no breach of Human Rights occurs.
Are you assessing whether your processing is subject to any other legal or regulatory duties?	Delete as appropriate Yes No
If yes, how is that assessment being made? If no, please indicate why not.	
1.6 Fair processing	
How are individuals being made aware of how their personal data is being used?	
How individuals are offered the opportunity to restrict processing for other purposes?	
When is that opportunity offered?	
1.7 Exemptions from the first principle	
The Act requires that in order for personal data to be processed fairly, a data controller must provide the data subject with the following information:- 1. the identity of the data controller 2. the identify of any nominated data protection representative, where one has been appointed 3. the purpose(s) for which the data are intended to be processed 4. any further information which is necessary, having regard to the specific circumstances in which the data are or are to be processed, to enable processing in respect of the data subject to be fair *Data Protection Act:* ***https://ico.org.uk/for-organisations/guide-to-data-protection/exemptions***	
Do you provide individuals with all of the information in the box above?	Delete as appropriate Yes No
If no, which exemption to these provisions is being relied upon?	

PRINCIPLE TWO: THE PURPOSE OR PURPOSES FOR PROCESSING PERSONAL DATA		
Personal data shall be obtained only for one or more specified and lawful purposes, and shall not be further processed in any manner incompatible with that purpose or those purposes.		
2.1 Use of personal data within the organisation		
What procedures are in place for maintaining a comprehensive and up-to-date record of use of personal data?		
Is any data processing carried out on your behalf (e.g. by a subcontractor)?	Delete as appropriate Yes No	
If yes, please identify		
2.2 Use of existing personal data for new purposes		
Does the project involve the use of existing personal data for new purposes?	Delete as appropriate Yes No	
If no, go to section 2.3		
If yes, How is the use of existing personal data for new purposes being communicated to:- *a) the data subject:* b) *the Data Protection Officer (responsible for Notification)*	a)	
	b)	
2.3 Disclosure of data		
How individuals / data subjects are made aware of disclosures of their personal data?		
PRINCIPLE 3: DATA MINIMISATION		
Personal data shall be adequate, relevant and not excessive in relation to the purpose or purposes for which they are processed.		
3.1 Adequacy and relevance of personal data		
How is the *adequacy* of personal data for each purpose determined?		
How is an assessment made as to the *relevance* (i.e. no more than the minimum required) of personal data for the purpose for which it is collected?		
What procedures are in place for periodically checking that data collection procedures are adequate, relevant and not excessive in relation to the purpose for which data are being processed?		

PRINCIPLE 4: ACCURATE AND UP TO DATE		
Personal data shall be adequate, relevant and not excessive in relation to the purpose or purposes for which they are processed. Every reasonable step must be taken to rectify or erase inaccurate or incomplete data.		
4.1 Accuracy of personal data		
How often is personal data being checked for accuracy?		
How is the accuracy of the personal data being checked with the Data Subject?		
4.2 Keeping personal data up to date		
How is personal data evaluated to establish the degree of damage to: (a) the data subject or (b) the data controller That could be caused through being out of date?	a)	
	b)	
PRINCIPLE 5 NO LONGER THAN NECESSARY		
Personal data processed for any purpose or purposes shall not be kept for longer than is necessary for that purpose or those purposes.		
5.1 Retention policy		
Is the project subject to any statutory / sectorial requirements on retention?	Delete as appropriate Yes No	
If yes please state relevant requirements		
5.2 Review and deletion of personal data		
When data is no longer necessary for the purposes for which it was collected: a) How is a review made to determine whether the data should be deleted? b) How often is the review conducted? c) Who is responsible for determining the review? d) If the data is held on a computer, does the application include a facility to flag records for review / deletion?	a)	
	b)	
	c)	
	d)	
If yes, please explain		

Are there any exceptional circumstances for retaining certain data for longer than the normal period?	Delete as appropriate Yes No
If yes, please provide justification	

PRINCIPLE 6 INTEGRITY & CONFIDENTIALITY (SECURITY OF PERSONAL DATA)	
Personal data must be processed in a manner that ensures appropriate security of the personal data, including protection against unauthorised or unlawful processing and against accidental loss, destruction or damage, using appropriate technical or organisational measures**.**	
6.1 Security Policy	
Is the level of security appropriate for the type of personal data processed?	Delete as appropriate Yes No
If yes please explain	
6.2 Unauthorised or unlawful processing of data	
Describe security measures that are in place to prevent any unauthorised or unlawful processing of: a) Data held in an automated format e.g. password controlled access to PCs b) Data held in a manual record e.g. locked filing cabinets	a) b)
Is there a higher degree of security to protect *sensitive personal data* from unauthorised or unlawful processing?	Delete as Appropriate Yes No
If yes, please describe the planned procedures. If no, please indicate why not.	
Describe the procedures in place to detect breaches of security (remote, physical or logical)? **logical (such as hacking etc.)*	
6.4 Destruction of personal data	
Describe the procedures in place to ensure the destruction of personal data no longer necessary?	
6.5 Contingency planning	
Is there a contingency plan to manage the effect(s) of an unforeseen event?	Delete as Appropriate Yes No

If yes, please give details		
Describe the risk management procedures to recover data (both automated and manual) which may be damaged/lost through: a) human error b) computer virus c) network failure d) theft e) fire f) flood g) other disaster.	a)	.
	b)	
	c)	
	d)	
	e)	
	f)	
	g)	
6.6 Choosing a data processor		
How do you ensure that the Data Processor complies with these measures?		

SUBJECTS RIGHTS/SUBJECT ACCESS	
Personal data shall be processed in accordance with the rights of data subjects under this Act.	
7.1 Subject access	
How do you locate all personal data relevant to a request (including any appropriate 'accessible' records)?	
7.2 Withholding of personal data in response to a subject access request	
Are there any circumstances where you would withhold personal data from a subject access request?	Delete as appropriate Yes No
If yes, on what ground. If no, go to 7.3	
How are the grounds for doing so identified?	
If yes, please provide justification	
7.3 Processing that may cause damage or distress	
Do you assess how to avoid causing unwarranted or substantial damage or unwarranted and substantial distress to an individual?	Delete as appropriate Yes No
If yes, please specify proposed procedures. If no, please indicate why not.	
Do you take into account the possibility that such damage or distress to the individual could leave your organisation vulnerable to a compensation claim in a civil court?	Delete as appropriate Yes No If yes, please explain

7.4 Right to object	
Is there a procedure for complying with an individual's request to prevent processing for the purposes of direct marketing?	Delete as appropriate Yes No N/A Other
If yes, please explain	

7.7 Automated decision	
Are any decisions affecting individuals made solely on processing by automatic means?	Delete as appropriate Yes No
If yes, what will be the procedure(s) for notifying an individual that an automated decision making process has been used?	

7.6 Rectification, blocking, erasure and destruction	
What is the procedure for responding to data subject's notice (in respect of accessible records) or a court order requiring: a) rectification; b) blocking; c) erasure or; d) destruction of personal data?	a)
	a)
	b) .
	c)

OVERSEAS TRANSFER (OUTSIDE OF THE EEA)	
Personal data shall not be transferred to a country or territory outside the European Economic Area unless that country or territory ensures an adequate level of protection for the rights and freedoms of data subjects in relation to the processing of personal data.	
8.1 Adequate levels of protection	
Are you transferring personal data to a country or territory outside of the EEA[2]? [1] The European Economic Area (EEA) comprises the 27 EU member states plus Iceland, Liechtenstein and Norway.	Delete as appropriate Yes No
If no, go to Part III If yes, where?	

