PRIMARY CARE 24 (MERSEYSIDE) BOARD MEETING (OPEN)

DATE:	**30 May 2019**
TIME:	**10.00am**
VENUE:	**The Boyd Room (Large Conference Room)**
DISTRIBUTION:	**All Board members & attendees**
BOARD MEMBERS:	STEVE HAWKINS (Chairman), PAULA GREY, DR MARY RYAN, JAY CARR, KATHRYN FOREMAN, PAUL CUMMINS, HELEDD COOPER, PAUL KAVANAGH-FIELDS, DR. SANDRA OELBAUM
IN ATTENDANCE:	SUSAN WESTBURY; CAROL ROGERS; MARGARET SWINSON, COMPANY SECRETARY

AGENDA

				Pages
1.	Chairman's Welcome, apologies for absence and opening comments			Verbal
2.	New declarations of interest			Verbal
3.	Patient Story:		CR	Verbal
4.	Minutes of the meeting held on 28 March 2019			1 – 5
5.	Matters arising, action list progress and Corporate Risk Register			6 – 7
6.	**Chairman and Non-Executives' Report**			
	6.1	Chairman's Report	SH	Verbal
7.	**Chief Executive**			
	7.1	Chief Executive's Report	MR	Verbal
8.	**Performance**			
	8.1	Integrated Performance Report	Executive Team	8 – 27
9.	**Strategy**			
	9.1	Board Assurance Framework & Risk Appetite discussion	PKF	28 – 29
10.	**Governance**			
	10.1	Policies for approval	MS	30 – 83
	10.2	Review of Board Terms of Reference	MS	84 – 88

11. Committee Reports

11.1	Quality & Workforce 22 May 2019	PG	89 – 90
11.2	Finance & Performance 22 May 2019	PC	91

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:	**25 July 2019**
Time:	**10am**
Venue:	**Urgent Care 24 Board Room**

Board Meeting:	Open Session
Venue:	Boyd Room, PC24
Date:	28 March 2019
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* Paul Kavanagh-Fields (PKF) – *Director of Nursing V* **Non-Executive Directors (NEDs)** Steve Hawkins – (SH) *Chairman V* Paula Grey (PG) – *V* Kathryn Foreman (KF) - *V* **In attendance:** Margaret Swinson (MS) – *Company Secretary* *V indicates a voting member of the Board*	Paul Cummins ({C) - V	**30 May 2019**

Item		Action
1.	**Chair's Welcome, apologies for absence and opening comments** SH opened he meeting, thanking everybody for attending. Apologies had been received from Paul Cummins.	
2.	**New declarations of interest** There were no new Declarations of Interest to note.	
3.	**Patient Story** The Associate Director of Nursing was unfortunately unable to attend the meeting to present the patient story to the Board. It was agreed this would be presented at the May meeting.	
4.	**Minutes of the meeting held on 31 January 2019** The minutes were agreed as an accurate record with one amendment to page 5, para 11.3 the word gripped being put into inverted commas.	
5.	**Matters arising and Action Log progress** None. **Risk Register** The Board noted the risk register	
6.	**Chairman and Non-Executives' Report**	

	6.1 Chairman's Report The Chairman reported on his visit to Old Swan with JC to visit both the Out of Hours and Extended Access services. JC had also found the visit valuable. The logistical challenges of the centre, from which three services were operated each with their own receptionists two from PC24 and one Mersey Care for the Walk In Centre, were noted. The Board: • Noted the Chairman's report.	
7.	**Chief Executive's Report** **7.1 Chief Executives Report** MR reported that: • She had met with Tony Leo, from NHS England, regarding the Sefton Practices. • She had met with Prof. Sarah O'Brien, Chief Officer at St Helens' CCG and Strategic Director at St Helen's Council with regard to providing services in St Helens. • PC24 had been expressed an interest in 4 APMS practices in Liverpool which had been part of a non-standard commissioning process, the outcome of which was expected after the Board meeting. In response to comment from the Board regarding work with Mersey Care, the Board was advised that PC24 was due to meet with Mersey Care to discuss the development of Urgent Treatment Centres. The possibility of joint graduate trainees was also under discussion. The Board noted that Mersey Care was open about the challenges it faced in Community Care, was working through legacy issues from the previous provider and had been trying to establish connections with Primary Care. The Board: • Noted the Chief Executive's Report.	
	7.2 Migrant Health Campaign MR presented a paper which outlined the Migrant Health Campaign, which had come to her attention via the Clinical Lead at the Asylum Service and others working with refugees and asylum seekers. The campaign sought to suspend health care charges for individuals presenting for urgent and necessary treatment in A&E departments and had attracted support from some of the staff at the Royal A&E and also the Royal Colleges. As PC24 is engaged in the care of refugees and asylum seekers, the Board was invited to discuss joining the campaign by expressing support for it and for the staff at the Royal Liverpool hospital. Before discussion of the paper, MS confirmed that the Rules of PC24 did not prevent the organisation from associating itself with such a campaign and PG declared an interest as a Trustee of Asylum Link Merseyside. The Board discussed the proposal noting that the organisation's involvement with the asylum seeker community as the first point of contact with health services and the point of referral into secondary care where the charges are applied, gave PC24 a strong resonance with the aims of the campaign. Furthermore, not to support it would be inconsistent with PC24's support for the asylum seeker community. The nature of the support to be offered was then discussed. It was agreed that MR would write a carefully worded letter to the Royal emphasising PC24's place on the journey of asylum seekers, expressing concern about the charges and requesting their	

	suspension. This message should be set in the context of PC24's work and ethos as a Social Enterprise. The Board: • Noted the paper and asked MR to draft a letter to the Royal.	
8.	**Performance** **8.1 Integrated Performance Report** SH reminded the Board that the various aspects of performance were reviewed in a number of internal and external meetings and the Board should take the report by exception. **Operations:** JC reported we services were recovering slowly from the winter performance demonstrated by generally stable performance across the service range. MR informed the Board that at the Contract Monitoring meeting it had been agreed that, after many years, the meeting could move from monthly to bi-monthly. Commissioners complimented PC24 on the high quality of their data reporting which was an exemplar across the Cheshire and Mersey region. SH asked that this be fed down to the relevant teams. Two points were raised by exception and responded to: • The consequences of a no deal Brexit. JC explained that Commissioners required PC24 and all other health organisations to examine the risks of a no deal Brexit and to report this to the Board. The Board noted that the matter had been considered, the risks assessed and that PC24 therefore fulfilled this request. • Co-Design event: KF advised that, at the event, representatives from Aintree had questioned the value, to them, of the Primary Care Streaming Service. JC confirmed that the utilisation at Aintree was below that of other locations but that the service was mandated by Government. The Chair thanked JC and the team for the hard work in putting together the performance report. **Finance & HR** Finance: HC presented the YTD figures which showed an expected surplus which would be managed to ensure that the position was both accurate and protected the coming financial year's position. HR: HC reported that appraisal statistics now included Sefton. The Interim Associate Director of HR had been working to establish information baselines in readiness for the arrival of Susan Westbury in mid-May. **8.2 Budget Setting** HC presented the proposed budget for 2019/20. The process leading to the budget presented had been extensive and overseen through the Finance & Performance Committee. Following discussions at the Committee, the proposed surplus had been increased to 1% and a contingency budget included. An assumption had been made for contract inflation.	

	PC24 had the opportunity to invest in some areas of infrastructure to strengthen the organisations position for the future. Such investment might include IT infrastructure and other areas where the organisation was carrying risk. The Board was reminded that accountability agreements for budget holders had been put in place. These set out the roles and responsibilities of both budget holders and the finance team. Training would be delivered to budget holders in Quarter 1 of the new financial year. KF (Chair of Audit) commended the Finance team for the rigour in the budget setting process. The Board noted the milestones set out in the plan for Sefton and for efficiencies, noting that HC had been prudent in order to keep the target achievable. The Board: • Noted performance for January and February 2019 • Took assurance that the necessary actions are being taken in respect of risks. • Approved the budget and thanked HC and the Finance Team for their work in the budget setting process	
9.	**Strategy** None for the open meeting	
10.	**Governance** **10.1 Policies for Approval** **Dress Code** The Board approved the Dress Code policy which had been reviewed at the Quality & Workforce meeting. The Board: • approved the policy and took assurance that the Policy Group was monitoring progress in relation to the existing policies. **10.2 Grievance and Disciplinary** The Board considered the Governance and Disciplinary policies noting that the disciplinary policy was supported by a suite of documents which would be updated in line with good practice and/or legislation changes. The Board noted that the Disciplinary Policy had been also stress tested against a recent case. The Board: • Approved the Grievance and Disciplinary policies. **10.3 Rules and Regulation Update** MS reported that the FCA had finally agreed the new rules and drew attention to the 'Regulations under rule 1.6' which had been drawn up to support the Rules and had been given provisional agreement by the Board in July 2018 pending approval of the Rules. The Board was invited to consider whether it wished to amend the Regulations which would now accompany Board papers.	

	The Board noted the document and agreed that it should be refreshed to take account of the new name and branding and reflect the new organisational values. The Board: • Noted the new Rules and Regulations and were happy with the principal of the document. • SH thanked MS for her work in getting the Rules approved.	
11.	**Committee Reports** **11.1 Quality & Workforce** PG presented the report highlighting that: • The actions from the CQC reports were being monitored by the Committee; • The Committee had received the report of the ANP Record Keeping audit, commending this excellent piece of work which should be replicated in other areas of the organisation's life and would form part of the evidence base for future CQC inspections; • The vacancies in the HR team has been recruited to. 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** PG presented the report noting that the highlights had already been brought to the Board's attention as part of the review of the IPR. She reaffirmed the good performance and robust budget setting process. The Committee noted the improved and positive financial situation. The Board: • Was assured that the Committee was 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: 30th May 2019

Time: **10am**

Venue: **The Boyd Room at PC24**

Open Section Action Points and Report back dates from UC24 Board Meeting 1 April 2019

Action No.	Board Meeting reference	Action Required:	Due From:	Required by:	Comments
1.	28.3.19 Item 7.2	Migrant Health Campaign: MR to draft a letter of support to the Royal and circulate to Board for approval	MR	Asap	Completed and sent
2.	28.3.19 Item 10.3	Regulations 'How we do things here' document to be re-branded and updated	MS	July Board	TORs being reviewed in May and revision of the document will follow to ensure consistency

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	Fulfilment of GP rotas for all services not achievable	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 underway	Major	Unlikely	8	Lack of GPs nationally continue to impact Continued agency usage risks last minute cancellations	Medium / High	27/04/2017	Reviewed 23/05/2019
Finance	CR23	Corporate risk	DoF	Potential impact of IR35 inclusion of Associate workforce could lead to significant financial pressure on UC24	Major	Possible	12	Staying close to local 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	22/11/2018	Reviewed 23/05/2019
Corporate	CR31	Corporate risk	CEO	Re-configuration of Urgent Care services across C&M could lead to loss of business and / or independence for PC24	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 Attending co-design events via CCG	Major	Possible	12	No specification yet issued for new configuration, however PC24 have attended co-design events.	Medium	23/11/2018	Reviewed 23/05/2019
Corporate	CR33	Corporate risk	CEO	Creation of Primary Care Networks and moves towards preferential contract allocation to them may impact on current PC24 business, potential to bid for work and finanical stability	Major	Possible	12	Medical Director has become Clinical Director of a PCN, allowing intelligence and decisions to be commicated early. Ongoing monitoring of NHSE / I communication relating to Networks.	moderate	unlikely	6	Creation of networks embryonic, personnel unclear and structures not yet defined. Clinical Directors not yet appointed in several networks, making communications difficult Establishment of networks has proved slow and patchy and impact on PC24 business as yet unknown	Medium	08/03/2019	24/05/2019

Title:	Meeting Date:	Agenda item no:
Integrated Performance Report	30th May 2019	
Prepared and presented by: Presented by Dr Mary Ryan (CEO) Prepared by Executive Directors	**Discussed by:** Executive Directors	
Link to PC24 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 March and April 2019 • To receive assurance that the necessary actions are being taken.	

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 March and April 2019.

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 March and April 2019
- Receive assurance that the necessary actions are being taken.

