Meeting in Public of the Enfield Clinical Commissioning Governing Body  
Wednesday 13th February 2013  
3.00pm – 4.30pm, Committee Room, Holbrooke House, Cockfosters Road, Barnet, Herts, EN4 0DR

**AGENDA**

<table>
<thead>
<tr>
<th>Lead</th>
<th>Action required</th>
<th>Appendices</th>
<th>Page No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

A private meeting will precede the Enfield Governing Body to discuss items of a confidential nature. Representatives of the press and members of the public will be excluded from this meeting. Section 1 (2) Public Bodies (Admissions to Meetings) Act 1960

1  Introduction

1.1 Welcome  
Chair  
Note  
Oral & Appendix A

Apologies for Absence and Declarations of Interest  
Apologies received – Dr Mohammed Abedi

1.2 Chair’s Introduction and Opening Remarks  
Chair  
To note  
Oral

1.3 Minutes of the last meeting and action notes  
Chair  
To approve  
Appendix B

1.4 Matters arising  
Chair  
Oral

1.5 Questions from the Public  
Chair  
Oral

NB: Observers will be given the opportunity to ask questions. These must relate to items that are on the agenda for this meeting and should not take longer than three minutes per person.

2. Overview Reports

2.1 Chair’s Report  
Chair  
To note  
Appendix C

And  
To approve recommendation

2.2 Chief Officer’s (Designate) Report  
Chief Officer (Designate)  
To note  
Appendix D

3. Strategy / Agreements

3.1 Communication and Engagement Strategy  
Director of Service Quality and Integrated Governance  
To approve  
Appendix E

3.2 Equality and Diversity Strategy  
Director of Service Quality and Integrated Governance  
To approve  
Appendix F
3.3 Collaborative Agreement  Director of Finance and Commissioning  To approve  Appendix G  105 - 122

4. Governance (policy ratification)

| 4.1 | H(i) -Governance Covering Report | Director of Service Quality and Integrated Governance | To ratify | Appendix H | 123 - 228 |

Governance Policies
- H(ii) - Policy for the Development and Management of Procedural Documents
- H(iii) - Data Protection Policy
- H(iv) - Information Lifecycle Management Policy
- H(v) - Internet Service Policy
- H(vi) - Information Sharing and Disclosure Policy

5. Quality and Safety

| 5.1 | Quality Report | Director of Service Quality and Integrated Governance | To note | Appendix I | 229 - 232 |

6. Finance

| 6.1 | Enfield Financial Position 2012-13 and QIPP | Director of Finance and Commissioning | To note | Appendix J | 233 - 236 |

7. For information – Any questions relating to these reports must be submitted to the Chair prior to the meeting.

8. Briefings

| 8.1 | Enfield Health and Well Being Board and CCG Joint Commissioning Board report | London Borough of Enfield - Director of Health, Housing & Adult Social Care | To note | Appendix K | 237 - 260 |

| 8.2 | 38 Degrees Briefing | Chair | To note | Appendix L | 261 - 276 |

| 8.3 | Professional Executive Committee (PEC) Report | Chair | To note | Appendix M | 277 - 282 |

9. NHS Enfield – web link:  
http://www.enfield.nhs.uk  
http://www.enfieldccg.nhs.uk  

For Information
ECCG are required by Department of Health to keep the NHS Enfield website active until 30 September 2013 with a holding page created and displayed from 1 April 2013 directing the public to the new CCG for up-to-date information

10. **Any Other Business**

11. **Questions from the Public**

<table>
<thead>
<tr>
<th>Questions from the Public</th>
<th>Chair</th>
<th>Oral</th>
</tr>
</thead>
</table>

12. **Appendices**

| Written Public questions and ECCG responses (from GB meeting 16 January 2013) | Chair | To approve | Appendix N | 283 - 290 |
| Oral Public questions and ECCG responses (from GB meeting 16 January 2013) | Chair | To approve | Appendix O | 291- 292 |