What types of data are transferred? (e.g. contact details, employee records)	
Is *sensitive personal data* transferred abroad?	Delete as appropriate Yes No
If yes, please give details	
Are measures in place to ensure an adequate level of security when the data are transferred to another country or territory?	Delete as appropriate Yes No
If yes, please describe. If no, please indicate why not.	
Have you checked whether any non-EEA states to which data is to be transferred have been deemed as having adequate protection?	Delete as appropriate Yes No
If yes, please give details	

C) DPP COMPLIANCE - CONCLUSIONS

Please provide a summary of the conclusions that have been reached in relation to this project's overall compliance with the DPPs. This could include indicating whether some changes or refinements to the project might be warranted.

IG Manager Name:

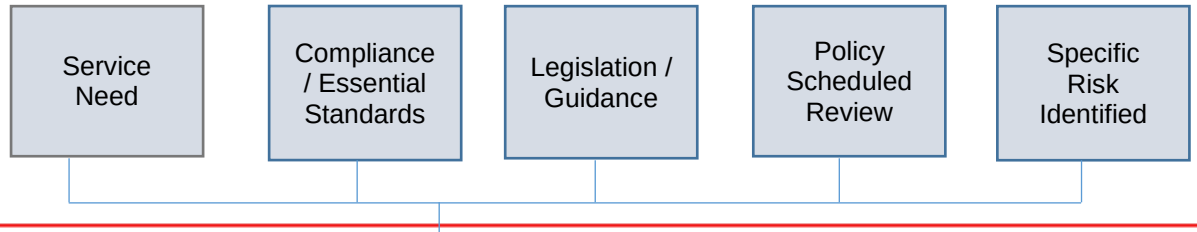
IG Manager Signature: **Date:**

Project Manager:

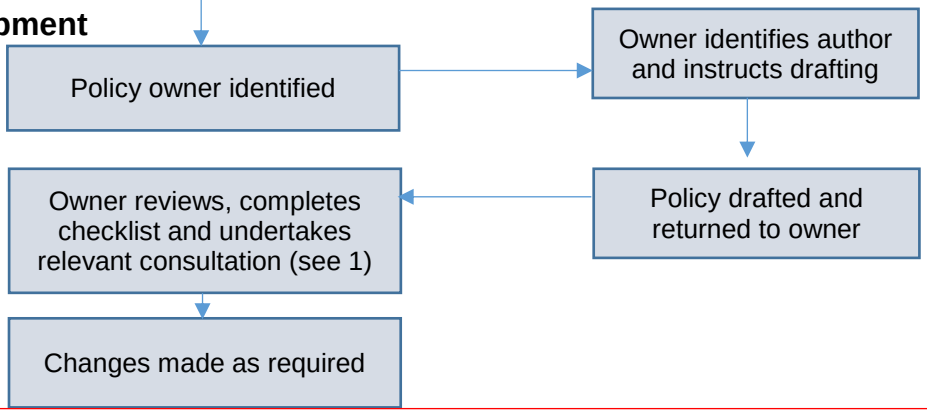
Project Manager Signature: **Date:**

Appendix 8 Summary of Process - Policies

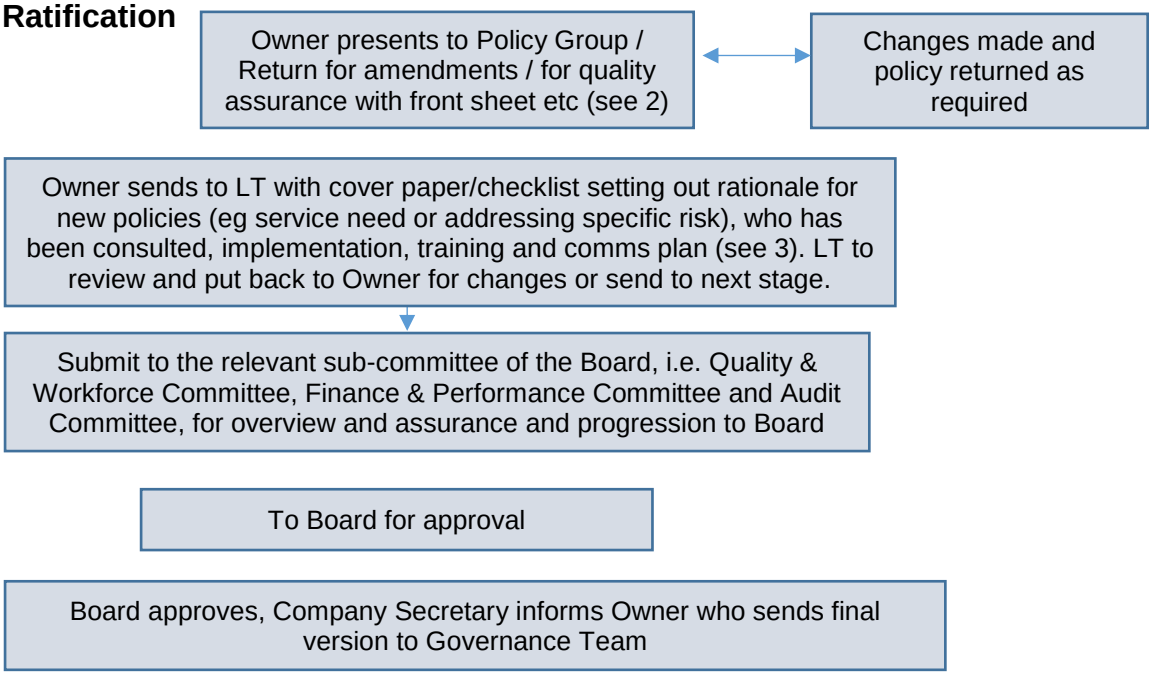
1 Decision for Policy



2 Policy Development

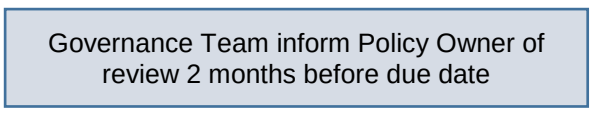


3 Ratification



4 Implementation

5 Review



Notes on Process Summary stages

A member of the Governance Team will have responsibility for maintaining the register of policies and ensuring Policy Owners are alerted in good time when policies are due for renewal.

1. Consultation by the policy owner should include individuals/groups relevant to the subject matter of the policy. Consultation may recommend amendments to the policy but does not mandate them unless they are required to secure compliance with legislation or regulation.