Service Delivery	App. ref	Target	YTD (from Apr)	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	Trend	May-19 Forecast	Exception Report Number
Integrated Urgent Care																		
OOH NQR 8 Calls answered in 60secs	1	95%	94.5%	95.4%	94.5%	94.5%	96.4%	90.3%	89.1%	92.3%	88.3%	91.7%	92.1%	94.4%	94.5%		95.5%	IUC001
OOH NQR 9 - Urgent DCA 20mins	1	95%	94.8%	95.0%	94.3%	94.6%	94.9%	97.4%	94.1%	94.2%	92.7%	91.5%	93.0%	94.2%	94.8%		93.6%	IUC002
OOH NQR 9 - Less Urgent DCA 60mins	1	95%	87.5%	92.2%	93.9%	88.5%	92.4%	93.8%	89.8%	83.7%	68.9%	75.5%	81.4%	89.1%	87.5%		75.6%	IUC003
OOH NQR 12 - Home Visits - Total	1	95%	93.6%	94.5%	94.0%	90.7%	92.9%	95.2%	92.5%	90.0%	76.6%	81.2%	89.6%	93.9%	93.6%		86.7%	IUC004
OOH NQR 12 - UCCs - Total	1	95%	99.1%	99.3%	99.8%	99.8%	99.9%	99.4%	99.5%	99.3%	98.1%	99.3%	99.6%	99.1%	99.1%		98.4%	
OOH activity	1	n/a	6,800	6,034	5,465	5,294	5,247	5,528	5,584	5,681	7,854	6,633	6,018	6,547	6,800		6,306	
Alder Hey Primary Care Streaming - appointment utilisation	2	50%	47.9%	56.2%	51.8%	52.9%	41.0%	52.3%	57.7%	71.0%	54.4%	64.5%	64.1%	63.9%	47.9%		58.7%	IUC005
Alder Hey Primary Care Streaming - average consultation length	2	15mins	19:07	15:48	14:43	15:16	14:14	15:00	16:09	14:01	15:34	14:42	16:26	16:25	19:07		17:19	IUC006
Alder Hey Primary Care Streaming - shift fulfilment rate	2	100%	74.9%	74.3%	55.1%	60.9%	46.2%	43.8%	67.1%	77.7%	66.4%	70.9%	70.3%	57.3%	74.9%		67.5%	IUC007
Aintree Primary Care Streaming - appointment utilisation	3	50%	34.2%	33.7%	35.5%	45.7%	36.9%	36.4%	36.3%	34.9%	35.1%	37.7%	39.3%	40.1%	34.2%		37.9%	IUC008
Aintree Primary Care Streaming - average consultation length	3	15mins	17:50	17:35	18:56	16:54	16:43	21:23	16:27	16:45	16:27	16:02	16:58	17:49	17:50		17:32	IUC009
Aintree Primary Care Streaming - shift fulfilment rate	3	100%	87.6%	83.5%	65.5%	70.4%	68.4%	87.5%	91.6%	91.6%	89.1%	93.9%	88.3%	96.8%	87.6%		90.9%	IUC010
RLUH Primary Care Streaming - appointment utilisation	4	50%	55.1%	46.4%	48.0%	57.0%	49.2%	58.8%	54.3%	56.9%	56.3%	57.5%	55.0%	62.4%	55.1%		57.5%	
RLUH Primary Care Streaming - average consultation length	4	15mins	19:34	20:43	19:37	18:59	19:23	17:57	20:05	17:38	18:17	18:42	18:24	19:27	19:34		19:08	IUC011
RLUH Primary Care Streaming - shift fulfilment rate	4	100%	83.5%	69.9%	78.4%	85.8%	76.9%	93.9%	83.1%	91.0%	81.1%	84.5%	91.4%	86.0%	83.5%		87.0%	IUC012
Knowsley Services - Home visits in 1, 2 and 6 hours	5	95%	100.0%	100.0%	100.0%	99.3%	100.0%	100.0%	97.1%	99.4%	99.1%	100.0%	99.1%	98.3%	100.0%		99%	
Knowsley Services - patients seen within 30 minutes of scheduled appt	5	95%	98.9%	98.5%	97.8%	99.0%	98.1%	97.8%	98.8%	99.2%	98.1%	98.6%	98.8%	99.4%	98.9%		99%	
Intermediate Care Service - consistent medical provision	6	90%	99.5%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	98.5%	97.2%	91.0%	100.0%	99.5%	99.5%		100%	
Liverpool Extended Access - utilisation rate of available appointments	7		70.2%						42.9%	58.0%	72.6%	77.5%	75.7%	64.3%	70.2%		67%	
Liverpool Extended Access - DNA rate of booked appointments	7		7.7%						9.3%	8.4%	7.4%	8.9%	9.1%	8.2%	7.7%		6%	
Liverpool Extended Access - Clinical rota shift fulfilment	7		94%						77%	86%	82%	76%	92%	80%	94%		89%	
St Helens Extended Access - utilisation rate of available appointments	7		65.1%						32.4%	43.6%	68.3%	78.3%	75.8%	72.8%	65.1%		70%	
St Helens Extended Access - DNA rate of booked appointments	7		14.4%						6.3%	9.1%	13.2%	13.0%	15.0%	14.1%	14.4%		12%	
St Helens Extended Access - Clinical rota shift fulfilment	7		71%						87%	75%	50%	78%	70%	78%	71%		73%	
Primary and Community Services																		
Asylum practice - number of arrivals in month (EMIS reporting from Apr 2018)	8	n/a	358	298	361	453	457	418	533	531	444	494	452	482	358		431	
Finance																		
Budget variance (£000's)	9	0	Month 1 not reported	-20	-19	-65	-80	-51	73	-7	39	31	52	-600	Month 1 not reported		0	
Revenue surplus position (£000's) (Year end forecast)	9	170	Month 1 not reported	2	-8	-54	-97	-47	194	109	155	147	169	-403	Month 1 not reported		14	
Sefton practices LES/DES income	9	544	Month 1 not reported	66	8	61	4	38	62	14	25	89	24	15	Month 1 not reported		45	
Total cash (£000's) (Year End forecast)	10	1,000	Month 1 not reported	733	1,009	923	1,360	978	1,156	955	1,245	766	948	1,433	Month 1 not reported		1,200	
Efficiency programme vs target	11	95%	Month 1 not reported	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	Month 1 not reported		100%	
Better Payment Practice Code		95%	Month 1 not reported	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	Month 1 not reported		100%	
Quality and Patient Safety																		
Friends and Family - likely / extremely likely to recommend (includes paper surveys at Knowsley in-hours services from June 2018; 3 Sefton practices from March 2019)	12	85%	89.3%	88.1%	89.7%	89.4%	92.5%	89.4%	85.7%	88.3%	86.5%	89.4%	85.8%	87.2%	89.3%		89%	
Compliments received in month	12	n/a	3	2	1	1	3	2	10	8	1	1	3	3	3		3	
Complaints received in month	13	n/a	8	7	5	7	10	6	11	2	5	10	6	8	8		7	
Complaints not resolved within 25 working days	12		5	4	2	7	9	3	10	9	5	17	7	7	5		6	
Incidents recorded in month	12	n/a	95	61	63	79	72	66	86	87	81	90	65	74	95		78	
Safeguarding incidents recorded	12	n/a	15	0	2	0	1	1	4	4	4	6	9	6	15		10	
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	16.0%	21.8%	21.2%	20.0%	16.6%	15.2%	16.0%	17.2%	15.5%	14.8%	15.4%	16.4%	16.0%		16%	
Mandatory training compliance (employed staff only) (new reporting method in use from April 2019)	14	95%	84.2%	87.2%	86.8%	87.7%	86.3%	87.7%	88.9%	88.2%	Not supplied	Not supplied	Not supplied	Not supplied	84.2%		84%	WOR001
Appraisal compliance	14	95%	0.0%	3.8%	25.7%	31.9%	32.2%	33.8%	34.0%	35.5%	34.5%	32.0%	47.5%	50.0%	0.0%		32%	WOR002

Exception reference	Description	Commentary	Owner	Timescale to resolve (if applicable)
IUC001	Partial compliance against NQR 8 - Calls answered within 60 secs	Consistent performance compared to previous month. New operational staff in training following recent successful recruitment drive expected to join the team throughout May.	Head of Service	May 2019
IUC002	Partial compliance against NQR 9 - Urgent DCA	Four-day Bank Holiday period occuring in April resulting in an increase in activity. Technical issues with NHS 111/NUMSAS scheme resulting in unexpected demand on the service at times throughout April. Interim Head of Service now in post: main area of focus is to review NQR performance, rota profile, productivity and utilisation levels and recommend improvements.	Head of Service	June 2019
IUC003	Non-compliance against NQR 9 - Less urgent DCA	See IUC002	Head of Service	June 2019
IUC004	Partial compliance against NQR 12 - Home visits	See IUC002	Head of Service	June 2019
IUC005	Full and non-compliance against Alder Hey Primary Care Streaming appointment utilisation	Decrease in appointment utilisation, shift fulfilment has improved throughout April. Issue will be raised at next Contract Review meeting.	Head of Service	June 2019
IUC006	Partial and non-compliance against Alder Hey Primary Care Streaming average consultation length	Consultation length determined by complexity of patient. A number of new staff have joined the service throughout April resulting in an increase in consultation times.	Head of Service	May 2019
IUC007	Non-compliance against Alder Hey Primary Care Streaming shift fulfilment rate	Increase in shift fulfilment following the recruitment of a salaried GP, performance remains consistent throughout May.	Head of Service	June 2019
IUC008	Non-compliance against Aintree Primary Care Streaming appointment utilisation	Low utilisation rates continue. Aintree are currently completing a review of their service, initial indications show that the number of acute patients are higher and not appropriate for PCS.	Head of Service	June 2019
IUC009	Partial compliance against Aintree Primary Care Streaming average consultation length	Consultation rates determined by acuity of patients which is in line with initial feedback of service review.	Head of Service	June 2019
IUC010	Partial and non-compliance against Aintree Primary Care Streaming shift fulfilment rate	In Hours fill rate of 95%; Out of Hours fill rate of 81%. Reduced cover on weekends due to clinical availability	Head of Service	June 2019
IUC011	Non-compliance against The Royal Primary Care Streaming average consultation length	Clinical Lead is currently reviewing a sample week to understand reasons for long consultation times, wider discussion to be held with the trust dependent on the outcome.	Head of Service	June 2019
IUC012	Non-compliance against The Royal Primary Care Streaming shift fulfilment rate	In Hours fill rate of 91%; Out of Hours fill rate of 77%. Reduced cover on weekends due to clinical availability	Head of Service	June 2019
WOR001	Non-compliance against PC24 staff mandatory training compliance	A piece of work has taken place to fully review the recording, monitoring and prompting process around staff training modules. As a result the reported information is now considered robust and the compliance levels are expected to rise over the next few months as the new process fully embeds into the organisation.	Associate Director of HR	July 2019
WOR001	Non-compliance against PC24 appraisal target	Appraisal completion and compliance will be investigated as part of the OD and workforce review once the onboarding of the new Associate Director of HR is complete	Associate Director of HR	Sep-19

IPR Narrative report - 2019/20 as at Month 1 (April)		
Service Delivery	Integrated Urgent Care	● OOH: Good performance throughout April. Activity levels increased slightly due to 4 day bank holiday period. Interim Head of Service in place and focusing on NQR improvement.
		● OOH: Overall rota fill rates have improved. Agency GP hours continue to decrease whilst ANP cover remains stable. Further work to be completed to maximise availability of ANPs.
		● Extended Access: Liverpool – Slight increase in service utilisation, ongoing engagement with the practices to encourage use of the service. St Helens – Slight decrease in service utilisation, review of locations is currently taking place with the CCG to improve service utilisation. Knowsley – Strong performance through April, on-going discussions with CCG in relation to outstanding IT issues.
	Primary and Community Services	● Asylum practice: Decrease in activity throughout April which is consistent for this time of year. Annual CQC call took place during April, feedback has been received; they are satisfied with arrangements in place and improvements made since inspection.
		● Sefton GP practices: Increase in the number of salaried GPs in post, with a further 3 GPs to join the team throughout May/June. 6/7 Practices now have an appointed salaried GP which supports service consistency across the practices. A number of functions have now been centralised which allows closer management oversight particularly relating to finances.
		● Sefton GP practices: The Sefton Implementation Group continues to meet on a fortnightly basis. The programme plan remains on track for delivery. Project dashboard is currently being developed which will provide 'at a glance' updates on all projects.
Finance		● As has been practice in previous financial years, there will not be a month 1 position reported.
Quality		● At the end of April 2019 there were 6 open complaints in Datix ● There were 3 compliments received in March 2019 and 3 compliments received in April 2019
Workforce		● The review of Terms and Conditions is to be scoped out by July 2019 and a Project Plan put in place for full review.
		● A People Strategy will be developed during 2019/2020 with a full engagement process with staff.

Appendices

App 1 OOH reporting template

National and Local Quality Requirements reporting template

Reporting time period: Monday 01/04/19 18:30 to Wednesday 01/05/19 07:59 Halton, Knowsley & Liverpool CCGs

Ref	NQR / LQR	Target description	Total volume	Compliant	Patient choice	Non-compliant	% compliance
1	NQR 2	Case details sent by 8am	6800	6755	2	43	99.4%
2	NQR 8	<0.1% calls engaged	2222	2222		0	0.0%
3	NQR 8	<5% calls abandoned after 30 seconds	2222	2200		22	1.0%
4	NQR 8	Calls answered <60 seconds	2134	2017		117	94.5%
5	NQR 9	Cases passed to 999 <3 minutes (Target =100%)	0	0	0	0	
6	NQR 9	Urgent cases DCA <20 minutes	1216	1078	75	63	94.8%
7	NQR 9	All other cases DCA <60 minutes	3809	3072	260	477	87.5%
8	LQR 1	NHS 111 6 hour priority <6 hours	1218	1116	47	55	95.5%
9	LQR 2	Repeat prescription requests <6 hours	32	29	1	2	93.8%
a		*Total cases received requiring assessment (5)+(6)+(7)+(8)+(9)*	*6275*				
b		*Total cases requiring action (6)+(7)+(8)+(9)*	*6275*				
		Following priority determined by Definitive Clinical Assessment (DCA)					
10	NQR 12	UCC Emergency <1 hour	0	0	0	0	
11	NQR 12	UCC Urgent <2 hours	412	392	8	12	97.1%
12	NQR 12	UCC Less urgent <6 hours	1587	1581	1	5	99.7%
c	*Total*	*Urgent Care Centre cases*	*1999*	*1973*	*9*	*17*	*99.1%*
13	LQR 3	Telephone Advice Emergency <1 hour	26	25	0	1	96.2%
14	LQR 3	Telephone Advice Urgent <2 hours	422	394	19	9	97.9%
15	LQR 3	Telephone Advice Less Urgent <6 hours	3510	3335	116	59	98.3%
d	*Total*	*Telephone Advice cases*	*3958*	*3754*	*135*	*69*	*98.3%*
16	NQR 12	Home visit Emergency <1 hour	1	1	0	0	100.0%
17	NQR 12	Home visit Urgent <2 hours	263	244	0	19	92.8%
18	NQR 12	Home visit Less urgent <6 hours	546	513	0	33	94.0%
e	*Total*	*Home Visit cases*	*810*	*758*	*0*	*52*	*93.6%*
f		*Total telephone and face-to-face consultations (c)+(d)+(e)*	*6767*	*6485*	*144*	*138*	

Information section

No Definitive Clinical Assessment (DCA)