13. **Date of Next Meeting**

20th March 2013
Venue TBC
<table>
<thead>
<tr>
<th>NAME</th>
<th>TITLE</th>
<th>NAME OF ORGANISATION AND NATURE OF ITS BUSINESS</th>
<th>POSITION HELD / NATURE OF INTEREST</th>
<th>DATE DECLARED</th>
<th>DATE UPDATED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr Raj Mazumder</td>
<td>Elected GP Member</td>
<td>Freezywater Primary Care Centre (GP Practice)</td>
<td>Partner</td>
<td>03/10/12</td>
<td>03/10/12</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Enfield CCG</td>
<td>GP Member</td>
<td>03/10/12</td>
<td>03/10/12</td>
</tr>
<tr>
<td></td>
<td></td>
<td>NHS NCL 111 / DoS</td>
<td>Clinical and Governance Lead</td>
<td>03/10/12</td>
<td>03/10/12</td>
</tr>
<tr>
<td>Dr Mike Gocman</td>
<td>Elected GP Member</td>
<td>Barndoc Ltd</td>
<td>Shareholder</td>
<td>24/04/12</td>
<td>24/04/12</td>
</tr>
<tr>
<td></td>
<td></td>
<td>GP Principle Abermethy House Surgery</td>
<td>Partner/GP Principal</td>
<td>24/04/12</td>
<td>24/04/12</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Primary Care Cancer Society (non profit making society supporting good practice)</td>
<td>Chair</td>
<td>24/04/12</td>
<td>16/12/12</td>
</tr>
<tr>
<td>Dr Ujjal Sarker</td>
<td>Elected GP Member</td>
<td>Ujal Sarkar Ltd (provider of forensic medical services)</td>
<td>Directorship</td>
<td>17/04/12</td>
<td>13/12/12</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Pallicare Ltd (palliative care provider)</td>
<td>Directorship</td>
<td>17/04/12</td>
<td>13/12/12</td>
</tr>
<tr>
<td></td>
<td></td>
<td>RCGP NE</td>
<td>Faculty Board Member</td>
<td>17/04/12</td>
<td>13/12/12</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Fitness to Practise Director</td>
<td>GMC Performance Assessment Team Leader</td>
<td>17/04/12</td>
<td>13/12/12</td>
</tr>
<tr>
<td></td>
<td></td>
<td>GMC Professional and Linguistic Assessments Board</td>
<td>Examiner</td>
<td>17/04/12</td>
<td>13/12/12</td>
</tr>
<tr>
<td></td>
<td></td>
<td>MFFLM membership (Faculty of Foresnsic &amp; Legal Medicine at the Royal College of Physicians)</td>
<td>Membership Examiner</td>
<td>17/04/12</td>
<td>13/12/12</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Faculty of Forensic and Legal Medicine at the Royal College of Physicians</td>
<td>Academic Committee Member</td>
<td>17/04/12</td>
<td>13/12/12</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Enfield LMC</td>
<td>Vice Chair</td>
<td>17/04/12</td>
<td>13/12/12</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Ujal Sarkar Ltd (provider of forensic medical services)</td>
<td>Spouse is Director</td>
<td>17/04/12</td>
<td>13/12/12</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Pallicare Ltd (palliative care provider)</td>
<td>Spouse is Director</td>
<td>17/04/12</td>
<td>13/12/12</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Chase Farm Hospital</td>
<td>Oncology Specialist doctor</td>
<td>17/04/12</td>
<td>13/12/12</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Barndoc Clinical Governance Committee &amp; Medical Committee Advisory</td>
<td>Member</td>
<td>17/04/12</td>
<td>13/12/12</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Metropolitan Police</td>
<td>Medicines Management Committee Member</td>
<td>17/04/12</td>
<td>13/12/12</td>
</tr>
<tr>
<td>Dr Tim Fenn</td>
<td>Elected GP Member</td>
<td>Forest Road Group Practice</td>
<td>Partner</td>
<td>16/04/12</td>
<td>17/10/12</td>
</tr>
<tr>
<td>Dr Alpesh Patel</td>
<td>Chair</td>
<td>Whitel Lodge Medical Practice GP Partnership</td>
<td>GP Partner</td>
<td>24/05/12</td>
<td>04/07/12</td>
</tr>
<tr>
<td></td>
<td></td>
<td>White Lodge Medical Practice Limited (Pharmacy)</td>
<td>Director/Shareholder</td>
<td>24/05/12</td>
<td>04/07/12</td>
</tr>
<tr>
<td>Name</td>
<td>Title</td>
<td>Employer</td>
<td>Role</td>
<td>Start Date</td>
<td>End Date</td>
</tr>
<tr>
<td>------</td>
<td>-------</td>
<td>----------</td>
<td>------</td>
<td>------------</td>
<td>----------</td>
</tr>
<tr>
<td>Evergreen Surgery Limited (GP Practice)</td>
<td>Director/Shareholder</td>
<td>24/05/12</td>
<td>04/07/12</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Magnolia Limited</td>
<td>Director/Shareholder</td>
<td>24/05/12</td>
<td>04/07/12</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Equity Health LLP</td>
<td>Director/Shareholder</td>
<td>24/05/12</td>
<td>04/07/12</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medicare Medical Services LLP (Walk in service)</td>
<td>Shareholder</td>
<td>24/05/12</td>
<td>04/07/12</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prime Point Limited</td>
<td>Shareholder</td>
<td>24/05/12</td>
<td>04/07/12</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Enfield Health Partnership Limited</td>
<td>Shareholder / GP Partner is a Director</td>
<td>24/05/12</td>
<td>04/07/12</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Barndoc Healthcare Limited</td>
<td>Shareholder</td>
<td>24/05/12</td>
<td>04/07/12</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ordnance Health Limited (company tendering for the APMS contract at Ordnance Road Surgery)</td>
<td>Shareholder</td>
<td>24/05/12</td>
<td>19/12/12</td>
<td></td>
<td></td>
</tr>
<tr>
<td>BEHMHT</td>
<td>Wife is a CAMHS Consultant</td>