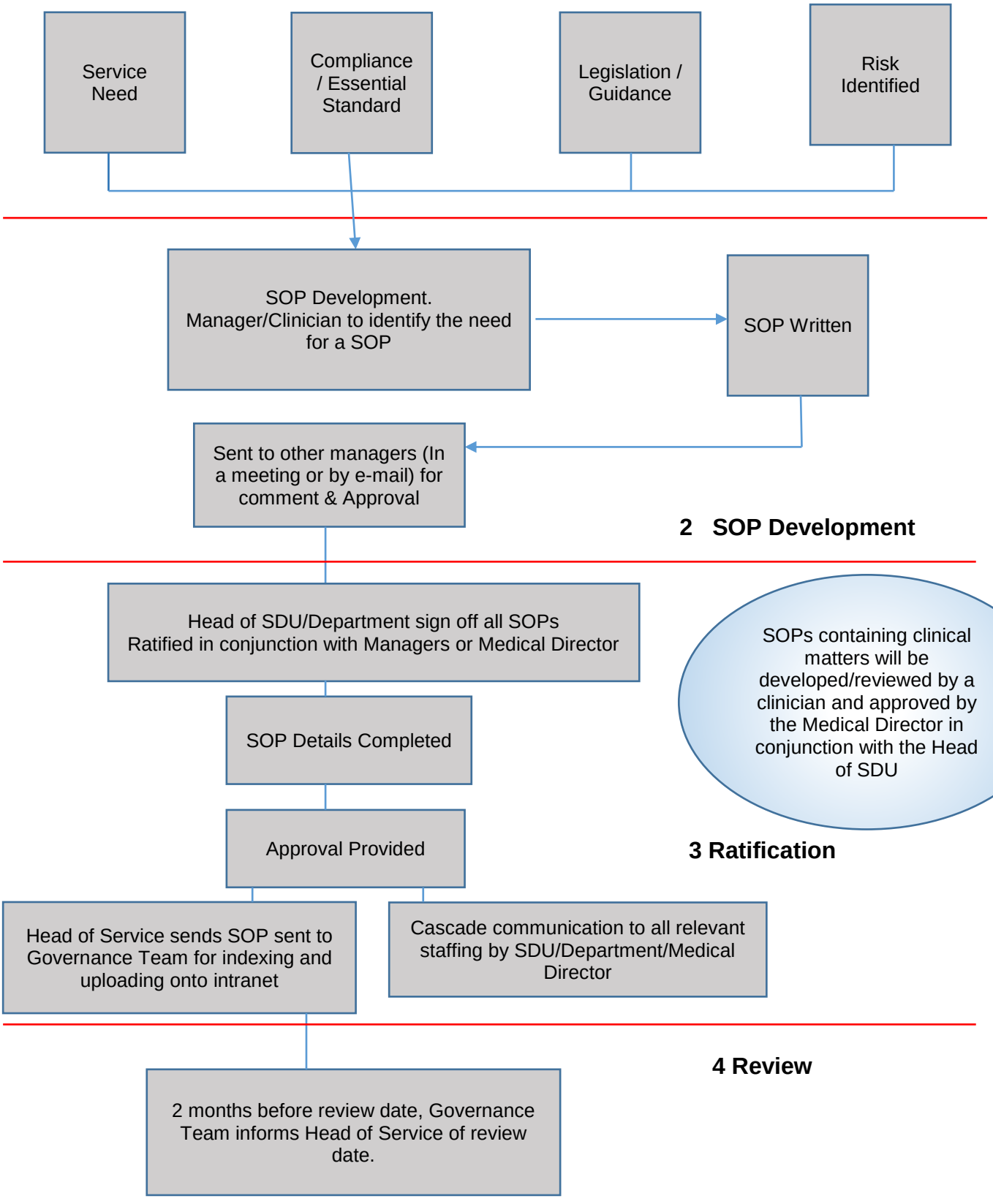
   The following may be relevant when planning consultation:

   a. Executive Directors
   b. Those with specific expertise eg IT, HR, Finance, Governance
   c. Groups who are required to implement the policy or deliver training
   d. Staff Council
   e. Clinical or pharmacy leads
   f. Heads of service
   g. Patient groups eg PPGs, Healthwatch

2. The Policy Group would be expected to draw in relevant individuals when reviewing policies eg Health & Safety or Medical Director
3. Cover paper for Leadership team should:
   a. Include a list of those individuals or bodies consulted during the policy preparation/review process
   b. Set out the implementation plan and training needs analysis, highlighting any particular issues in relation to the implementation of the policy
   c. Alert LT to any significant risks or changes in service which triggered the need for a new policy
   d. Outline training and communication plans showing who will be responsible and the timeline
4. Implementation, including the training and communication plan, should be monitored through an action log reported, along with other live policy implementation plans, monthly to Leadership team

Appendix 9 Summary of Process - Standard Operating Procedures

1 Decision for Standard Operating Procedure



Appendix 10

Checklist for Policies

Policy Title **Policy Owner**

	Notes	**Done and by whom**
Reason for new policy, please specify any specific risks being addressed or state review/renewal		
Policy Owner consultation undertaken		
Implementation and training plan		
Identify any particular implementation challenges		

Communication plan		
Date considered by Policy Group and any additional consultation undertaken		
Completion of document history		

	Date	**By**
Submitted to Leadership Team		
Submitted to Board Committee		
Submitted to Board		
Forwarded to Governance Team		
Uploaded to Intranet		
Communication to Staff		
Training/implementation plan completed		

END OF POLICY

Anti-Fraud, Bribery and Corruption Strategy & Policy

November 2018

Anti-Fraud, Anti-Bribery and Anti-Corruption Policy

DOCUMENT CONTROL

Version	Version 1
Supersedes:	Counter Fraud Policy and Bribery Policy
Date Ratified by Board:	
Reference Number:	
Title & Department of originator:	Heledd Cooper, Finance
Title of responsible committee/department:	Finance & Performance Committee
Effective Date:	November 2018
Next Review date:	November 2020
Target audience:	All
Impact Assessment Date:	
Summary	

Version	**Date**	**Control Reason**	**Title of Accountable Person for this Version**

Reference Documents	**Electronic Locations (Controlled Copy)**	**Location for Hard Copies**
	Urgent Care 24 Intranet / SOPs Clinical / Operations … **Delete as appropriate***	**Policy File, Wavertree Headquarters**

Consultation: Committees / Groups / Individual	**Date**

Contents

1. Summary

Urgent Care 24 (UC24) is committed to reducing the level of fraud, bribery and corruption within the NHS to an absolute minimum and keeping it at that level, freeing up public resources for better patient care. UC24 does not tolerate fraud, bribery and corruption and aims to eliminate all such activity as far as possible.

UC24 wishes to encourage anyone having reasonable suspicions of fraud, bribery or corruption to report them. It is also UC24's policy that no employee will suffer in any way as a result of reporting reasonably held suspicions. This protection is given under the Public Interest Disclosure Act that UC24 is required to comply with.

For the purposes of this policy "reasonably held suspicions" shall mean any suspicions other than those which are totally groundless (and/or raised maliciously).

This policy is intended as both a guide for all employees and stakeholders on the anti-fraud, bribery and corruption activities being undertaken within the UC24 as well as informing all staff and stakeholders on how to report any concerns or suspicions they may have.

2. Introduction

2.1 General

One of the basic principles of public sector organisations is the proper use of public funds. The majority of people who work in the public sector are honest and professional and they find that fraud, bribery and corruption, which is committed by a minority, is wholly unacceptable as it ultimately leads to a reduction in the resources available for patient care. UC24 does not tolerate fraud, corruption or bribery.

All instances where fraud, bribery and corruption are suspected will be thoroughly investigated.