19	Cases not requiring DCA; triaged by other clinician	327
20	Patient episode continued, service provided	196
21	Patient episode ended, no service provided	2

Repeat prescription cases outcomes

22	Repeat prescription requests (6 hour advice)	31
23	Repeat prescription requests forwarded to UCC	1
24	Repeat prescription requests forwarded for visit	0

Final case-type totals

25	*Total Ambulance cases*	*0*
26	*Total Telephone Advice cases*	*3958*
27	*Total UCC attendances*	*1999*
28	*Total Home Visits*	*810*
29	*Total Repeat prescription requests*	*31*
g	*Total cases completed (=a+19+20+21)*	**6800**

Referrals to secondary care

30	Hospital referred (referred for admission / advised A&E)	615

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	0	0	0	
Runcorn	0	0	0	
The Royal	0	0	0	
Widnes	0	0	0	
Total	**0**	**0**	**0**	
Urgent	**2 hour total**	**Pat. choice**	**Compliant**	**% result**
Aintree	24	0	24	100.0%
Garston	64	2	58	93.8%
Huyton	41	0	40	97.6%
Kirkby	3	0	3	100.0%
Old Swan	139	1	132	95.7%
Runcorn	99	2	97	100.0%
The Royal	15	3	12	100.0%
Widnes	27	0	26	96.3%
Total	**412**	**8**	**392**	**97.1%**
Less urgent	**6 hour total**	**Pat. choice**	**Compliant**	**% result**
Aintree	147	0	146	99.3%
Garston	236	0	236	100.0%
Huyton	159	0	158	99.4%
Kirkby	32	0	32	100.0%
Old Swan	584	1	580	99.5%
Runcorn	251	0	251	100.0%
The Royal	93	0	93	100.0%
Widnes	85	0	85	100.0%
Total	**1587**	**1**	**1581**	**99.7%**
Grand total	**1999**	**9**	**1973**	

Template property of Liverpool CCG

Source: Adastra/Business Intelligence Team

Author: Performance Improvement Analyst (DF)

App 2 Alder Hey 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)
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%
Nov-18	930	207	723	513	210	71.0%	2.84	25	4.9%	0	77.7%
Dec-18	966	325	641	349	292	54.4%	2.28	23	6.6%	0	66.4%
Jan-19	961	280	681	439	242	64.5%	2.70	14	3.2%	0	70.9%
Feb-19	868	258	610	391	219	64.1%	2.70	22	5.6%	0	70.3%
Mar-19	1089	465	624	399	225	63.9%	2.63	26	6.5%	0	57.3%
Apr-19	930	233	697	334	363	47.9%	2.02	27	8.1%	0	74.9%

Month	Average consultation length (minutes) per month
May-18	15:48
Jun-18	14:43
Jul-18	15:16
Aug-18	14:14
Sep-18	15:00
Oct-18	16:09
Nov-18	14:01
Dec-18	15:34
Jan-19	14:42
Feb-19	16:26
Mar-19	16:25
Apr-19	19:07

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)
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%
Nov-18	1116	94	1022	339	683	33.2%	1.10	75	22.1%	0	91.6%
Dec-18	1086	118	968	340	628	35.1%	1.09	55	16.2%	0	89.1%
Jan-19	1140	70	1070	403	667	37.7%	1.24	80	19.9%	0	93.9%
Feb-19	1032	121	911	358	553	39.3%	1.29	47	13.1%	0	88.3%
Mar-19	1122	36	1086	436	650	40.1%	1.30	59	13.5%	0	96.8%
Apr-19	1080	134	946	324	622	34.2%	1.14	42	13.0%	0	87.6%

Month	Average consultation length (minutes) per month
May-18	17:35
Jun-18	18:56
Jul-18	16:54
Aug-18	16:43
Sep-18	21:23
Oct-18	16:27
Nov-18	16:45
Dec-18	16:27
Jan-19	16:02
Feb-19	16:58
Mar-19	17:49
Apr-19	17:50

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)
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%
Nov-18	824	74	750	398	352	53.1%	1.75	37	9.3%	0	91.0%
Dec-18	852	161	691	389	302	56.3%	1.80	47	12.1%	0	81.1%
Jan-19	904	140	764	439	325	57.5%	1.85	43	9.8%	0	84.5%
Feb-19	776	67	709	390	319	55.0%	1.85	28	7.2%	0	91.4%
Mar-19	836	117	719	449	270	62.4%	2.04	34	7.6%	0	86.0%
Apr-19	848	140	708	390	318	55.1%	1.80	30	7.7%	0	83.5%

Month	Average consultation length (minutes) per month
May-18	20:43
Jun-18	19:37
Jul-18	18:59
Aug-18	19:23
Sep-18	17:57
Oct-18	20:05
Nov-18	17:38
Dec-18	18:17
Jan-19	18:42
Feb-19	18:24
Mar-19	19:27
Apr-19	19:34

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

App 5 Knowsley PCS

Key Performance Indicators (monthly) – April 2019 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	15	14		93.3% (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		3			
	6	Number of post event messages sent from Adastra within 24 hours	100%	235	235	0	100.0%
Triage	7a	Number of cases triaged via Pathfinder referral in 20 minutes (Halton & Knowsley)	95%	52	47	0	90.4%
	7b	Number of cases triaged via CAS referrals in 20 minutes (Halton & Knowsley)	95%	35	32	1	94.3%
	7c	Number of cases triaged via CAS referral in 60 minutes (Halton & Knowsley)	95%	9	9	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%	1	1	0	100.0%
	8c	Number of patients visited within 6 hours of triage end (Pathfinder & CAS referrals) (Halton & Knowsley)	95%	11	11	0	100.0%
	8d	Number of patients visited within 6 hours of request by surgery (Knowsley surgeries)	95%	139	139	0	100.0%
Appointments	9a	Number of patients seen on day of scheduled appointment (Knowsley surgeries) on weekdays	95%	1261	1101	160	100.0%
	9b	Number of patients seen on day of scheduled appointment (Knowsley surgeries) on weekends	95%	153	112	41	100.0%
	9c	Number of patients seen on day of scheduled appointment (Walk-in Centres (all CCGs), Pathfinder & CAS – Halton & Knowsley)	95%	25	25	0	100.0%
	10a	Number of patients seen within 30 minutes of scheduled appointment time (Knowsley surgeries) on weekdays	95%	1101	1078	10	98.8%
	10b	Number of patients seen within 30 minutes of scheduled appointment time (Knowsley surgeries) on weekends	95%	112	109	2	99.1%
	10c	Number of patients seen within 30 minutes of scheduled appointment time (Walk-in Centres)	95%	0	0	0	
	10d	Number of patients seen within 30 minutes of scheduled appointment time (Pathfinder referrals – Halton & Knowsley)	95%	8	8	0	100.0%
	10e	Number of patients seen within 30 minutes of scheduled appointment time (CAS referrals – Halton & Knowsley)	95%	17	17	0	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%	13	12	0	92.3%

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
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	163	163	0	
November 2018 – Knowsley GP Standby	38	35	3	
				98.5%
December 2018 – Knowsley GP	167.5	163.5	4	
December 2018 – Knowsley GP Standby	27	25.5	1.5	
				97.2%
January 2019 – Knowsley GP	192	172	20	
January 2019 – Knowsley GP Standby	30.5	30.5	0	
				91.0%
February 2019 – Knowsley GP	140	140	0	
February 2019 – Knowsley GP Standby	40	40	0	
				100.0%
March 2019 – Knowsley GP	159.5	159.5	0	
March 2019 – Knowsley GP Standby	28.5	27.5	1	
				99.5%
April 2019 – Knowsley GP	173	173	0	
April 2019 – Knowsley GP Standby	26	25	1	
				99.5%
May 2019 – Knowsley GP	170	170	0	
May 2019 – Knowsley GP Standby	37	37	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	Clinical rota shift fulfilment
Oct-18	3850	1650	153	42.9%	9.3%	77%
Nov-18	4298	2491	210	58.0%	8.4%	86%
Dec-18	3719	2699	199	72.6%	7.4%	82%
Jan-19	3951	3063	273	77.5%	8.9%	76%
Feb-19	4145	3139	285	75.7%	9.1%	92%
Mar-19	5416	3484	285	64.3%	8.2%	80%
Apr-19	4555	3198	245	70.2%	7.7%	94%

St Helens Extended Access						
Month	Appts available	Appts booked	Appts DNA'd	% of appts booked	% of appts DNA'd	Clinical rota shift fulfilment
Oct-18	641	208	13	32.4%	6.3%	87%
Nov-18	807	352	32	43.6%	9.1%	75%
Dec-18	810	553	73	68.3%	13.2%	50%
Jan-19	1064	833	108	78.3%	13.0%	78%
Feb-19	1064	807	121	75.8%	15.0%	70%
Mar-19	1258	916	129	72.8%	14.1%	78%
Apr-19	1144	745	107	65.1%	14.4%	71%

Source: RotaMaster / EMIS / Adastra

Author: Business Intelligence Lead / Service Delivery Administrator (LF)

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)
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	53	341	231	52	533
Nov 18	506	159	73	451	345	67	531
Dec 18	421	108	49	386	144	30	444
Jan 19	426	197	*Not reported*	367	227	47	494
Feb 19	500	265	*Not reported*	316	290	45	452
Mar 19	404	161	*Not reported*	372	250	33	482
Apr 19	333	184	*Not reported*	338	206	47	358

Source: PC24 Asylum practice Practice Manager / EMIS

Author: Business Intelligence Lead/Primary Care Administrator

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?"				
	Feb-19	Mar-19	Apr-19	May-19 MTD (to 16th)
Extremely Likely	60.7%	69.3%	67.9%	70.7%
Likely	25.1%	17.1%	21.4%	17.9%
Neither Likely or Unlikely	3.9%	5.3%	3.1%	3.9%
Unlikely	3.9%	2.1%	2.8%	3.1%
Extremely Unlikely	5.0%	4.9%	3.4%	2.6%
Don't know	1.4%	1.2%	1.3%	1.7%

Source: Synapta / Knowsley PCS paper surveys
Author: Business Intelligence Lead / Knowsley PCS Service Manager

Compliments

SDU/Dept/Area	Primary & Community Services			Out Of Hours (incl Alder Hey)	Internal
	Asylum	Daytime Services (incl EAS)	GP Practices		
Mar-19	0	1	2	0	0
Apr-19	0	2	1	0	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		
Mar-19	7	20	10	31	6
Apr-19	12	33	5	44	1

Source: Datix
Author: Governance Administrator (SD)

Complaints not resolved within 25 days

During the month of March 2019 there were 7 complaints that were not closed within the 25 working day timeframe.
During the month of April 2019 there were 5 complaints that were not closed within the 25 working day timeframe.

Source: Datix
Author: Governance Administrator (SD)

Safeguarding reports

Total number of incidents reported during March 2019 was 74; of these, 6 were reported as safeguarding incidents and of the 6 incidents reported, 1 was reported to safeguarding.
Total number of incidents reported during April 19 was 95; of these, 15 were reported as safeguarding incidents and of the 15 incidents reported, 6 were reported to safeguarding.

Source: Datix
Author: Governance Administrator (SD)

App 13 Complaints received

Date Received	Service	Description	Action Taken	Commissioner	Grade	Outcome	Closed
27.03.19	Primary Care Services Litherland Practice	Delay in treatment	Under Review	NHS England	Not graded	Under Review	Ongoing
25.03.19	Out of Hours Operations	Clinical Care	Under Review	Liverpool	Low	Under Review	Ongoing
22.03.19	Primary Care Services Netherton Practice	Clinical Care	Under Review	NHS England	Not graded	Under Review	Ongoing
19.03.19	Primary Care Services Netherton Practice	Care & Treatment and Attitude and Behaviour	Under Review	NHS England	Low	Under Review	Ongoing
18.03.19	Primary Care Streaming - AHCH	Care & Treatment and Attitude and Behaviour	Under Review	Liverpool	Low	Under Review	Ongoing
12.03.19	Out of Hours Operations	Care & Treatment	Reviewed	Liverpool	Low	Upheld	Closed
07.03.19	Primary Care Service Litherland Practice	Care & Treatment	Under Review	NHS England	Not graded	Under Review	Ongoing
01.03.19	Liverpool EAS	Care & Treatment	Reviewed	Liverpool	Low	Not Upheld	Closed
26.04.19	Primary & Community Services, Thornton Practice	Health Records	Under Review	NHS England	Not graded	Under Review	Ongoing
22.04.19	Integrated Urgent Care, OOH Clinician	Attitude and Behaviour	Under Review	Liverpool CCG	Mod	Under Review	Ongoing
04.04.19	Integrated Urgent Care, Liverpool Extended Access Service	IG Breach – LEAS case report	Closed	Liverpool CCG	Mod	Upheld	Closed
04.04.19	Integrated Urgent Care, OOH Clinician	Clinical Treatment	Under Review	Liverpool CCG	Not Graded	Under Review	Ongoing
25.04.19	Integrated Urgent Care, PCS RLUH	Clinical Treatment	Under Review	Liverpool CCG	Not Graded	Under Review	Ongoing
25.04.19	Integrated Urgent Care, Garston UCC	Attitude and Behaviour	Under Review	Liverpool CCG	Low	Partially Upheld	Ongoing
30.04.19	Integrated Urgent Care, Runcorn UCC	Attitude and Behaviour	Under Review	Halton CCG	Not Graded	Under Review	Ongoing
25.04.19	Primary & Community Services, Netherton Practice	Attitude and Behaviour	Under Review	NHS England	Mod	Under Review	Ongoing

Source: Datix
Author: Governance Administrator (SD)