<td>24/05/12</td>
<td>04/07/12</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dr Pavan Sardana</td>
<td>Elected GP Member</td>
<td>Enfield LMC</td>
<td>01/05/12</td>
<td>01/05/12</td>
<td></td>
</tr>
<tr>
<td>Dr Janet High</td>
<td>Elected GP Member</td>
<td>Park Lodge Medical Centre, 3 Old Park Road, London N13 4RG</td>
<td>GP Principal</td>
<td>14/04/12</td>
<td>14/04/12</td>
</tr>
<tr>
<td>Dr Anshu Baghat</td>
<td>Elected GP Member</td>
<td>Grovelands medical centre</td>
<td>Principle</td>
<td>26/10/12</td>
<td>26/10/12</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Grenoble Gardens surgery</td>
<td>Principle</td>
<td>26/10/12</td>
<td>26/10/12</td>
</tr>
<tr>
<td></td>
<td></td>
<td>GPMedic Ltd</td>
<td>Director</td>
<td>26/10/12</td>
<td>26/10/12</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Barndoc healthcare Ltd</td>
<td>Shareholder and Members advisory committee member</td>
<td>26/10/12</td>
<td>26/10/12</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Police and referral management</td>
<td>NCL Clinical lead</td>
<td>26/10/12</td>
<td>26/10/12</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Pharma in NCL</td>
<td>Spouse works as Account Manager</td>
<td>26/10/12</td>
<td>26/10/12</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Police and referral management</td>
<td>NCL Clinical lead</td>
<td>26/10/12</td>
<td>26/10/12</td>
</tr>
<tr>
<td>Dr Shahed Ahmad</td>
<td>Director of Public Health</td>
<td>UCLH and BCF NHS Trust</td>
<td>Wife is a Consultant Oncologist</td>
<td>09/05/12</td>
<td>02/11/12</td>
</tr>
<tr>
<td>Karen Trew</td>
<td>Vice Chair / Non-Executive Director</td>
<td>NHS Enfield Primary Care Trust</td>
<td>Vice Chair</td>
<td>24/05/12</td>
<td>24/05/12</td>
</tr>
<tr>
<td></td>
<td></td>
<td>NHS Camden Primary Care Trust</td>
<td>Non-Executive Director</td>
<td>24/05/12</td>
<td>24/05/12</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Shadow Enfield Clinical Commissioning Group Governing Body</td>
<td>Lay Member</td>
<td>11/10/12</td>
<td>11/10/12</td>
</tr>
<tr>
<td>Liz Wise</td>
<td>Accountable Officer</td>
<td></td>
<td></td>
<td>No interests declared</td>
<td></td>
</tr>
<tr>
<td><strong>Non Voting Members</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ray James</td>
<td>Director of Health, Housing</td>
<td>Housing and Adult Social Care at Enfield Council - commissioner of social care services from a range of providers including voluntary sector organisations.</td>
<td>Director of Health</td>
<td>24/05/12</td>
<td>31/10/12</td>
</tr>
<tr>
<td></td>
<td></td>
<td>London Region of ADASS (Association of Directors of Adult Social Services)</td>
<td>Chair, London Region of ADASS</td>
<td>24/05/12</td>
<td>31/10/12</td>
</tr>
<tr>
<td>Rathai Thevananth</td>
<td>Practice Manager</td>
<td>Arnos Grove Medical Centre</td>
<td>Father (Dr S Thilainathan) is a GP</td>
<td>01/05/12</td>
<td>01/05/12</td>
</tr>
<tr>
<td>Richard Quinton</td>
<td>Head of Finance</td>
<td>QFM Ltd (private consultancy company)</td>
<td>Director - 100% owned</td>
<td>04/05/12</td>
<td>29/10/12</td>
</tr>
<tr>
<td></td>
<td></td>
<td>The Phoenix Project (IOW) (social Enterprise for adults with Learning Disabilities on the Isle of Wight)</td>
<td>Trustee</td>
<td>04/05/12</td>
<td>29/10/12</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Imdeq Ltd (a consultancy that may provide services to the NHS)</td>
<td>Spouse (Isabella Quinton) is Director. 100% owned</td>
<td>04/05/12</td>
<td>29/10/12</td>
</tr>
<tr>
<td>Robert Elkeles</td>
<td>Governing Body Member - Secondary Care</td>
<td>The Peace Hospice Watford</td>
<td>Vice Chair and Trustee</td>
<td>04/12/2012</td>
<td>04/12/2012</td>
</tr>
<tr>
<td>Professional Executive Committee Representatives</td>
<td>NHS Consultants Association</td>
<td>Committee Member</td>
<td>Observations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>--------------------------------------------------</td>
<td>-------------------------------</td>
<td>------------------</td>
<td>--------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mo Abedi</td>
<td>PEC Chair</td>
<td>Medicare Medical Services LLP</td>
<td>Director / Shareholder</td>
<td>11/05/12</td>
<td>11/05/12</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Equity Health LLP</td>
<td>Director / Shareholder</td>
<td>11/05/12</td>
<td>11/05/12</td>
</tr>
<tr>
<td></td>
<td></td>
<td>DM786 Ltd.</td>
<td>Director</td>
<td>11/05/12</td>
<td>11/05/12</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Prime Point Ltd.</td>
<td>Director / Shareholder</td>
<td>11/05/12</td>
<td>11/05/12</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Evergreen Surgery Ltd.</td>
<td>Director / Shareholder</td>
<td>11/05/12</td>
<td>11/05/12</td>
</tr>
<tr>
<td></td>
<td></td>
<td>East Enfield Medical Practice</td>
<td>GP principle</td>
<td>11/05/12</td>
<td>11/05/12</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Enfield Health Partnership Ltd.</td>
<td>Shareholder</td>
<td>11/05/12</td>
<td>11/05/12</td>
</tr>
<tr>
<td>Ordnance Health Limited (company tendering for the APMS contract at Ordnance Road Surgery)</td>
<td></td>
<td>Spouse has same interests</td>
<td>11/05/12</td>
<td>20/12/12</td>
<td></td>
</tr>
</tbody>
</table>