2.2 Generic areas of action

UC24 is committed to taking all necessary steps to counter fraud, bribery and corruption. To meet this objective, it has adopted the national strategic approach, advanced by the NHS Counter Fraud Authority, which specifies the following:

- to ensure that the organisation's strategic governance arrangements have embedded anti-crime measures across all levels.
- to inform and involve NHS staff and staff providing NHS services, and the public through raising awareness of crime risks against the NHS, and publicising those risks and effects of crime.

- prevent and deter individuals who may be tempted to commit crime against the NHS and ensure that opportunities for crime to occur are minimised.
- to detect and investigate crime and hold to account those individuals who have committed crimes by prosecuting and seeking redress.

2.3 Aims and Scope

This policy relates to all forms of fraud, bribery and corruption and is intended to provide direction and help to employees and all stakeholders who may identify suspected fraud, corruption or bribery. It is not intended to provide a comprehensive approach to preventing and detecting fraud, bribery and corruption. The overall aims of this policy are to:

- improve the knowledge and understanding of everyone in UC24, irrespective of their position, about the risk of fraud, bribery and corruption within the organisation and its unacceptability
- assist in promoting a climate of openness and a culture and environment where staff and stakeholders feel able to raise concerns sensibly and responsibly
- UC24's responsibilities in terms of anti-fraud, bribery and corruption activities
- ensure the appropriate sanctions are considered following an investigation, which may include any or all of the following:
    - criminal prosecution.
    - civil prosecution.
    - Internal/external disciplinary action.

This policy applies to all employees of UC24, regardless of position held, as well as Associate GPs, clinicians, consultants, contractors, and/or any other parties who have a business relationship with UC24. It will be brought to the attention of all employees by various methods and will form part of the induction process for new staff.

3. Definitions

3.1 Fraud

The Fraud Act 2006 introduced an entirely new way of investigating and prosecuting fraud. It is no longer necessary to prove that a person has been deceived, or for a fraud to be successful. Focus is now placed on the dishonest behaviour of the suspect and their intent to make a gain either for themselves or another; to cause a loss to another; or, expose another to a loss.

There are several specific offences under the Fraud Act 2006; however, there are three primary ways in which it can be committed;

- **Fraud by false representation (s.2)** – lying about something using any means, e.g. falsifying a CV or a UC24 job application form.
- **Fraud by failing to disclose (s.3)** – not saying something when you have a legal duty to do so, e.g. failing to declare a conviction, disqualification or commercial interest when such information may have an impact on your UC24 role, duties or obligation and where you are required to declare such information as part of a legal commitment to do so.
- **Fraud by abuse of a position of trust (s.4)** – abusing a position where there is an expectation to safeguard the financial interests of another person or organisation, e.g. an employee using commercially confidential UC24 information in order to make a personal gain.

It should be noted that all offences under the Fraud Act 2006 occur where the act or omission is committed dishonestly and with intent to cause gain or loss. The gain or loss does not have to succeed, so long as the intent is there. Successful prosecutions under the Fraud Act 2006 may result in an unlimited fine and/or a potential custodial sentence of up to 10 years.

3.2 Bribery and Corruption

Bribery and corruption prosecutions can be brought using specific pieces of legislation:

- Prevention of Corruption Acts 1906 and 1916, for offences committed prior to 1st July 2011, and,
- Bribery Act 2010, for offences committed on or after 1st July 2011.

The Bribery Act 2010 reforms the criminal law of bribery, making it a criminal offence to;

- **give promise or offer a bribe (s.1), and/or**
- **request, agree to receive or accept a bribe (s.2).**

Corruption is generally considered to be an "umbrella" term covering such various activities as bribery, corrupt preferential treatment, kickbacks, cronyism or embezzlement. Under the 2010 Act, however, bribery is now a series of specific offences.

Generally, bribery is defined as: an inducement or reward offered, promised or provided to someone to perform their functions or activities improperly in order to gain a personal, commercial, regulatory and/or contractual advantage.

A bribe does not have to be in cash; it may be the awarding of a contract, the provision of gifts, hospitality, sponsorship, the promise of work or some other benefit. The persons making and receiving the bribe may be acting on behalf of others – under the Bribery Act 2010, all parties involved may be prosecuted for a bribery offence.

The Bribery Act 2010 is also extra-territorial in nature. This means that anyone involved in bribery activity overseas may be liable to prosecution in the UK if the bribe is in respect of any UK activity, contract or organisation. To this end, the Bribery Act 2010 also includes an offence of bribing a foreign public official [s.6].

In addition, the Bribery Act 2010 introduces a new 'corporate offence' [s.7] of the failure of commercial organisations to prevent bribery. As a result, UC24 may be held liable (and punished with a potentially unlimited fine) when someone "associated" with it bribes another in order to get, keep or retain business for the organisation. However, the organisation will have a defence, and avoid prosecution, if it can show it had 'adequate procedures' in place designed to prevent bribery.

Finally, under section 14 of the Bribery Act 2010, a senior officer of the organisation (e.g. Chief Executive, Chair) would also be liable for prosecution if they consented to or connived in a bribery offence carried out by another. Under such circumstances, the Chief Executive may be prosecuted for a parallel offence to that brought against the primary perpetrator. Furthermore, the organisation could also be subject to an unlimited fine because of the Chief Executive's consent or connivance.

UC24 adopts a 'zero tolerance' attitude towards bribery and does not, and will not, pay or accept bribes or offers of inducement to or from anyone, for any purpose. UC24 is fully committed to the objective of preventing bribery and will ensure that adequate procedures, which are proportionate to our risks, are in place to prevent bribery and which will be regularly reviewed. We will seek to obtain the strongest penalties – including criminal prosecution, disciplinary and/or civil sanctions – against anyone associated with UC24 who is found to be involved in any bribery or corruption activities.

A conviction under the Bribery Act 2010 may ultimately result in an unlimited fine and/or a custodial sentence of up to 10 years imprisonment.

3.3 Employees

For the purposes of this policy, 'employees' includes UC24 staff, Associate GPs, clinicians and non-Executive members.

4. Codes of Conduct

The codes of conduct for NHS boards and NHS managers set out the key public service values. They state that high standards of corporate and personal conduct,

based on the recognition that patients come first, have been a requirement throughout the NHS since its inception. These values are summarised as:

Accountability - Everything done by those who work in UC24 must be able to stand the tests of parliamentary scrutiny, public judgements on propriety and professional codes of conduct.

Probity - Absolute honesty and integrity should be exercised in dealing with NHS patients, assets, staff, suppliers and customers.

Openness - The health body's activities should be sufficiently public and transparent to promote confidence between UC24 and its staff and the public.

All staff should be aware of and act in accordance with these values. In addition, staff are expected to;

- act impartially in all their work.
- refuse gifts, benefits, hospitality or sponsorship of any kind that might reasonably be seen to compromise their judgement or integrity; and, to avoid seeking to exert influence to obtain preferential consideration. All such gifts should be returned and hospitality refused.
- declare and register gifts, benefits or sponsorship of any kind, in accordance with limits agreed locally, whether refused or accepted.
- declare and record financial, non-financial or personal interest (e.g. company shares, research grant) in any organisation with which they have to deal, and be prepared to withdraw from those dealings if required, thereby ensuring that their professional judgement is not influenced by such considerations.
- make it a matter of policy that offers of sponsorship that could possibly breach the Code be reported to the Board.
- not misuse their official position or information acquired in the course of their official duties, to further their private interests or those of others.
- ensure professional registration (if applicable) and/or status are not used in the promotion of commercial products or services.
- beware of bias generated through sponsorship, where this might impinge on professional judgement or impartiality.
- neither agree to practice under any conditions which compromise professional independence or judgement, nor impose such conditions on other professionals.