App 14 Workforce

Staff Turnover

UC24	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19
Start of Month Staff Numbers	240	242	241	237	240	239	243	241	198	203	209	213
Starters	5	2	3	4	3	7	4	2	7	9	8	7
Leavers	3	3	7	1	4	3	6	0	2	3	4	1
TUPE												
Staff in probation period	27	24	25	23	19	24	27	23	27	32	37	37
Staff due to receive appraisal	213	218	216	214	221	215	214	220	171	177	176	182
End of Month Staff Numbers	242	241	237	240	239	243	241	243	203	209	213	219
Turnover Rate	1.24%	1.24%	2.93%	0.42%	1.67%	1.24%	2.48%	0.00%	1.00%	1.46%	1.90%	0.46%
Annualised rate	14.9%	14.9%	35.1%	5.0%	20.0%	14.9%	29.8%	0.0%	12.0%	17.5%	22.7%	5.6%
Rolling Annualised rate	21.8%	21.2%	20.0%	16.6%	15.2%	16.0%	17.2%	15.5%	14.8%	15.4%	16.4%	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	8	56	69	69	72	73	76	76	48	84	88	0
Total staff requiring appraisal	213	218	216	214	213	215	214	220	150	177	176	182
	3.8%	25.7%	31.9%	32.2%	33.8%	34.0%	35.5%	34.5%	32.0%	47.5%	50.0%	0.0%

Source: Rotamaster
Author: HR Manager

Mandatory training compliance

New method in use

Courses due to be completed by end of working month	1680	1694	1687	1659	1680	1673	1701	*Not supplied*	*Not supplied*	*Not supplied*	*Not supplied*	2111
Courses completed by end of working month	1465	1470	1480	1432	1473	1488	1500	*Not supplied*	*Not supplied*	*Not supplied*	*Not supplied*	1778
	87.2%	86.8%	87.7%	86.3%	87.7%	88.9%	88.2%	*Not supplied*	*Not supplied*	*Not supplied*	*Not supplied*	84.2%

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

Service Delivery	App. ref	Target	YTD (from Apr)	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	Trend	May-19 Forecast	Exception Report Number
Sefton GP practices - cover of Clinical Sessions (GPs & ANPs)	2.1	100%	93.2%	96.8%	93.0%	93.4%	95.0%	98.9%	95.0%	106.2%	93.3%	101.3%	89.9%	94.9%	93.2%		93%	PCS001
Sefton GP practices - Salaried/Associate cover of clinical sessions (GPs & ANPs)	2.1	70%	49.6%	42.3%	39.4%	26.2%	21.4%	28.7%	25.5%	38.6%	35.0%	32.8%	35.1%	35.8%	49.6%		40%	PCS002
Sefton GP practices - Agency Cover (GP & ANP) cover of clinical sessions	2.1	30%	50.4%	58.7%	60.6%	67.2%	73.6%	70.3%	69.5%	67.7%	65.0%	67.2%	54.9%	64.2%	50.4%		56%	PCS002
Sefton GP practices - appointment utilisation	2.2	>90%	83.6%	83.2%	78.7%	79.2%	82.1%	83.2%	85.3%	86.2%	84.3%	87.1%	88.5%	88.5%	83.6%		87%	PCS003
Sefton GP practices - appointment DNA rate	2.2	<5%	6.9%	5.6%	5.2%	6.4%	5.1%	4.5%	5.1%	5.6%	6.3%	5.9%	5.1%	5.5%	6.9%		6%	PCS003

Exception reference	Description	Commentary	Owner	Timescale to resolve (if applicable)
PCS001	Sefton GP Practices - % cover of clinical sessions	The number of sessions covered by salaried GPs continues to increase with a further 3 GPs joining the team throughout May/June. Clinical Pharmacist currently in training support the decrease of locum cover.	Head of Service	June 2019
PCS002	Sefton GP Practices - % of salaried vs agency cover	See PCS001	Head of Service	June 2019
PCS003	Sefton GP Practices appointment utilisation and 'did not attend' rate	Appointment utilisation decreased throughout April, consistent feedback indicates reduction in demand. DNA rates remain high across the practices, Practice Managers are working with the teams to understand the main reason.	Primary Care Service Manager	June 2019

App 2.1 **Sefton GP practices**

Salaried v Agency clinicians utilisation

Practice	Weekly Contracted Clinical Sessions - (Based on Surgery Size)	Contracted March sessions	Actual Salaried/ Associate GP sessions	Actual GP Agency Sessions	Actual Salaried ANP sessions	Actual Agency ANP sessions	Total actual sessions	Salaried GP utilisation of clinical sessions (compared to actual)	Agency GP utilisation of clinical sessions (compared to actual)	Salaried ANP utilisation of clinical sessions (compared to actual)	Agency ANP utilisation of clinical sessions (compared to actual)	Total Coverage (actual compared to planned)	Total salaried cover (GPs & ANPs) (compared to actual)	Total Agency cover (GPs & ANPs) (compared to actual)	Comments
Crosby	14 sessions	60	20	28	0	4	52	38%	54%	0%	8%	87%	38%	62%	
Maghull	15 sessions	64	0	50	0	14	64	0%	78%	0%	22%	100%	0%	100%	
Crossways	13 sessions	54	21	24	0	0	45	47%	53%	0%	0%	83%	47%	53%	
Litherland	14 sessions	64	49	6	0	9	64	77%	9%	0%	14%	100%	77%	23%	
Seaforth	10 sessions	42	31	10	0	0	41	76%	24%	0%	0%	98%	76%	24%	
Thornton	13 sessions	55	0	44	0	9	53	0%	83%	0%	17%	96%	0%	100%	
Netherton	12 sessions	52	12	38	0	2	52	23%	73%	0%	4%	100%	23%	77%	
Totals		**391**	**133**	**200**	**0**	**38**	**371**	**35.8%**	**53.9%**	**0.0%**	**10.2%**	**94.9%**	**35.8%**	**64.2%**	

Practice	Weekly Contracted Clinical Sessions - (Based on Surgery Size)	Contracted April sessions	Actual Salaried/ Associate GP sessions	Actual GP Agency Sessions	Actual Salaried ANP sessions	Actual Agency ANP sessions	Total actual sessions	Salaried GP utilisation of clinical sessions (compared to actual)	Agency GP utilisation of clinical sessions (compared to actual)	Salaried ANP utilisation of clinical sessions (compared to actual)	Agency ANP utilisation of clinical sessions (compared to actual)	Total Coverage (actual compared to planned)	Total salaried cover (GPs & ANPs) (compared to actual)	Total Agency cover (GPs & ANPs) (compared to actual)	Comments
Crosby	14 sessions	54	25	18	0	8	51	49%	35%	0%	16%	94%	49%	51%	
Maghull	15 sessions	61	0	46	0	10	56	0%	82%	0%	18%	92%	0%	100%	
Crossways	13 sessions	48	25	12	0	6	43	58%	28%	0%	14%	90%	58%	42%	
Litherland	14 sessions	66	43	2	0	18	63	68%	3%	0%	29%	95%	68%	32%	
Seaforth	10 sessions	40	16	21	0	0	37	43%	57%	0%	0%	93%	43%	57%	
Thornton	13 sessions	51	42	0	0	4	46	91%	0%	0%	9%	90%	91%	9%	
Netherton	12 sessions	50	20	27	0	2	49	41%	55%	0%	4%	98%	41%	59%	
Totals		**370**	**171**	**126**	**0**	**48**	**345**	**49.6%**	**36.5%**	**0.0%**	**13.9%**	**93.2%**	**49.6%**	**50.4%**	

Source: Sefton practices Practice Managers

Author: Primary Care Administrator

App 2.2 Sefton GP practices

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%

Nov-18	Available Appointments	Appointments Booked	DNAs	Appointments Attended	% of available appointments booked	% DNA	Overall Utilisation
Thornton	1044	978	76	902	93.7%	7.8%	86.4%
Maghull	1199	1141	30	1111	95.2%	2.6%	92.7%
Crossways	884	746	19	727	84.4%	2.5%	82.2%
Crosby	977	866	43	831	88.6%	5.0%	85.1%
Netherton	1015	888	51	835	87.5%	5.7%	82.3%
Seaforth	881	857	94	763	97.3%	11.0%	86.6%
Litherland	1209	1102	55	1047	91.1%	5.0%	86.6%
Totals	7209	6578	368	6216	91.2%	5.6%	86.2%

Dec-18	Available Appointments	Appointments Booked	DNAs	Appointments Attended	% of available appointments booked	% DNA	Overall Utilisation
Thornton	894	821	67	754	91.8%	8.2%	84.3%
Maghull	940	898	24	874	95.5%	2.7%	93.0%
Crossways	720	612	8	604	85.0%	1.3%	83.9%
Crosby	982	882	53	829	89.8%	6.0%	84.4%
Netherton	790	709	43	666	89.7%	6.1%	84.3%
Seaforth	777	693	80	613	89.2%	11.5%	78.9%
Litherland	1066	931	72	859	87.3%	7.7%	80.6%
Totals	6169	5546	347	5199	89.9%	6.3%	84.3%

Jan-19	Available Appointments	Appointments Booked	DNAs	Appointments Attended	% of available appointments booked	% DNA	Overall Utilisation
Thornton	1446	1365	125	1240	94.4%	9.2%	85.8%
Maghull	1334	1241	45	1198	93.0%	3.6%	89.8%
Crossways	1042	914	20	894	87.7%	2.2%	85.8%
Crosby	1033	998	59	939	96.6%	5.9%	90.9%
Netherton	1138	1006	68	938	88.4%	6.8%	82.4%
Seaforth	867	826	58	768	95.3%	7.0%	88.6%
Litherland	1485	1372	78	1294	92.4%	5.7%	87.1%
Totals	8345	7722	453	7271	92.5%	5.9%	87.1%

figures for Seaforth amended !

Feb-19	Available Appointments	Appointments Booked	DNAs	Appointments Attended	% of available appointments booked	% DNA	Overall Utilisation
Thornton	1082	1046	49	997	96.7%	4.7%	92.1%
Maghull	1156	1087	30	1057	94.0%	2.8%	91.4%
Crossways	914	776	24	752	84.9%	3.1%	82.3%
Crosby	896	840	42	798	93.8%	5.0%	89.1%
Netherton	1047	973	79	894	92.9%	8.1%	85.4%
Seaforth	727	701	65	636	96.4%	9.3%	87.5%
Litherland	1212	1162	71	1091	95.9%	6.1%	90.0%
Totals	7034	6585	360	6225	93.6%	5.5%	88.5%

Mar-19	Available Appointments	Appointments Booked	DNAs	Appointments Attended	% of available appointments booked	% DNA	Overall Utilisation
Thornton	1082	1046	49	997	96.7%	4.7%	92.1%
Maghull	1156	1087	30	1057	94.0%	2.8%	91.4%
Crossways	914	776	24	752	84.9%	3.1%	82.3%
Crosby	896	840	42	798	93.8%	5.0%	89.1%
Netherton	1047	973	79	894	92.9%	8.1%	85.4%
Seaforth	727	701	65	636	96.4%	9.3%	87.5%
Litherland	1212	1162	71	1091	95.9%	6.1%	90.0%
Totals	7034	6585	360	6225	93.6%	5.5%	88.5%

Apr-19	Available Appointments	Appointments Booked	DNAs	Appointments Attended	% of available appointments booked	% DNA	Overall Utilisation
Thornton	882	844	78	766	95.7%	9.2%	86.8%
Maghull	943	913	27	886	96.8%	3.0%	94.0%
Crossways	861	701	21	680	81.4%	3.0%	79.0%
Crosby	993	928	46	882	93.5%	5.0%	88.8%
Netherton	994	908	60	848	91.3%	6.6%	85.3%
Seaforth	979	865	113	752	88.4%	13.1%	76.8%
Litherland	1340	1119	87	1032	83.5%	7.8%	77.0%
Totals	6992	6278	432	5846	89.8%	6.9%	83.6%

Source: Sefton practices Practice Managers
Author: Primary Care Administrator

Title:	Meeting Date:	Agenda item no:
Board Assurance Framework	30 May 2019	9.1
Prepared and presented by: Paul Kavanagh Fields	**Discussed by:** Leadership Team	
Link to PC24 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: • Approve the Board Assurance Framework	

		Assessment of preparedness		
Board assurance arrangements preparedness		1	2	3
1.	The organisations strategic plan objectives are clearly defined and understood?			
2.	The organisation has a clearly defined approach to the management of risk?			
3.	The organisation's approach to the management of risk ensures the focus is on those risks that will have a material impact on the achievement of its objectives?			
4.	The organisation has a clear understanding of risk mitigation, including existing controls and planned actions?			
5.	The organisation has clearly established risk management reporting and monitoring?			
6.	There is commitment to the development of board assurance arrangements from the top of the organisation and this is shared throughout?			
7	The organisation has established a board assurance policy and plan that is integrated with its risk management and other management arrangements?			
8.	There is a clearly defined structure within the organisation that will support the development, establishment and embedding of the board assurance arrangements?			
9.	The organisation has clearly defined roles and specified responsibilities in connection with the application and operation of the board assurance arrangements?			
10.	The board assurance BAF monitoring and review arrangements have been defined for the purposes of ensuring the right information gets to the right place and people to aid risk management and assurance decision-making?			
11.	The board assurance framework BAF produces useful information?			
12.	The organisation has mechanisms in place to ensure communication of outcomes from the risk management and board assurance framework BAF to inform the organisation of issues arising?			
13.	The board is clear about its roles and responsibilities and feels that these are discharged effectively?			
14.	At least annually the board undertakes a review of its own effectiveness and this is used to inform a board improvement/ development plan?			

Title:	Meeting Date:	Agenda item no:
Policies for approval	30 May 2019	10.1
Prepared and presented by: Margaret Swinson	**Discussed by:** Quality & Workforce	
Link to PC24 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: • Approve the Overpayments, Controlled Drugs and Non-Medical Prescribing policies.	

1.0 Purpose:

1.1 The purpose of this report is to present the Overpayments, Controlled Drugs and Non-Medical Prescribing policies for approval. The policies have been subject to consultation and were recommended for approval by the Finance & Performance Committee (Overpayments Policy) and Quality & Workforce Committee (Controlled Drugs and Non-Medical Prescribing policies).

1.2 The Board is advised that, since the Overpayments Policy was developed and reviewed, it has come to light that there are legal restrictions on the collection of unpaid National Insurance Contributions from employees. Approval of this policy is sought on the basis that an amendment will be introduced to reflect this particular legal position.

2.0 Recommendations:

The meeting is invited to:

- Approve the Overpayments, Controlled Drugs and Non-Medical Prescribing policies.

Recovery of Overpayments Policy

Version	V1
Supersedes:	
Date Ratified by Board:	
Reference Number:	
Title & Department of originator:	Associate Director of HR & OD, HR Department
Title of responsible committee/department:	Finance & Performance Committee
Effective Date:	
Next Review date:	1 year
Target audience:	All Staff
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
Employment Rights Act 1996 Equality Act 2010 Safeguarding Vulnerable Groups Act, 2006 Data Protection Act 2018 Working Time Regulations 1998 Disciplinary and Grievance Procedures, Code of Practice, ACAS, 2009 Disciplinary and Grievances at Work, The ACAS Guide, ACAS, 2011 Code of Conduct for NHS Manager, DH, 2002	Primary Care 24 Intranet	Policy File, Wavertree Headquarters

Consultation: Executive Team MIAA Counter Fraud Team	**Date**
This document sets out the policy by which all overpayments in the organisation are managed.	

CONTENTS Page

1. PURPOSE

i. PC24 has many procedures, systems and controls in place to ensure that employees are paid correctly at all times. However, on occasions it is accepted that unfortunately errors will occur as no system is perfect and no employee infallible.

ii. Should an overpayment occur then once it has been identified, it will be recorded, the circumstances investigated, and immediate action taken to minimise or prevent the situation occurring again in the future and the recovery process will be actioned.

iii. PC24 will continuously keep its procedures, systems and controls under review to ensure they are rigorous and that the likelihood an overpayment will occur is avoided.

iv. This document should be read in conjunction with the following policies:

- Grievance Policy (PC24POL15)
- Disciplinary Policy (PC24POL14)
- Standing Financial Instructions (PC24SFI)
- Anti-Fraud, Anti-Bribery and Anti-Corruption Policy (PC24POL101)

2.0 SCOPE OF THE POLICY

i. This policy applies to all salaried employees of Primary Care 24.

ii. An overpayment of salary to an employee or ex-employee normally arises as the result of either an “error of calculation”, which results in a payment being made in error, or as the result of incorrect, insufficient or late notification of a change to the individual’s circumstances or contract of employment.

iii. The aim of the policy is to standardise the process that will be followed to ensure the consistent management of a salary overpayment, made to either an existing employee or ex-employee of PC24.

iv. Recovery of an overpayment is allowed in law, provided the employee was not led to believe that they were entitled to the payment.

v. The law which govern these arrangements is the Employment Rights Act 1996 and specifically Section 13 which prevents an employer making an unlawful deduction from pay. The main purpose for this legislation is to stop an employer imposing fines on employees or simply deciding to take money off an employee with no just cause. An important exception to Section 13 is the ability to recover overpayments.

The law recognises that when a mistake is made then the employer has a right to recover the monies paid in error provided they have acted reasonably.

3.0 RESPONSIBILITIES

3.1 Director of Finance and Associate Director of Human Resources and OD

i. The Director of Finance is responsible for ensuring that an appropriate Policy and Procedure is in place to deal with overpayments of Salary.

ii. The ADHR is also responsible for ensuring that managers are supported in the implementation of the policy and procedure and that it is reviewed and monitored regularly.

3.2 Line Managers

i. It is the responsibility of managers to ensure that notification of appointments/leavers, amendments of contracts, mileage claims, allowances, overtime etc. are completed correctly, properly authorised and submitted on time and entered into Rota Master in good time for the change to be made by the appropriate date.

ii. They are also responsible for ensuring their staff are fully aware of this procedure and that it is the employee's responsibility to report any inaccuracies in their pay as soon as they become aware of it.

3.3 Human Resources / Payroll and Finance

i. HR, Payroll and Finance are responsible for ensuring due process is followed and that all claims are in line with PC24 procedures and the employees' terms and conditions of employment.

ii. They are responsible for investigating the circumstances surrounding any errors which occur and for minimising and preventing similar errors occurring again in the future. They are also responsible for ensuring appropriate action is taken for the reporting and recovery of any overpayments in accordance with the appropriate Financial Governance arrangements.

3.4 All Staff

i. Employees should regularly check their payslips and make their Line Managers aware of any incorrect payments as soon as they become aware of them. Where employees do not understand their payslip, they should contact the Human Resources department in the first instance.

ii. If an employee fails to report the overpayment which then continues over a period of time and it is later discovered that the employee dishonestly failed to report the overpayment knowingly, the matter will be immediately escalated to the Director of Finance for risk assessment and potential further investigation through the organisation's disciplinary and/or counter fraud processes.

4.0 RECOVERY OF OVERPAYMENTS OF SALARY/ALLOWANCES AND EXPENSES PROCEDURE

i. The following procedure will be followed in circumstances where an overpayment has been made to an employee's salary, any allowance that may have been claimed or expenses, such as travel or subsistence. This list is not intended to be exhaustive.

ii. Employees are paid on the 25th of every month (or the earlier if the 25th falls on a weekend or bank holiday).

iii. If the overpayment is discovered in the month it is paid, arrangements will be made to recover the overpayment in full the following month on the basis that the employee knows of the overpayment and should not have spent it within that time.

iv. Where the overpayment is discovered in a subsequent month (i.e. other than the month in which it occurred), repayment will normally be made over a longer period of no more than 3 months.

v. Overpayments will normally be deducted from the employee's salary although they may alternatively request to pay by cheque.

vi. In circumstances where the recovery of the overpayment at the proposed rate

would cause financial hardship, HR / Finance will consider the circumstances of the case on an individual basis and consideration will be given to extending the repayment period. This may involve requests for income and expenditure information.

vii. In all cases the employee will be contacted by telephone in the first instance (wherever this is practical and possible) by their line manager who will explain the reason for the overpayment and the period over which repayment will be made in accordance with the legal provisions set out in section 2 (v) above. In all instances the employee will be provided with a written breakdown of the overpayment together with the reasons and the agreed period over which the overpayment will be recovered. The Manager will also inform HR and Finance.

viii. Where the Line Manager has tried to contact an employee or have not received any response or agreement to their requests to recover the monies then the Line Manager will ask to arrange a meeting with the employee. If this too proves unsuccessful, then the employee will be notified that the monies will be recovered without their explicit consent.

ix. If the employee leaves, then any overpayment will be recovered from their final salary. Where the final salary is insufficient to recover the overpayment then arrangements will be made with the individual to recover the balance. If the individual fails to repay the outstanding balance the matter may be referred to a debt recovery agency who will pursue recovery on behalf of PC24. In certain situations PC24 may consider civil action to recovery monies owed to it.

x. Where an overpayment is discovered after an employee has left PC24, Finance will write requesting the overpayment is made in full by cheque. Where an ex-employee contacts the HR/Finance Team to discuss arrangements for the repayment of the debt by instalments, the basis of repayment will be agreed on

a “reasonableness” basis. Payment can be arranged via a standing order. In the event the individual fails to respond or make the necessary repayments, the matter may be referred a debt recovery agency who will pursue recovery on behalf of PC24.

5.0 UNDERPAYMENTS

i. If a member of staff believes that they have been underpaid they should discuss this with their Line Manager in the first instance. If a discussion is then required with Payroll the employee should contact Human Resources department on 0151 254 2553, option 2.

ii. Once an underpayment is identified this would normally be rectified in the following month. If it is the fault of the organisation a special payment can be arranged under special circumstances.

iii. Underpayments caused by late or incorrect submission of information by Line Managers will be rectified the following month, unless a request is made and agreed for an emergency payment.

6.0 RELATED POLICIES

Grievance Policy (PC24POL15)
Disciplinary Policy (PC24POL14)
Standing Financial Instructions (PC24SFI)
Anti-Fraud, Anti-Bribery and Anti-Corruption Policy (PC24POL101)

7.0 MONITORING AND COMPLIANCE

An annual report will be submitted to the Finance & Performance Committee to provide assurance that this policy is being applied consistently and fairly.

8.0 TRAINING

All staff will be made aware of this policy and Human Resources will provide managers support in their role to ensure that all matters are dealt with fairly and consistently.

9.0 EQUALITIES AND HEALTH INEQUALITIES

PC24 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. PC24 will take remedial action when necessary to address any unexpected or unwarranted disparities and monitor practice to ensure that this policy is fairly implemented.

10.0 PERSONAL INFORMATION

PC24 is committed to an environment that protects personal information aspects in the development of any policy. When proposing change there is a new requirement for policy writers to investigate when the personal information aspect of the policy complies with the data protection principles in Schedule 1 of the Data Protection Act 2018. All individuals with responsibility for reviewing/writing policies should consider Privacy Impact Assessment compliance.

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

PrimaryCare:24

Controlled Drug Policy

Version	V1
Supersedes:	New Policy
Date Ratified by Board:	
Reference Number:	
Title & Department of originator:	Head of Medicines Management
Title of responsible committee/department:	Quality and Workforce Committee
Effective Date:	May 2019
Next Review date:	May 2020 (or when there is a change in Policy)
Target audience:	All Medical and Non-Medical Prescribers and all staff who handle Controlled Drugs
Impact Assessment Date:	17 January 2019

Version	Date	Control Reason	Title of Accountable Person for this Version

Reference Documents	Electronic Locations (Controlled Copy)	Location for Hard Copies
National Guidance Dept of Health and NICE Health Act 2006	Urgent Care 24 Intranet / SOPs Clinical / Operations … **Delete as appropriate***	**Policy File, Wavertree Headquarters**

Consultation: Committees / Groups / Individual	Date
Policy Group Quality & Workforce Committee	March 2018 May 2018

Indicative SOPs for IUC as Appendices: Please refer to current SOPs

1. Introduction

1.1 Controlled drugs (CDs) have abuse potential and therefore all activities surrounding their handling must be auditable and comply with legal requirements.

1.2 The Organisations Accountable Officer (the Head of Medicines Management is responsible for ensuring the governance arrangements regarding Controlled Drugs. Any concerns about individuals or organisations regarding CDs must be reported to the Accountable Officer.

1.3 This procedure covers all activities relating to the safe and secure handling of CDs in the Organisation and applies to all staff involved in these activities.

1.4 Management of Controlled Drugs requires meticulous record keeping and audit trail. All records must be clear, legible and unambiguous.

1.5 Following the Shipman Enquiry, there are now strengthened governance arrangements regarding Controlled Drugs, as included in the supporting document Standard Operating Procedure CL005 and current national guidance provided by the Department of Health http://www.dh.gov.uk/en/Healthcare/Medicinespharmacyandindustry/Prescriptions/ControlledDrugs/index.htm

1.6 Guidance relating to all aspects of Controlled Drugs is available in the Royal Pharmaceutical Society's publication Medicines, Ethics and Practice http://www.nice.org.uk/mpc/index.jsp.pdf

1.7 '*A guide to good practice in the management of controlled drugs in primary care (England)*' Third edition December 2009 Updated Oct 2012 (National Prescribing Centre) takes into account the significant legislative changes introduced since the publication of the first edition in December 2005 and should be of value where controlled drugs are used. http://www.npci.org.uk/cd/public/guidance.php#pc

2. PURPOSE

2.1 The purpose of this policy is to promote the safe, secure and effective use of Controlled drugs and to set out the UC24 policy on the management and governance of Controlled drugs in accordance with statutory requirements.

3. SCOPE

3.1 The policy applies to all areas where Controlled drugs are used and to all staff who handle Controlled drugs.

4. RESPONSIBILITIES

4.1 The Chief Executive is ultimately responsible for ensuring the Organisation complies with legal requirements and national recommendations for medicines management

4.2 The Board has a responsibility to ensure training and competency assessment is available to all relevant staff

4.3 The Medical Director is the Executive Lead responsible for this policy covering safe medicines practice within the Organisation, but will delegate authority for the operational implementation and on-going management of this policy to the Accountable Officer.

4.4 Regulations made under the Health Act 2006 require the Organisation to appoint an Accountable Officer, responsible for the safe and effective use of Controlled drugs in their organisation.

4.5 The Organisation is accountable through the Accountable Officer for ensuring the safe management of Controlled drugs. The Organisation has a responsibility to assure the quality of its CD management as an integral part of its clinical governance processes.

4.6 The Care Quality Commission is responsible for overseeing the management of Controlled drugs by healthcare organisations in England.

4.7 All staff involved in the handling of Controlled drugs must follow the processes outlined in this policy and the Standing Operating Procedures relevant to their practice.

5. ACCOUNTABLE OFFICER

5.1 The Organisation must ensure that it has an Accountable Officer in place at all times and that the Accountable Officer is registered with the Care Quality Commission.

5.2 The Accountable Officer should be someone who reports directly to an Executive Director.

5.3 The Accountable Officer should not personally be involved in the routine prescribing, supply, administration or disposal of Controlled drugs.

5.4 The Accountable Officer for UC24 is the Head of Medicines Management.

5.5 The Accountable Officer is responsible for all aspects of the safe and secure management of Controlled drugs in the organisation. This includes ensuring that safe systems are in place for the management and use of Controlled drugs, monitoring and auditing of the management systems and investigation of concerns and incidents related to Controlled drugs. The Accountable Officer must assess, investigate and retain records of concerns regarding management or use of Controlled drugs by relevant individuals. The Accountable Officer is responsible for ensuring that adequate training is provided by the organisation for all relevant staff that handle Controlled drugs.