All staff are also reminded that every UC24 employee, regardless of position or status, are expected to comply with the principles contained within the NHS Standards of Business Conduct (HSG (93)5).

Relevant personnel are also reminded that their professional bodies will also have codes of conduct or standards of behaviour which they will be expected to adhere to.

5. Roles and Responsibilities

Through our day-to-day work, we are in the best position to recognise any specific risks within our own areas of responsibility. We also have a duty to ensure that those risks – however large or small – are identified and eliminated. Where you believe the opportunity for fraud, corruption or bribery exists, whether because of poor procedures or oversight, you should report it to the Director of Finance

This section states the roles and responsibilities of employees, stakeholders and other relevant parties in reporting fraud or corruption.

UC24 will implement both the corporate responsibilities and three key principles for action as set out in the four sections below. This will be achieved through suitable training and the use of appropriate expertise as required.

5.1 Strategic Governance

UC24 will ensure that anti-crime measures are embedded at all levels across the organisation.

5.2 Inform and Involve

UC24 will use anti-fraud publicity material to persuade both employees and stakeholders, along with the public that fraud, bribery and corruption is serious and takes away resources from important services. Such activity will demonstrate that fraud, bribery and corruption are considered to be not acceptable and are being tackled.

5.3 Prevent and Deter

UC24 has policies and procedures in place to reduce the likelihood of fraud, bribery and corruption occurring. These include a system of internal control, Standing Financial Instructions and documented procedures, which involve physical and supervisory checks, financial reconciliations, segregation and rotation of duties, and clear statements of roles and responsibilities.

Where fraud, bribery and corruption has occurred UC24 will introduce measures to minimise the future occurrence of fraud, bribery and corruption and will ensure that any necessary changes to systems and procedures take place as soon as is possible to prevent similar incidents from happening in the future.

5.4 Hold to Account

UC24 will hold to account those who have committed crimes against the organisation through detecting and investigating fraud, bribery and corruption, prosecuting, and seeking redress.

Following the conclusion of an investigation, if there is evidence of fraud, available sanctions will be considered. This may include criminal prosecution, civil proceedings and disciplinary action, as well as referral to a professional or regulatory body.

Recovery of any losses incurred will also be sought through civil proceedings if appropriate; to ensure losses to UC24 are returned for their proper use.

5.5 Role of UC24

UC24 has a duty to ensure that it provides a secure environment in which to work, and one where people are confident to raise concerns without worrying that it will reflect badly on them. This extends to ensuring that staff feel protected when carrying out their official duties and are not placed in a vulnerable position. If staff have concerns about any procedures or processes that they are asked to be involved in, UC24 has a duty to ensure that those concerns are listened to and addressed.

UC24's Director of Finance is liable to be called to account for specific failures in its system of internal controls. However, responsibility for the operation and maintenance of controls falls directly to line managers and requires the involvement of all UC24 employees including those who provide support services on behalf of the organisation. UC24 therefore has a duty to ensure employees who are involved in or who are managing internal control systems receive adequate training and support in order to carry out their responsibilities. Therefore, the Chief Executive and Director of Finance will monitor and ensure compliance with this policy.

5.6 Employees

UC24's Standing Financial Instructions, policies and procedures place an obligation on all employees including Non-Executives to act in accordance with best practice.

Employees are expected to act in accordance with the standards laid down by their professional institutes, where applicable, and have a personal responsibility to ensure that they are familiar with them.

Employees also have a duty to protect the assets of the UC24, including information, and property.

In addition, all employees have a responsibility to comply with all applicable laws, regulations and UC24 policies relating to ethical business behaviour, procurement, personal expenses, conflicts of interest, confidentiality and the acceptance of gifts and hospitality. This means, in addition to maintaining the normal standards of personal honesty and integrity, all employees should always:

- avoid acting in any way that might cause others to allege or suspect them of dishonesty

- behave in a way that would not give cause for others to doubt that UC24 employees deal fairly and impartially with official matters
- be alert to the possibility that others might be attempting to deceive.

All employees have a duty to ensure that public funds are safeguarded, whether or not they are involved with cash or payment systems, receipts or dealing with contractors or suppliers.

If an employee suspects that there has been fraud, corruption or bribery, or has seen any suspicious acts or events, they must report the matter to the Director of Finance.

5.7 Managers

Managers must be vigilant and ensure that procedures to guard against fraud, bribery and corruption are applied and monitored. They should be alert to the possibility that unusual events or transactions could be symptoms of fraud, bribery and corruption.

Managers must instil and encourage an anti-fraud, bribery and corruption culture within their teams and ensure that information on procedures is made available to all employees.

All instances of actual or suspected fraud, bribery and corruption which come to the attention of a manager must be reported immediately. Managers must not attempt to investigate the allegation themselves.

Line managers at all levels have a responsibility to ensure that an adequate system of internal control exists within their areas of responsibility and that controls operate effectively.

5.8 NHS Counter Fraud Authority

The NHS Counter Fraud Authority is a special health authority charged with identifying, investigating and preventing fraud and other economic crime within the NHS and the wider health group.

As a special health authority focused entirely on counter fraud work, the NHS CFA is independent from other NHS bodies and directly accountable to the Department of Health and Social Care (DHSC).

The NHS CFA's main objectives are:

- to deliver the Department of Health (DH) strategy, vision and strategic plan, and be the principal lead for counter fraud activity in the NHS in England;
- to be the single expert intelligence led organisation providing a centralised investigation capacity for complex economic crime matters;
- to lead, guide and influence the improvement of standards in counter fraud work, in line with HM Government Counter Fraud Professional Standards,

across the NHS and wider health group, through review, assessment and benchmark reporting of counter fraud provision across the system;

- to take the lead and encourage fraud reporting across the NHS and wider health group, by raising the profile of fraud and its effect on the health care system.

5.9 Director of Finance

Director of Finance (DOF) has powers to approve financial transactions initiated by departments across the organisation.

The DOF prepares documents and maintains detailed financial procedures and systems and that they apply the principles of separation of duties and internal checks to supplement those procedures and systems.

The DOF, in conjunction with the Chief Executive, monitors and ensures compliance with the UC24's requirements regarding fraud, bribery and corruption.

The DOF will, depending on the outcome of investigations (whether on an interim/on-going or concluding basis) and/or the potential significance of suspicions that have been raised, inform appropriate senior management accordingly.

The DOF will inform and consult the Chief Executive in cases where the loss may be above the agreed limit or where the incident may lead to adverse publicity.

If an investigation is deemed to be appropriate, the Director of Finance may delegate the investigation to another body to investigate (e,g. the Police, external investigators), whilst retaining overall responsibility.

The DOF will consult and take advice from the Associate Director of HR if a member of staff is to be interviewed or disciplined. The DOF and/ or the appointed fraud investigator will not conduct a disciplinary investigation, but the employee may be the subject of a separate investigation by HR.