5.6 During the absence of the Accountable Officer the Medical Director will cover the role of Accountable Officer.

5.7 If staff have concerns about the practice of the Accountable Officer they should approach the Medical Director**.**

6. LOCAL INTELLIGENCE NETWORK

6.1 The Organisation must collaborate with the local intelligence network of other healthcare organisations, police forces, social services authorities and the relevant inspection and regulatory bodies to enable them to share information about potential CD offences and potential or actual systems failures.

7. PROCEDURES

7.1 Each of the activities that relate to Controlled drugs, regardless of where in the organisation they occur, must be described in a Standard Operating Procedure (SOP).

7.2 Standard Operating Procedures should be formally approved by the Accountable Officer and the Organisations Policy Review Group. They should be kept up to date, reflecting current legal and good practice requirements for Controlled drugs.

7.3 Staff in the organisation must work to Standard Operating Procedures that are appropriate to their area of work.

7.4 The activities covered by Standard Operating Procedures are listed below and are appended to the policy.

1. Requisitioning Controlled drugs
2. Key-holding and Issuing Controlled drugs
3. Record-keeping of Controlled drugs
4. Prescribing Controlled drugs
5. Transport, Storage and Disposal of Controlled Drugs
6. Printing and Collection of Controlled Drug Prescriptions

8. MONITORING AND COMPLIANCE

8.1 The Accountable Officer must provide quarterly reports to the Board.

8.2 Appropriate arrangements must be in place for monitoring and auditing the management and use of Controlled drugs.

These must include:

- Regular monitoring and analysing of prescribing by medicines management team.
- Accountable Officer will analyse and respond to untoward incidents as and when they occur.

9. TRAINING

9.1 Training will be provided for clinical and non-clinical employees with the purpose of:

- Raising awareness of the Controlled Drug Policy
- Informing individuals of the Standard Operating Procedures
- Highlighting the need for feedback and audit in the review process

10. EQUALITIES AND HEALTH INEQUALITIES

10.1 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. PERSONAL INFORMATION

11.1 UC24 is committed to an environment that protects personal information aspects in the development of any policy. When proposing change there is a new requirement for policy writers to investigate when the personal information aspect of the policy complies with the data protection principles in Schedule 1 of the Data Protection Act 1998. All individuals with responsibility for reviewing/writing policies should consider Privacy Impact Assessment compliance.

APPENDIX 1

STANDARD OPERATING PROCEDURE DOCUMENT (SOP)

Title	**Requisitioning Controlled Drugs**	**Doc. No.**	
Scope			
Purpose			
Guidelines			

PROCEDURE		**RESPONSIBILITY**
1	A medical stock check is carried out by the medicines management team and the logistics manager (in one of their absences another designated manager / director must be present to witness) every time the Controlled Drugs safe(s) have been opened.	Urgent Care 24 Logistics Manager / Medical Director / Medicines Management Team
2	If CD stock is required the medicines management team complete a FP10 CDF, the medical director, or in their absence, a member of the medical leadership team signs the form and a copy is made. Once signed the FP10 CDF is then faxed across to the designated pharmacy for stock requisition. They will then contact us when it is ready to collect.	Urgent Care 24 Logistics Manager / Medical Director / Medicines Management Team
3	Two members of the medicines management team then take the completed FP10 CDF to the designated pharmacy (Sedems pharmacy) which is appropriately licensed by the Home Office for this purpose. • The pharmacist issues items as per signed FP10 CDF • Medicines management team member signs the FP10 CDF for receipt of the medication and the pharmacist retains this copy Appropriate ID and a signed authorisation card must be carried by the medicines management team member when collecting these items	Urgent Care 24 Medicines Management Team / Designated Pharmacist

4	Medication is transported from the designated pharmacy by medicines management team members in a safe fitted in the Urgent Care 24 vehicle and taken directly to Wavertree Headquarters. The medical director, a member of the medical leadership team or any director of the organisation, accompanied by a medicines management team member, access the Controlled Drug safe to deposit the stock in the safe and update the Controlled Drug register as described in the Record Keeping SOP.	Designated Pharmacist / Urgent Care 24 Medicines Management Team / Medical Lead / Organisation Director
5	The copy of the FP10 CDF is placed in locked fireproof metal cabinet within the medicines management room and kept for seven years.	Urgent Care 24 Medicines Management Team
6	If there is any discrepancy between the register and stock held, this should be reported to the Controlled Drugs responsible officer and the medical director (if this is a different person), logged as an incident on Datix and an investigation undertaken. If the investigation reveals an unexplained stock discrepancy, this should be reported to the Controlled Drugs accountable officer at NHS England and to the Merseyside Police Controlled Drugs responsible officer.	Urgent Care 24 Medical Director / Responsible Officer
7	**ALL** Quarterly reports on all incidents related to Controlled Drugs must be sent to the regional NHS England Controlled Drugs accountable officer. These reports will be prepared by a member of the medicines management team and signed off by the Controlled Drugs accountable officer (or Medical Director or their designated deputy if there is no designated CDAO or the CDAO is absent).	Urgent Care 24 Medicines Management Team / CDAO / Medical Director

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 2

STANDARD OPERATING PROCEDURE DOCUMENT (SOP)

Title	**Key Holding and Issuing Controlled Drugs**		**Doc. No.**	
Scope	**Clinical Directorate**	**Operational Directorate**	**Urgent Care 24 Director On-Call**	
Purpose	To ensure safe and effective storage and supply of Controlled Drugs at Urgent Care 24.			
Guidelines	Urgent Care 24 hold a stock of Controlled Drugs (CDs) at Wavertree Headquarters. These are locked in two secure safes located within the medicines management (MM) room. The CDs contained within Wavertree Headquarters must only be issued following a careful clinical assessment, and where it has not been possible to source the drugs through a pharmacy. **Under no circumstances should any patient or relative be informed to attend Wavertree Headquarters to collect any prescriptions for CDs or other items. This must be done via an Urgent Care Centre.** See **SOP CL049 / OP026** – 'Procedure for Printing and Collection of Controlled Drugs Prescriptions' for how this process is to be carried out. Every instance of medication issued and replaced must be accurately recorded on the appropriate register(s) / paperwork.			
PROCEDURE			**RESPONSIBILITY**	
	1. **Decision** The prescriber, following a careful clinical assessment, makes a decision to issue Controlled Drugs to a patient. If it is not reasonable to source the drugs through a pharmacy, the prescriber asks the shift manager to enable access to drugs required from the stock at Wavertree HQ			

1	contained within the overnight palliative safe which is held within the Medicines Management Storage Room. If a repeat prescription for Controlled Drugs of Schedule 3 or above (which cannot be faxed to a pharmacy) is required when pharmacies are open, the patient or their designated representative must collect the prescription from one of the Urgent Care Centres.	Urgent Care 24 Clinician
2	**2. Access to Medicines Management Storage Room** The clinician and shift manager access the locked medicines management room and open the overnight palliative safe. It is mandatory for two members of staff to be present at all times and for them to sign in and out of the medicines room. Access to the medicines management room is via a keypad number only accessible by the shift manager and the medicines management team. Once the medicines management room has been accessed the log sheet located on the outside door of the medicines management room must be signed by the shift manager.	
	3. Access Safe 1 – Overnight Palliative Safe Safe 1 is the safe for clinicians and shift managers to access if it is decided that CDs will be required. The safe is an electronic safe contained within a metal cabinet. The safe holds three small boxes (Box 1, Box 2 and Box 3) which contain 5 ampoules of diamorphine. No other CDs are stored in this safe. A code for this safe is generated daily by the Medicines Management Team. The code is sent to the relevant manager on-call and shift manager for that evening, along with the code for the key-safe	

3	number for the cabinet. Weekend codes are issued Friday through to Sunday and changed on Monday. The codes, and the personnel who they have been issued to, are recorded by the medicines management team. The shift manager and clinician access safe 1 together. The clinician obtains stock from Box 1,2 or 3 The details are entered into the Controlled Drug Register stating: • Date • Name and call number of the patient • Quantity taken • Quantity remaining • Signature of clinician and witness The book is returned to the safe, the safe is locked and the keys returned to the key safe. The shift manager makes a note in the operational log book. The clinician and shift manager must place the CD in the safe located in the UC24 fleet vehicle. The shift manager will make a note in their report that Controlled Drugs have been used for the medicines management team to act upon the following day.	Urgent Care 24 Clinician / Shift Manager / Director On-Call / Medicines Management Team

4	**4. Access to Safe 2 – Main Store** Safe 2 holds the main bulk of the CD stock and the yellow CD register. The yellow CD register is the main record for recording addition and transferring of stock. Access to this safe is via directors only who hold the code to the key safe. On extreme rare occasions it may be called for extra CDs to be needed by a clinician if all the CDs within safe 1 have been used or the safe is inaccessible for any other reason i.e. unable to locate code / key. In this instance the clinician who is requesting the CD must contact the director on-call via the shift manager and give a thorough reason as to why they are requesting access to safe 2. If the director is satisfied they will then provide the clinician with the code to the key-safe to access this safe. The key-safe is located within the medicines management room. Under no circumstances is this code or any of the other codes to be divulged to any other persons. The clinician can then access safe 2. The Controlled Drugs register must be completed by the clinician and counter-signed by the shift manager. The shift manager will contact the director on-call before 8am the following day, giving a reminder that the key code will require changing.	Urgent Care 24 Clinician / Shift Manager

	It is the responsibility of the director on-call who was contacted by the manager for the code, to ensure that the code is changed before 10am the next working day, either by visiting UC24 Headquarters themselves or if this is not practicable then to arrange with a fellow director for this to occur. It is the responsibility of the director on-call to notify all directors of the change of code either by text or e-mail. The code held by the directors is only changed once it has been disclosed to any other persons, other than a director. As stated in step 1 the overnight palliative safe code is changed daily with exceptions of the weekend.	
17	**5. Audit** Quarterly reports on all incidents related to Controlled Drugs must be sent to the regional NHS England Controlled Drugs accountable officer. These reports will be prepared by a member of the medicines management team and signed off by the Controlled Drugs accountable officer (or Medical Director or their designated deputy if there is no designated CDAO or the CDAO is absent).	Urgent Care 24 Medicines Management Team / CDAO / Medical Director

Appendix 3

STANDARD OPERATING PROCEDURE DOCUMENT (SOP)

Title	**Record Keeping – Controlled Drugs**		**Doc. No.**	
Scope				
Purpose	To ensure that recording of controlled drugs complies with the requirements of the Misuse of Drugs Act and UC24 Controlled Drug Policy.			
Guidelines				

PROCEDURE		**RESPONSIBILITY**
1	Controlled drugs held as stock must be recorded in the CD record book. All entries should be signed by a registered nurse or relevant clinician and should be witnessed by a second registered nurse or other registered health professional. Each page in the CD record book must specify at the head of the page the generic name, brand name (if applicable), strength and form of the drug to which the entries on that page relate. Each drug and each strength and each form must be on separate pages so that a running balance can be kept easily. Entries should be in chronological order in ink or be otherwise indelible. If a mistake is made it should be bracketed in such a way that the original entry is still clearly legible. This should be signed, dated and witnessed by a second registered nurse or other registered health professional. The witness should also sign the corrections. There should be an explanation for the correction. If in doubt of correct actions to take contact a member of the Medicines Management Team.	

	No entries in the CD record book must be overwritten, crossed-out, erased or otherwise obscured or obliterated.	
2	**TRANSFER TO A NEW PAGE** On reaching the end of a page, the balance should be transferred to the next available page and the following details recorded: • At the bottom of the finished page, record the new page number where the balance has been transferred to. • On the new page, record the quantity transferred and the page number where the balance has been transferred from. • Update the index at the front of the CD record book with the new page number. • The transfer should be witnessed and signed by a second registered nurse or other registered health professional.	
3	**PROCEDURE FOR CONTROLLED DRUGS RECEIVED** Controlled drugs received from pharmacy should be recorded on the relevant page in the CD record book and the following details recorded: • Date of receipt and entry • Name of pharmacy making supply • Serial number of requisition • Quantity received • Balance in stock • Signature of registered healthcare professional making the entry • Signature of witness • Name, strength and form (should be specified at head of page) When recording controlled drugs received from pharmacy, the number of units received should be recorded in words not figures to reduce the chance of entries being altered.	
4	**ADDITIONAL INFORMATION**	

	The registered nurse in charge or clinician with responsibility for CD stock at the location is responsible for keeping the CD record book up to date and in good order. After every administration, the balance in stock in the CD record book, of the CD preparation used, should be checked against the stock in the cupboard. If a discrepancy is found this should be investigated without delay. CD records must be kept for a period of at least two years from the date when the last entry was made, but if they contain a record of destruction of a controlled drug they must be kept for seven years. These should then be destroyed as confidential waste.	

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 4

STANDARD OPERATING PROCEDURE DOCUMENT (SOP)

Title	**Prescribing Controlled Drugs**		**Doc. No.**	
Scope				
Purpose				
Guidelines				
PROCEDURE			**RESPONSIBILITY**	
1	Prescriptions for controlled drugs listed in schedule 2, 3 or 4 of the Misuse of Drugs Regulations 1985 must be written in accordance with the requirements of those regulations. Controlled Drugs and drug dependence: British National Formulary.			
2	Non-Medical Independent prescribers may prescribe Controlled Drugs so long as they are trained in controlled drug prescribing, prescribe in accordance with the regulations, have declared they are competent to do so on their Declaration of Practice, understand their use and are working within their clinical competencies.			
3	It is unlawful for a prescriber to issue a prescription containing a schedule 2 or 3 controlled drug (except Temazepam) unless it complies with the following requirements: • Signed by person issuing it with usual signature • Dated • State prescriber's address • Be on the standardised form • Specify dose to be taken • State form and strength of preparation • State total quantity to be supplied in words and figures • Specify name and address of person for whose treatment it is			

	issued.	
4	Prescriptions for Schedule 2 and 3 Controlled Drugs may be computer generated where only the signature of the prescriber needs to be handwritten.	
5	When making decisions about prescribing controlled drugs take into account: • The benefits of controlled drug treatment • The risks of prescribing, including dependency, overdose and diversion • All prescribed and non-prescribed medicines the person is taking (particularly any centrally acting agents) and whether the person may be opioid naïve. • Evidence-based sources, such as NICE and the British national formulary (BNF), for prescribing decisions when possible.	
6	When prescribing controlled drugs: • Document clearly the indication and regimen for the controlled drug in the person's care record. • Check the person's current clinical needs and, if appropriate, adjust the dose until a good balance is achieved between benefits and harms • Discuss with the person the arrangements for reviewing and monitoring treatment • Be prepared to discuss the prescribing decision with other health professionals if further information is requested about the prescription.	
7	When prescribing 'when required' controlled drugs: • Document clear instructions for when and how to take or use the drug.	

	• Include dosage instructions on the prescription (with the maximum daily amount or frequency of doses) so that this can be included on the label when dispensed • Ask about and take into account any existing supplies the person has of 'when required' controlled drugs.	
8	Only prescribe enough of a controlled drug to meet the person's clinical needs this should be for no more than 7 days.	
9	A recognised opioid dose conversion guide should be used when prescribing, reviewing or changing opioid prescriptions to ensure that the total opioid load is considered.	
10	When prescribing controlled drugs inform the person's GP of all prescribing decisions and record this information in the person's care record so the GP has access to it.	

STANDARD OPERATING PROCEDURE DOCUMENT (SOP)

Title	**Prescribing Controlled Drugs**	**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 5

STANDARD OPERATING PROCEDURE DOCUMENT (SOP)

Title	Transport, Storage and Disposal of Controlled Drugs	**Doc. No.**	
Scope			
Purpose			
Guidelines			

PROCEDURE		**RESPONSIBILITY**
1 Transport	• All Prescribers have a duty of care to maintain safe custody of controlled drugs and keep them out of sight and locked in the vehicle during transportation. • During transportation Controlled Drugs should be locked in the safe that is secured in the boot of UC24 vehicles. • Controlled drugs should not be routinely transported to and from a patient's home by the Prescriber involved in the delivery of an episode of patient care; this is however permissible when other methods of supply are not appropriate.	
2 Storage	• Controlled Drugs must be stored in a locked specified Controlled Drug cupboard (fixed to the wall or floor) which has been approved by a pharmacist and is reserved solely for the storage of CDs. • The CD cupboard must be separate from other cupboards or be inside other locked medicines cupboards used to store internal medicines. • No team must store Controlled Drugs unless there is an Appointed Practitioner in Charge responsible for their storage and use. • Access to the CD Cupboard must be limited to Designated Members of Staff.	

	• Controlled drugs in a patient's own home are the property of the patient.	
3 Disposal	• Controlled drugs for destruction, for example out of date stock, should be set aside in the controlled drug receptacle with packaging and clearly labelled 'for destruction' so as not to be used by mistake. • If Schedule 2 controlled drugs need to be destroyed, it is a legal requirement that this must be witnessed by an authorised individual and appropriate records made in the controlled drugs register. There is no such obligation for schedule 3 drugs. ▪ If the controlled drugs require destruction, details of the denatured drug must be entered into the controlled drugs register, including its name, form, strength and quantity as well as the date of destruction and the signature of the authorised person in whose presence it was destroyed. The authorised person designated to destroy the controlled drugs for Urgent Care 24 is the Community Pharmacy Clinical Governance Facilitator. ▪ Clinicians working for Urgent Care 24 attending a patient who has died should not remove controlled drugs that are no longer required. Disposal of such drugs lies within the responsibility of the Community District Nursing teams. ▪ In exceptional circumstances, where the Clinician assesses that there is a risk to patients or the public if they do not remove the controlled drugs themselves, the Clinician should remove the controlled drugs and take them directly to a pharmacy for disposal, informing the Shift Manager of this action, who should record the incident on Datix then inform the Duty Manager on call.	

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

STANDARD OPERATING PROCEDURE DOCUMENT (SOP)

Title	Transport, Storage and Disposal of Controlled Drugs	**Doc. No.**	
Scope			
Purpose			
Guidelines			
PROCEDURE		**RESPONSIBILITY**	
1 Transport	• All Prescribers have a duty of care to maintain safe custody of controlled drugs and keep them out of sight and locked in the vehicle during transportation. • During transportation Controlled Drugs should be locked in the safe that is secured in the boot of UC24 vehicles. • Controlled drugs should not be routinely transported to and from a patient's home by the Prescriber involved in the delivery of an episode of patient care; this is however permissible when other methods of supply are not appropriate.		
2 Storage	• Controlled Drugs must be stored in a locked specified Controlled Drug cupboard (fixed to the wall or floor) which has been approved by a pharmacist and is reserved solely for the storage of CDs. • The CD cupboard must be separate from other cupboards or be inside other locked medicines cupboards used to store internal medicines. • No team must store Controlled Drugs unless there is an Appointed Practitioner in Charge responsible for their storage and use. • Access to the CD Cupboard must be limited to Designated Members of Staff.		

	• Controlled drugs in a patient's own home are the property of the patient.	
3 Disposal	• Controlled drugs for destruction, for example out of date stock, should be set aside in the controlled drug receptacle with packaging and clearly labelled 'for destruction' so as not to be used by mistake. • If Schedule 2 controlled drugs need to be destroyed, it is a legal requirement that this must be witnessed by an authorised individual and appropriate records made in the controlled drugs register. There is no such obligation for schedule 3 drugs. ▪ If the controlled drugs require destruction, details of the denatured drug must be entered into the controlled drugs register, including its name, form, strength and quantity as well as the date of destruction and the signature of the authorised person in whose presence it was destroyed. The authorised person designated to destroy the controlled drugs for Urgent Care 24 is the Community Pharmacy Clinical Governance Facilitator. ▪ Clinicians working for Urgent Care 24 attending a patient who has died should not remove controlled drugs that are no longer required. Disposal of such drugs lies within the responsibility of the Community District Nursing teams. ▪ In exceptional circumstances, where the Clinician assesses that there is a risk to patients or the public if they do not remove the controlled drugs themselves, the Clinician should remove the controlled drugs and take them directly to a pharmacy for disposal, informing the Shift Manager of this action, who should record the incident on Datix then inform the Duty Manager on call.	

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.

Non-Medical Prescribing Policy

Version	V1.0
Supersedes:	New policy
Date Ratified by Board:	
Reference Number:	Governance manager if new policy
Title & Department of originator:	Head of Medicines Management
Title of responsible committee/department:	Quality and Workforce Committee
Effective Date:	May 2020
Next Review date:	May 2020 (or when there is a change in Policy)
Target audience:	All non-medical prescribers
Impact Assessment Date:	17.05.19
Summary	This policy provides a governance framework for non-medical prescribing in Primary Care 24 (PC24), setting out the principles for safe, effective, evidenced based prescribing, in accordance with the relevant legislation.

Version	Date	Control Reason	Title of Accountable Person for this Version

Reference Documents	Electronic Locations (Controlled Copy)	Location for Hard Copies
Evidence which includes published and/or	Primary Care 24 Intranet	**Policy File, Wavertree Headquarters**

unpublished studies and expert opinion and Department of Health Statutory Requirements and Department of Health Guidance Privacy Impact Assessment Compliance Checklist		

Consultation: Committees / Groups / Individual	**Date**
Quality and Workforce Committee	**May 2019**

Contents

1. INTRODUCTION

1.1 Non-medical prescribing contributes to the delivery of high quality, flexible and patient/service user-centred services. It also supports the delivery of national and local targets.

1.2 Primary Care 24 (PC24) has developed this policy to fulfil the requirements to patients and service users receiving prescribed medications from staff employed by PC24.

1.3 PC24 is committed to ensuring that all staff are trained and competent to perform their role effectively and safely

2. PURPOSE

2.1 The purpose of this policy is to provide a governance framework for non-medical prescribing in Primary Care 24 (PC24), setting out the principles for safe, effective, evidenced based prescribing, in accordance with the relevant legislation. The aim being to:

- Provide better access to and use of medicines
- Better, and more flexible use of workforce skills;

Ensure that quality and patient/service user safety underpins this provision

3. SCOPE

3.1 This policy applies to all non-medical prescribers with the aim of ensuring that the following objectives are met:

3.2 All Non-Medical Prescribers in the organisation are aware of their responsibilities regarding the safe and effective prescribing of medicines.

3.3 All Non-Medical Prescribers in the organisation maintain high standards of practice at all times in the prescribing of medicines enabling them to act in the best interest of the patient.

3.4 When there are incidents where the policy either cannot be followed *or has not been followed*, that these are reported using Integrated Risk Management Datix reporting system.

3.5 All Non-Medical Prescribers must prescribe in accordance with the local Formulary and prescribing recommendations.

4. THIS POLICY SHOULD BE READ IN CONJUNCTION WITH THE FOLLOWING PC24 POLICIES:

Medicines Policy

Controlled Drugs Policy

4.1 The policy should read in conjunction with the following legislation and professional standards and guidance provide the legal and professional framework for non-medical prescribing:

- The Human Medicines Regulations 2012
- Medicines Act 1968
- Misuse of Drugs Act 1971
- The Medicinal Products: Prescription by Nurses Act 1992
- Health Act 2006
- Non-medical Prescribing V5 - 8 - August 2017
- Home Office Circular 009/2012 Nurse and Pharmacist Independent Prescribing, 'mixing of medicines', possession authorities under patient group directions and personal exemption provisions for Schedule 6 Part 2
- The Medicines and Human Use (Prescribing) (Miscellaneous Amendments) Order of May 2006

- The safer management of controlled drugs. Under the Controlled Drugs (Supervision of Management and Use) Regulations 2013
- British National Formulary
- British National Formulary for Children
- Medicines Matters: A guide to mechanisms for the prescribing, supply and administration of medicines (in England) Published 10th October 2018, updated 26th October 2018
- A Competency Framework for all Prescribers, Publication date: July 2016 Review date: Royal Pharmaceutical Society of Great Britain, July 2020
- Standards of conduct, ethics and performance. General Pharmaceutical Council
- Standards of Proficiency for Nurse and Midwife Prescribers (NMC)
- Standards for Medicines Management Nursing & Midwifery Council (NMC)
- Record Keeping: Guidance for Nurses and Midwives (NMC)

5. DEFINITIONS

5.1 Independent Prescribing

Prescribing by a practitioner responsible for the assessment of patients with undiagnosed and diagnosed conditions, and for decisions about the clinical management required.

5.2 Nurse and Paramedic Independent Prescribers (V300)

Nurses and Paramedics, who have successfully completed an independent prescribing course, or previously an extended formulary nurse prescribing course, are able to prescribe any medicine for any medical condition **within their clinical competence** including Controlled Drugs.

5.3 Pharmacist Independent Prescribers

Pharmacists who have successfully completed an independent prescribing course are able to prescribe any medicine, for any medical condition within **their clinical competence** including Controlled Drugs.

5.4 Declaration of Practice

A self-declaration form that is submitted annually by all Non-Medical Prescribers that states the areas of prescribing competency.

5.5 NMP Register

An electronic register of non-medical prescribers within the organisation maintained and audited by the Non-Medical Prescribing Lead

5.6 Principles of Independent Prescribing

In partnership with the patient, independent prescribing is one element of the clinical management of a patient. It requires:

- An initial patient clinical assessment
- Interpretation of that assessment and establishing of a diagnosis
- A decision on safe and appropriate therapy
- A process for ongoing monitoring.

6. RESPONSIBILITIES:

6.1 Non- Medical Prescribing Lead

- Will maintain a register of Non-Medical Prescribers. The record will include the names of the Non-Medical Prescribers, their professional registration number, their service, CD permissions, mobile contact numbers, scope of practice and the date they last completed the self-declaration.
- Will ensure annual Declarations of Practice Forms are returned fully endorsed
- Will monitor NMP prescribing
- Communicate relevant information to NMPs.

- Link with relevant external NMP Forums and Groups
- Ensure that NMPs work within their own competency and to suspend prescribing activity if this is not confirmed.
- Ensure that NMP procedures are implemented and that the NMP adheres to the relevant regulatory body's Standards of Practice.

6.2 All Non-Medical Prescribers

- All NMPs must be registered as a prescriber with their professional body and accept professional accountability and clinical responsibility for their prescribing practice.
- They must work at all times within their clinical competence and with reference to their regulatory body's professional standards.
- They must recognise their own limitations and where required, seek advice and make appropriate referrals to other professionals with different expertise.
- They must only prescribe medicines for a patient whom they have assessed themselves.
- They must ensure that patients are aware that they are being treated by a non- medical prescriber and of the scope and limits of their prescribing.
- They must prescribe for the patient in accordance with their own competencies, agreed treatment plans, relevant national and local formularies appropriate to their qualification and prescribing status. This includes complying with prescribing guidance and acting on drug/appliance safety alerts.
- They must be registered as an active prescriber within the organisation by ensuring they complete the annual Declaration of Practice Form, obtaining the appropriate signatures for authorisation and returning to the NMP Lead for database submission. If there are any changes a new form must be completed.

- They must maintain accurate and contemporaneous records of all details of the consultation with the patient/service user, onto the patient user record immediately, or failing that as soon as possible after the consultation. Only in very exceptional circumstances (e.g. the intervention of a weekend or public holiday) if this period exceed 48 hours from the time of writing the prescription. (DOH April 2006).
- Must recognise and deal with pressures (e.g. from the pharmaceutical industry, patients, relatives or colleagues) that might inappropriately affect their prescribing decision and refuse to be influenced by such pressures. Any prescription must be in the best interests of the patient only. The NMP must report such pressures to the Associate Director of Nursing and/ or the Medicines Management Lead.
- Must ensure they have adequate Indemnity Insurance. Where a NMP prescribes with the consent of the employer as part of their professional duties and in accordance with the employer's policies and the Law, the employer is held vicariously liable for their actions (NHS Indemnity). In addition NMPs are accountable to their Professional Regulatory Body. NMP's that are self-employed / agency must demonstrate they have their own indemnity insurance.