5.10 Internal and External Audit

The role of internal and external audit includes reviewing controls and systems and ensuring compliance with financial instructions. Any incident or suspicion of fraud, corruption or bribery that comes to internal or external audit's attention will be passed immediately to the DOF. The outcome from a fraud investigation may necessitate further work by internal or external audit to review systems and controls.

5.11 Human Resources

HR will liaise closely with managers from the outset if an employee is suspected of being involved in fraud, corruption and/or bribery. HR staff are responsible for

ensuring the appropriate use of the U24's disciplinary procedure. The HR function will advise those involved in the investigation on matters of employment law and other procedural matters, such as disciplinary and complaints procedures, as requested.

Close liaison between the Director of Finance and HR will be essential to ensure that any parallel sanctions (i.e. criminal, civil and disciplinary sanctions) are applied effectively and in a coordinated manner.

HR will take steps at the recruitment stage to establish, as far as possible, the previous record of potential employees, as well as the veracity of required qualifications and memberships of professional bodies, in terms of their propriety and integrity. In this regard, temporary and fixed-term contract employees are treated in the same manner as permanent employees.

5.12 Information Management and Technology

UC24's Head of Information Technology will contact the Director of Finance immediately in all cases where there is suspicion that UC24's ICT is being used for fraudulent purposes, particularly in relation to the Computer Misuse Act 1990 and shared working arrangements will be established. HR will also be informed if there is a suspicion that an employee is involved.

5.13 Chief Executive Responsibilities

The Chief Executive as the organisation's accountable officer has the overall responsibility for funds entrusted to it. The Chief Executive must ensure adequate policies and procedures are in place to protect the organisation and the public funds it receives.

6. Reporting Fraud, Bribery and Corruption

6.1 Reporting fraud, bribery and/or corruption

This section outlines the action to be taken if fraud, corruption or bribery is discovered or suspected. If an employee has any of the concerns, they must inform UC24's Director of Finance immediately,

If the referrer believes that the Director of Finance is implicated, they should notify a Senior officer is not believed to be involved who will then inform the Associate Director HR and Audit Committee Chair.

An employee can contact any executive officer of UC24 to discuss their concerns if they feel unable, for any reason, to report the matter to the Director of Finance or the Chief Executive.

The desktop guide **(Appendix A)** provides a reminder of the key contacts and a checklist of the actions to follow if fraud, bribery and corruption, or other illegal acts, are discovered or suspected. Managers are encouraged to copy this to staff and to place it on staff notice boards in their department.

If any employee or stakeholder feels unable, for any reason, to report the matter internally they can also call:

NHS Counter Fraud Authority.

Telephone: 0800 028 40 60 or

Action Fraud the UK's national fraud and cyber-crime reporting centre.

Telephone: 0300 123 2040

Report on-line: Report Fraud On-line

This provides an easily accessible route for the reporting of genuine suspicions of fraud, bribery and corruption. It allows those people who are unsure of internal reporting procedures to report their concerns in the strictest confidence. All calls are dealt with by experienced trained staff and any caller who wishes to remain anonymous may do so.

Anonymous letters, telephone calls, etc. are occasionally received from individuals who wish to raise matters of concern, but not through official channels. While the suspicions may be erroneous or unsubstantiated, they may also reflect a genuine cause for concern and will always be taken seriously.

The Director of Finance will make sufficient enquiries to establish whether or not there is any foundation to the suspicion that has been raised.

UC24 wants all employees and stakeholders to feel confident that they can expose any wrongdoing without any risk to themselves. In accordance with the provisions of the Public Interest Disclosure Act 1998, UC24 has produced a Reporting a Concern (Whistleblowing) Policy. This procedure is intended to complement this policy as well as other relevant UC24 policies and ensures there is full provision for staff to raise any concerns with others if they do not feel able to raise them with their line manager/management chain. Corporate policies can be found on UC24's intranet.

6.2 INVESTIGATIONS WITH CLINICAL IMPLICATIONS

When investigating suspicions of fraud, it is important to consider whether there may be any clinical or health and safety implications which could have an adverse impact on the organisation. An example of this would be an individual working for the organisation is suspected of using a false name/identity. In such cases, the overriding

consideration must be one of patient care. It must be appreciated that every case is different and it is therefore impossible to produce definitive guidance to follow.

In such an instance, it is important that the Director of Finance is informed of the potential risk at the earliest opportunity. The Director of Finance will decide which of his/her senior colleagues, should be informed and consulted with before reaching a decision. Any appropriate professional body may also be notified. It is essential that this happens to ensure that the Director of Finance's decision can take account of the full consideration of the clinical and non-clinical risks facing the organisation. To ensure that the investigation is not compromised however, it is vital that the number of people aware of the investigation is kept to an absolute minimum. If in any doubt, advice will be sought from the NHS Counter Fraud Authority.

It may be appropriate or necessary for immediate action to be taken. All previously agreed parties should be involved in this process and should be kept informed of any action taken and the outcomes. Any decision to contact or suspend the individual(s) under suspicion must involve the Director of Finance and Associate Director of HR unless either of those individuals is implicated in the reported activity.

Under no circumstances will issues of fraud take priority over patient care.

7. Review

7.1 Monitoring and auditing of policy effectiveness

Monitoring is essential to ensuring that controls are appropriate and robust enough to prevent or reduce fraud. Arrangements might include reviewing system controls on an ongoing basis and identifying weaknesses in processes.

Where deficiencies are identified as a result of monitoring, UC24 should explain how appropriate recommendations and action plans are developed and how any recommendations made should be implemented.

7.2 Dissemination of the policy

The Anti-Fraud, Bribery and Corruption Policy will be made available to all staff, via a variety of forms of communications, including the UC24's intranet.

It is highly important that all staff understand and are aware of the policy.

7.3 Review of the policy

UC24's Anti-Fraud, Bribery and Corruption Policy will be reviewed bi-annually. The Director of Finance will review the policy on behalf of the UC24 before ratification.

Appendix A: Anti-fraud, bribery and corruption: dos and don'ts
A desktop guide for UC24 staff

FRAUD is the dishonest intent to obtain a financial gain from, or cause a financial loss to, a person or party through false representation, failing to disclose information or abuse of position. CORRUPTION is the deliberate use of bribery or payment of benefit-in-kind to influence an individual to use their position in an unreasonable way to help gain advantage for another. BRIBERY is to give promise to offer a bribe, and to request, agree to receive or accept a bribe.

Fraud, Corruption and Bribery mean that money that is there to spend on patient care is no longer available, we need everyone to play a part in making sure that this doesn't happen and report any suspicions you may have.

DOs

- **Note your concerns**

Record details such as your concerns, names, dates, times, details of conversations and possible witnesses. Time, date and sign your notes.

- **Retain evidence**

Retain any evidence that may be destroyed, or make a note.

- **Report your suspicion**

Confidentiality will be respected – delays may lead to further financial loss.

DON'Ts

- **Confront the suspect or convey concerns to anyone other than those authorised, as listed below**

Never attempt to question a suspect yourself; this could alert a fraudster or accuse an innocent person.

- **Try to investigate, or contact the police directly**

Never attempt to gather evidence yourself unless it is about to be destroyed; gathering evidence must take into account legal procedures in order for it to be useful.

- **Be afraid of raising your concerns**

The Public Interest Disclosure Act 1998 protects employees who have reasonable concerns. You will not suffer discrimination or victimisation by following the correct procedures.