7. LIMITATIONS OF NON-MEDICAL PRESCRIBING

7.1 Non-Medical prescribers will not prescribe any medicine for themselves or for anyone, with whom they have a close personal or emotional relationship.

7.2 This will include friends, family or colleagues. If a NMP is approached to prescribe for someone with whom they have a close personal or emotional relationship they must refer the person to another practitioner for assessment and/or treatment.

8. CONSENT

Valid consent must be obtained before starting treatment which includes administration of medicines. Refer to PC24 Capacity to Consent Policy. If a patient is unable to consent at the time the treatment decision is made due to lacking mental capacity as per the Mental Capacity Act 2007 a best interest decision will be required in order to undertake the most appropriate action for the patient at that time. This must incorporate consideration of the known wishes, feelings, beliefs and values of the patient.

9. MONITORING AND COMPLIANCE

NMP prescribing will be monitored and audited to ensure that prescribing is safe, effective, cost effective and in line with local and national guidance.

10. TRAINING AND DEVELOPMENT

10.1 All NMPs have a professional responsibility to keep themselves up to date with clinical and professional developments. NMPs will be expected to implement best practice in the management of conditions for which they may prescribe. Continuing Professional Development (CPD) needs may be met by a range of blended learning opportunities including clinical supervision, learning reflections, attendance at education events and shadowing colleagues. Prescribing should be discussed at the Personal Development Review (PDR) and any training needs met through CPD. The NMP will access on-going education offered and be self-directed in meeting learning and development needs.

10.2 The following is a list of acceptable forms of PC24 NMP CPD:

- Attending NMP CPD session – either offered by the PC24 or external to the organisation.
- ELearning in area of prescribing competency
- Individual study related to Management of Medicines / therapeutics

- Review of personal ePACT prescribing data (were available to staff member)
- Shadowing a prescribing colleague
- Evidence of reading journals or articles directly linked to scope of practice with reflection
- Work based Learning or reflecting on a patient journey

10.3 NMPs should maintain a prescribing section within their professional portfolio. NMPs need to be aware of the RPSGB Single Competency Framework for Prescribing and utilise this as a tool to benchmark any learning needs they may have in relation to their prescribing.

11. IMPLEMENTATION

This Policy will be implemented via the document owner with the support of the Heads of Service, Associate Directors and any relevant Committees.

The document owner will outline the plan for implementation in conjunction with the production of the policy

12. DISSEMINATION

Once this policy has been approved, it will be loaded onto the staff intranet, this will be supported by a message through PC24's newsletter, NEWS24. Quality & Patient Safety team will be responsible for this action.

13. EQUALITIES AND HEALTH INEQUALITIES

13.1 PC24 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. PC24 will take remedial action when necessary to address any unexpected or unwarranted disparities and monitor practice to ensure that this policy is fairly implemented.

14 PERSONAL INFORMATION

14.1 PC24 is committed to an environment that protects personal information aspects in the development of any policy. When proposing change there is a new requirement for policy writers to investigate when the personal information aspect of the policy complies with the data protection principles in Schedule 1 of the Data Protection Act 1998. All individuals with responsibility for reviewing/writing policies should consider Privacy Impact Assessment compliance.

This policy complies with the Data Protection Act 1998, therefore no Privacy Impact Assessment is necessary.

15. POLICY REVIEW

This policy will be reviewed 3-yearly or sooner if national guidance or legislation requires, or if there are changes to PC24's internal processes.

Appendix 1. Non-Medical Prescribers Annual Declaration

Last Name	
First Name	
Title	
Base	
NMC PIN Number or GPhC Registration	
E Mail address *(NET address if possible)*	
Telephone Number	

Type of Non-Medical Prescriber	**YES**	**NO**
Nurse Independent Prescribing – from the community practitioners formulary for nurse prescribers (V100 and V150)		
Nurse independent and supplementary prescribing (V300)		
Pharmacist independent and supplementary prescribing		
I am prescribing electronically		
I am prescribing using pre-printed prescription pads		
I keep my skills and knowledge up to date by the following method (s)	**YES**	**NO**
A) Attending CPD Events/ Study Days		
B) Reading current literature/ publications		
C) Reading professional body standards/ legislation updates		
D) Other *(Please state below in block capitals)*		

Will you prescribing for children under 12 years of age?	**Will you prescribe Controlled Drugs? INCLUDING BENZODIAZEPINES**
Yes □ No □	Yes □ No □

DECLARATION:

I declare that I will prescribe in accordance with my training and competencies.

I declare that if there are any changes I will inform the organisations NMP lead and understand that a new declaration must be completed.

I understand that I must complete a new declaration annually.

If there is any extended break in my prescribing activities exceeding one year I understand that my prescribing will be suspended until my competency and confidence is demonstrated.

I can provide evidence that I have undertaken the minimum of 1 NMP CPD activity and /or attended 1 locality NMP forum during the past 12 months.

Signature	Print Name	Date

Title:	Meeting Date:	Agenda item no:
Review of Board Terms of Reference	30 May 2019	10.2
Prepared and presented by: Margaret Swinson	**Discussed by:**	
Link to PC24 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: • Review the Board Terms of Reference and agree any amendments.	

1.0 Purpose & Background:

1.1 The purpose of this report provide an opportunity for the Board to review its Terms of Reference (attached) and offer suggestions for amendment.

1.2 The usual policy of annual review did not take place during 2018 due to the process for amendment of the Society's Rules which was completed in February 2019.

1.3 The attached Terms of Reference reflect the changes consequent on the adoption of the new Rules, these are shown as tracked changes in the document.

1.4 The review of the 'How we do things' regulations document will be completed when the Board Terms of Reference are agreed.

2.0 Matters for consideration

2.1 The Board might wish to consider the following:

- Staff representation: When the Rules were adopted in 2012 a system was put in place for the staff to elect a representative to attend the Board. This was only partially successful and was superseded by the establishment of the Staff Council, the Terms of Reference for which include a member attending the Board. This, in practice, has not happened.

- Specifically including in this document the provision that the minutes from the non-confidential part of the meeting be posted on the website.
- An explicit invitation for staff to attend the non-confidential part of meetings as observers whether or not they are due to present items of business.

3.0 Recommendations:

The meeting is invited to:

- Review the Board Terms of Reference and agree any amendments.

PrimaryCare:24

Terms of Reference
Board
2016

Background
• The Board is established under the Rules of ~~Urgent Care 24~~Primary Care 24 (Merseyside) Ltd (PC24) (the Rules) and these Terms of Reference are presented under Rule 6.13~~4~~ setting out the conduct of its meetings. Where these Terms of Reference are silent the provisions of section 6 of the Rules will govern proceedings at the Board.
Duties & Responsibilities
• To set the strategic direction of ~~Urgent Care 24 Ltd~~PC24 within the overall purpose and commitments set out in the Rules of the Society and the policies and priorities set out for the NHS in the areas where it provides or seeks to provide services.
• To set and monitor achievement of the key objectives for the organisation.
• To oversee the delivery of services by monitoring performance against objectives, key performance indicators and quality requirements, ensuring that appropriate corrective action is taken when necessary.
• To ensure high standards of corporate governance and personal and professional behaviour are maintained in the conduct of the organisation's business.
• To ensure effective financial and operational performance and oversee business planning and development within the overall organisational strategy.
• To establish the committees required by the Rules or such other committees and working groups required for the good governance of the organisation.
• To identify areas of risk for the organisation and ensure that there is appropriate monitoring, and that corrective action is taken to mitigate and manage the risk.
• To oversee the arrangements for patient engagement and to ensure that there is effective patient feedback on the services provided by the organisation.

- To provide effective leadership to the organisation from both an internal and external perspective.

Meeting frequency

- Meetings normally to be held bi-monthly ~~(with the exception of August and December)~~ or at the discretion of the Chair.

Attendees

- The Non-Executive Chair of the Board, being the individual recruited to the role under Clause 7 of the Rules.

- The Non-Executive Directors appointed to the Board as required by the Rules of the Society.

- The following Executive Directors:

  Chief Executive
  Director of Finance
  Director of Quality & Patient Safety
  Deputy Chief Executive/Chief Operating Officer

  Under Rule 6.11~~2~~, each of the directors above will have one vote~~, however in the event of a tied vote the Chair of the meeting shall have a second or casting vote~~.

- The quorum is set out in Rule 6.9~~10~~ and is the higher of
  - 3 (including at least 1 non-executive Director) and
  - half the number of directors (including at least half of the non-executive directors)

- Attendees:

  The following shall also attend the non-confidential part of the Board meeting:

  Staff Representative
  Other members of the Executive Team as required by the Board
  Company Secretary

  The following shall attend the confidential part of the Board meeting:

  Other members of the Executive Team as required by the Board
  Company Secretary

  Other staff members may be invited to attend either the non-confidential or confidential parts of the Board meeting to present particular items of business at the request of the Chief Executive or the Chair.

Governance
• The Board will give account of its performance to the Annual Members Meeting

Confidentiality
The Board will aim to conduct its business in an open and transparent manner. However, there may be occasions when it is necessary for reasons of confidentiality, to discuss matters in the confidential part of the Board meeting. Such matters might cover areas of commercial sensitivity or patient/staff confidentiality.

Review
The effectiveness of the Board will be reviewed annually, benchmarking its work against the organisation's objectives.
The Terms of Reference will be reviewed annually.

Title:	Meeting Date:	Agenda item no:
Quality & Workforce Committee report	30 May 2019	11.1
Prepared and presented by: Paula Grey	**Discussed by:** Quality & 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 & Workforce Committee meeting held on Wednesday 12 May 2019 which the Committee agreed should be brought to the Board's attention.

2.0 Matters for Report

2.1 The Committee noted that the Datix upgrade to move to Cloud storage had been completed. Testing of access from remote sites was now under way.

2.2 The Committee noted progress against the CQC action plan, and in particular the ongoing need for a salaried GP in Maghull following the withdrawal of the recruited individual for personal reasons. This was being followed up as a matter of priority.

2.3 The Committee noted that the CQUIN in relation to Safeguarding had been achieved.

2.4 The Committee received the Core Review B report from Audit South West and noted the management response to the recommendations. The implementation of the recommendations would be monitored through the Committee.

2.5 The Committee recommended two policies 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.

Title:	Meeting Date:	Agenda item no:
Finance and Performance Committee report	30.05.19	11.2
Prepared and presented by: **Paul Cummins**	**Discussed by:** Finance and Performance Committee	
Link to PC24 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 22 May 2019 which the Committee agreed should be brought to the Board's attention.

2.0 Matters for Report:

2.1 The Committee noted the finance and operational performance reports and thanked the staff concerned.

2.2 The Committee noted that in light of the ongoing issues with the current payroll provider, the specification for a new payroll service was being developed with a view to a procurement process being initiated.

2.3 The Committee recommended the Overpayments 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.

Regulations under Rule 1.6

Introduction

Under Rule 1.6 the Board may make Regulations in addition to the Rules of the Society. These Regulations set out how the Board conducts its business and outlines the current mechanism through which the Board gives expression to the Rules where the Rules are not specific about that expression.

In all its engagement the organisation's values of:

Providing quality patient services

Being an excellent employer

Working in collaboration to achieve positive system change

remain paramount.

PC24 seeks to value each individual's contribution to the organisation and to model an inclusive approach in recruitment and service delivery.

Conduct of Board & Committee Meetings

The Board and its Committees commit themselves to:

* Attending meetings
* Reading briefings & papers
* Arriving on time
* Participating wholeheartedly
* Submitting papers of high quality and uniformity for consideration before deadlines expire

Board meeting attendance will be reported annually.

The Board Code of Conduct

- Mutual trust & respect
- Honesty
- Determination, tolerance & sensitivity
- Rigorous & challenging questioning, tempered by respect
- Tolerance of diverse points of view, new ideas, different perspectives, embrace diversity
- Assist and support new Board members or those in attendance at meetings, whether internal or external
- Avoid giving offence be ready to apologise
- Avoid taking offence, stay open to discussion
- Be sensitive to colleagues' need for support when challenging or being challenged
- Be open to hearing a minority view and treat all ideas with respect
- Respect the need for confidentiality alongside candour and accountability
- Ensure meeting time is well used and individual points are relevant and short
- Strive to continuously improve the quality of paperwork, content of papers, administration of Board meetings

Staff Engagement

PC24 is committed to being a good employer. The following mechanisms provide opportunity for engagement with staff:

- Elected Staff Council
- Annual Start of the Year Conference
- Regular communication from the Chief Executive
- Staff Awards
- Post Box for internal communication
- Team and Staff meetings
- Reporting a Concern (Whistleblowing) process and policy

PC24 provides additional benefits for staff including:

- Confidential Employee Assistance Helpline
- Salary Sacrifice schemes
- Subsidised gym membership

Patient Engagement

The PC24 Board is committed to hearing a Patient Story at each of its bi-monthly Board meetings, and to noting any lessons learned for implementation in the organisation.

PC24 values and reports feedback from patients to staff, the Board and service Commissioners. This feedback is obtained through

- Friends & Family SMS feedback including free text comment
- Complaints and compliments reported through the website, post, email or face to face
- Specific Patient surveys
- Patient Participation Groups

Other Stakeholder Engagement

In its services, PC24 works with a range of stakeholders:

- Commissioners
- GP Practices and individual GPs
- Other health and social care professionals
- Third sector and other social enterprise organisations
- Education and learning

PC24 engages with these stakeholders through its monthly clinician education programme, taking a full part in system working groups and boards, meeting with third sector organisations, initiating inter-organisational working and being open to working in collaboration in the interest of patients.