- **Do nothing**

If you suspect that fraud against UC24 or the NHS has taken place, you must report it immediately.

You can contact our Director of Finance:

3-6 Enterprise Way
Wavertree Technology Park
Liverpool, L13 1FB
Office: 0151 254 2553 - ext. 1001
Email: heledd.cooper@uc24.nhs.uk

Or the NHS Counter Fraud Authority:

For further information about the NHS Counter Fraud Authority please visit https://cfa.nhs.uk/home

Gifts & Hospitality Policy

Gifts & Hospitality Policy

Version	Version 2
Supersedes:	Gifts & Hospitality Policy
Date Ratified by Board:	
Reference Number:	
Title & Department of originator:	Heledd Cooper, Finance
Title of responsible committee/department:	Finance & Performance Committee
Effective Date:	November 2018
Next Review date:	November 2020
Target audience:	All
Impact Assessment Date:	
Summary	

Version	**Date**	**Control Reason**	**Title of Accountable Person for this Version**

Reference Documents	**Electronic Locations (Controlled Copy)**	**Location for Hard Copies**
	Urgent Care 24 Intranet / SOPs Clinical / Operations … **Delete as appropriate***	**Policy File, Wavertree Headquarters**

Consultation: Committees / Groups / Individual	**Date**

Contents

APPENDICES

1.0 PURPOSE

1.1 This policy aims to ensure that all Urgent Care 24 employees are not placed in a position which risks, or appears to risk conflict between their private interests and their duties with Urgent Care 24.

1.2 The Bribery Act 2010 revised the legal framework to combat bribery in the public and private sectors. It makes it an offence to receive a financial or other advantage as a reward for an improper act such as the award of a contract. A gifts and hospitality policy is a key tool for organisations to demonstrate they have arrangements in place to discourage the offer or acceptance of such rewards.

1.3 The policy covers the receipt of hospitality, gifts and sponsorship from commercial, non-commercial (e.g. patients, carers or relatives of the same) and no profit making bodies.

2.0 SCOPE

2.1 This policy applies to all employees, Associate GP's, locums and any other person acting in the name of the organisation.

2.2 This policy should be read in conjunction with the Anti-Fraud, Bribery and Corruption Strategy & Policy and the Declaration of Interest Policy which also set out generic guidelines and responsibilities in relation to gifts and hospitality.

3.0 RESPONSIBILITIES

3.1 All employees are responsible for not allowing themselves to be put in a position that might be deemed by others as inappropriate in terms of accepting hospitality or gifts.

3.2 All employees have a responsibility to adhere to the terms and conditions of this policy and strategy.

3.3 Directors, Line Managers and Heads of Departments who are specified as the responsible people within the policy must ensure the correct procedure is carried out.

3.4 Any queries on the application or interpretation of this policy must be discussed with the author of the policy prior to any action taking place.

3.5 This policy and strategy will be reviewed on a bi-annual basis and updated as appropriate.

4.0 DEFINITIONS

- Gift

  Any item of cash or goods, or any service provided, which is provided for personal benefit, free of charge or at less than commercial value.

- Hospitality

  Any offer of meals, refreshments, travel, accommodation and other expenses in relation to attendance at meetings, conferences, education and training events.

- Sponsorship

  This is classed as sponsorship provided for attendance at courses, conferences, post/project funding, meetings and publications in connection with the activities which they carry out on behalf of the CCG or their GP practices.

5.0 AIMS/PRINCIPLES OF POLICY

5.1 Provision of Hospitality

5.1.1 Hospitality should not normally be considered as part of the arrangements when conducting Urgent Care 24 business and should only be provided when necessary. It is not justifiable to provide hospitality solely to reciprocate hospitality received on some previous occasion. Staff should not ask for or accept hospitality that may affect, or be seen to affect, their professional judgement. Acceptance must only come where there is a legitimate business reason and it is proportionate to the nature and purpose of the event.

5.2 Meetings

5.2.1 Hospitality must be secondary to the purpose of the meeting. Working lunches should be considered **only** when a meeting takes place over the lunch-time period and when some of the people attending are from external organisations and even then, should not be provided as a matter of course.

When considered essential, working lunches should be limited to sandwiches or a modest buffet type meal. Working lunches should not be provided for meetings that are due to finish by 1.00 p.m. or for meetings that are due to start after 1.00 p.m. The provision of alcoholic beverages is not permissible and will not be paid for by UC24.

5.3 Acceptance of Hospitality

5.3.1 Modest hospitality may be accepted provided it is normal and reasonable in the circumstances e.g. lunches in the course of working visits may be accepted, though it should be similar to the scale of hospitality that Urgent Care 24 as an employer would be likely to offer.

5.3.2 If a meal and associated refreshments falls under the value of £25 these may be accepted and need not be declared, between the value of £25 and £75 they may be accepted but must be declared on the form at Appendix 1 and passed to your line managers for checking. Offers over the value of £75 should be refused unless Executive approval is given. A clear reason must be entered on the register as to why approval was given.

5.4 Refusal of Hospitality

5.4.1 Hospitality of any kind which might reasonably be seen to compromise an employee's personal judgement or integrity and exerting influence to obtain preferential consideration should be refused.

5.5 Casual gifts

5.5.1 UC24 Staff should not accept gifts that may affect, or be seen to affect their professional judgement.

5.5.2 Gifts from Supplier or Contractors

Gifts from suppliers or contractors doing business (or likely to do business) with the CCG should be declined whatever their value. However, low cost promotional items like stationary below the value of £6 (estimated or known cost), are permissible and do not need to be declared. In cases of doubt, the Line Manager, Director of Finance or the Chief Executive Officer should be consulted.

5.5.3 Gifts from Other Sources (e.g. patients, families, service users)

Individuals should not actively seek gifts. Where a gift is received and it is estimated to be below £50 this may be accepted and does not need to be declared. Gifts above this limit should be treated with caution and only be accepted on behalf of the organisation. This should be made clear to the person making the offer. All gifts above the £50 limit should be declared using the form at Appendix 1 and passed to your line manager for approval.

5.6 Financial Donations

5.6.1 Gifts in the form of a donation of money to UC24 or bequests to individual staff (i.e. from grateful patients) should not be accepted and this should be reported to the Director of Finance.

5.7 Sponsorship

5.7.1 Commercial sponsorship refers to all funding from sources external to the NHS. This includes funding of all or part of the cost of a member of staff, NHS research, training, pharmaceuticals, equipment, meeting rooms, costs associated with meetings, hotel and transport costs, or provision of speakers or premises. Staff should be aware that the offer of travel or places on courses by external companies should not be viewed as 'free'.

5.7.2 There may be times when sponsorship of NHS events or learning and development opportunities by external parties is justified. However, there is potential for conflicts of interest between the organiser and the sponsor, particularly regarding the ability to market products and services. As a result there should be proper safeguards in place to prevent conflicts occurring.

5.7.3 When sponsorships are offered the following principles must be adhered to:

- Sponsorship of UC24 events by external bodies should only be approved by a Director if the organiser can demonstrate a clear benefit to UC24.
- During dealings with sponsors there must be no breaches of patient or individual confidentiality.
- No information should be supplied to the sponsor from which they could gain a commercial advantage.
- The involvement of a sponsor in an event should be clearly identified and the organiser must make clear that sponsorship does not equate to endorsement of the company or its products.

5.7.4. Advance approval must be sought for all commercial sponsorship.

5.7.5. Sponsorship arrangements involving amounts less than £25 need not be declared or registered. The £25 limit will apply to each sponsorship arrangement i.e. if more than one member of staff attends a training event valued at £20 per person the event should be recorded as the total sponsorship arrangement is in excess of £25.

6.0 PROCEDURE

6.1 Reporting of Hospitality and Gifts

6.1.1 Urgent Care 24 employees must declare any hospitality over £25.00 per person, with Executive approval over £75.
A Declaration of Hospitality form can be found at **Appendix 1.**

6.1.2 The individual to whom an offer of a gift/hospitality is made should declare the offer to the Company Secretary at the earliest opportunity, but within at least 14 days of receipt, so that it can be recorded on the register. All offers declared need to be countersigned by the individuals' line manager, with additional approval from Executives where the policy requires this.

6.2 Hospitality and Gift Register

7.2.1 The Company Secretary will maintain a register of declared hospitality and gifts which will be made available to the Urgent Care 24 Audit Committee.

7.0 RESPONSIBILITIES

7.1 The following roles and responsibilities have been determined to support the management of gifts and hospitality:

7.1.1 Audit Committee
The Audit Committee is responsible for ensuring that the policy is effectively managed and implemented along with receiving regular oversight reports.

7.1.2 Director of Finance
The Chief Executive Officer/ Director of Finance has overall accountability and responsibility for implementation of this policy.

7.1.3 Directors/ Associate Directors
Directors/ Associate Directors must ensure that managers within their directorate are made aware of the provisions set out within the policy and are implemented, in particular:

- Ensuring all employees are aware of their responsibilities, the law and the CCG's policy on acceptance of Gifts and Hospitality.
- Ensuring that breaches of policy are dealt with in a fair and consistent manner.

7.1.4 Company Secretary

The Company Secretary is responsible for:

- Ensuring staff are advised on the contents of this policy;
- Ensuring that adequate records are maintained;
- Maintaining the Gifts and Hospitality Register;
- Preparation of the Gifts and Hospitality Reports and presentation to the Audit Committee.

7.1.5 Employees

All staff are responsible for:

- Following the policy.
- Declaring any receipt of gifts or hospitality covered within the confines of this policy.
- Ensuring any gifts which have been accepted are declared and reported to the Company Secretary for entry onto the Gifts and Hospitality Register.

8.0 BREACHES OF THE POLICY

8.1 Non-compliance with this policy will be deemed as a disciplinary matter and breaches of the policy will be investigated and handled in accordance with UC24's disciplinary procedure. Where it is proven that actual fraud has taken place then criminal charges may be brought. Details of breaches will be reported to the Board.

Appendix one

Declaration of the Receipt of Hospitality/Gift(s)/ Sponsorships

RECIPIENT NAME: _____
Please print

JOB TITLE: _____

DEPARTMENT: _____

In accordance with Urgent Care 24's Policy on Gifts and Hospitality I wish to declare that I am in receipt of the following hospitality/gifts/ sponsorship.

Date received	Received from (Name of Supplier)	Form of Hospitality/ Gift/ Sponsorship	Estimated Value	Accepted/ Declined

I understand that the above information will be recorded in the Hospitality Register

Recipient Signature: _____

Date: _____

Manager's Signature: _____

Date: _____

Executive Signature (where applicable): _____

Date: _____

Upon completion this form should be returned to the Company Secretary, 3-6 Enterprise Way, Wavertree Technology Park, Liverpool, L13 1FB or e-mail: TBC

NHS
Urgent Care 24
safe • caring • effective

Title:	Meeting Date:	Agenda item
Quality and Workforce Committee report	21.11.2018	**no:** 11.1
Prepared and presented by: Dr Paula Grey	**Discussed by:** Quality and Workforce Committee	
Link to UC24 Values: ✓ Providing quality patient services ✓ Being an excellent employer ✓ Working collaboration to achieve positive system change. **CQC Domain References** ✓ Safe ✓ Effective ✓ Caring ✓ Responsive ✓ Well-led	**Resource implications:** **Purpose of the report:** ✓ Assurance ☐ Decision ☐ Discussion ✓ Noting **Decisions to be taken:** The meeting is invited to: • be assured that the Committee is giving due scrutiny to the information presented to it; • note the main issues from the meeting.	

1.0 Purpose:

1.1 The purpose of this paper is to advise the Board on matters discussed at the Quality and Workforce Committee meeting held on Wednesday 21 November 2018 which the Committee agreed should be brought to the Board's attention.

2.0 Matters for Report

2.1 The Committee reported that the current safeguarding issues and the plan to appoint a GP as Safeguarding Lead for the organisation, were to be dealt with as a matter of priority.

2.2 The Committee noted that the technical capacity of Datix and RotaMaster to respond effectively to the needs of the organisation in relation to Rota and Workforce management, as well as possible training gaps within the staff, were currently being assessed; and that the ultimate goal was to put systems in place that provided the necessary level of support to the organisation.

2.3 The Committee noted that the HR team were looking at ways to ensure that appraisals were completed and reviewed within the appropriate deadlines;

2.4 The Committee welcomed and recommended the Policy for Policy management to the Board for approval;

2.5 The Committee noted the updates to the Safeguarding Children's and Safeguarding Adults policies.

3.0 Recommendations:

The meeting is invited to:

- be assured that the Committee is giving due scrutiny to the information presented to it;
- note the main issues from the meeting.

NHS
Urgent Care 24
safe • caring • effective

Title:	Meeting Date:	Agenda item
Finance and Performance Committee report	21.11.2018	**no:** 11.2
Prepared and presented by: Paul Cummins	**Discussed by:** Finance and Performance Committee	
Link to UC24 Values: ✓ Providing quality patient services ✓ Being an excellent employer ✓ Working collaboration to achieve positive system change. **CQC Domain References** ✓ Safe ✓ Effective ✓ Caring ✓ Responsive ✓ Well-led	**Resource implications:** **Purpose of the report:** ✓ Assurance ☐ Decision ☐ Discussion ✓ Noting **Decisions to be taken:** The meeting is invited to: • be assured that the Committee is giving due scrutiny to the information presented to it; • note the main issues from the meeting.	

1.0 Purpose:

1.1 The purpose of this paper is to advise the Board on matters discussed at the Finance and Performance Committee meeting held on Wednesday 21 November 2018 which the Committee agreed should be brought to the Board's attention.

2.0 Matters for Report

2.1 The Committee noted the good and consistent OOH performance for the months of September and October with five areas of partial compliance;

2.2 The Committee noted the good performance of the newly launched Extended Access services in Liverpool and St. Helens;

2.3 The Committee noted the persisting serious financial challenges with regards to the 7 GP Practices in Sefton;

2.4 The Committee noted with reassurance the update to the actions being undertaken and the forward plan for the management of Estates and Health & Safety across the organisation;

2.5 The Committee reviewed and commended the Anti-Fraud, Bribery and Corruption Strategy & Policy and the Gifts & Hospitality Policy to the Board for approval

3.0 Recommendations:

The meeting is invited to:

- be assured that the Committee is giving due scrutiny to the information presented to it;
- note the main issues from the meeting.