**Observer**

<table>
<thead>
<tr>
<th>Name</th>
<th>Capacity</th>
<th>Interests Declared</th>
<th>Observations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mahendra Makan</td>
<td>Chair LDC</td>
<td>No interests declared</td>
<td>04/10/2012</td>
</tr>
<tr>
<td>Lynne Lambert</td>
<td>Enfield LINk Lead</td>
<td>No interests declared</td>
<td>23/10/2012</td>
</tr>
<tr>
<td>Gerald Alexander</td>
<td>Chair, BEH Local Pharmaceutical Committee</td>
<td>National Pharmacy Association Ltd and associated companies (professional association - representative body for community pharmacy and trade association)</td>
<td>Director (Board Member)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>The Cadge Pharmacy - within Haringey PCT (a provider to NAS services to NAS Haringey)</td>
<td>Director</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Middlesex Pharmaceutical Group of Local Pharmaceutical Committees</td>
<td>Consultant</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Barnet, Enfield &amp; Haringey Local Pharmaceutical Committee</td>
<td>Chair</td>
</tr>
</tbody>
</table>
Minutes
Meeting of the Enfield Clinical Commissioning Group Governing Body – PART 1
Wednesday 16 January 2013 at 3.00pm
Room 1, Dugdale Centre, Thomas Hardy House,
39 London Road, EN2 6DS

Members Present:
Dr Alpesh Patel AP Chair, GP Board Member
Dr Janet High JH Clinical Vice Chair GP Board Member
Karen Trew KT Lay Vice-Chair Board Member
Teri Okoro TO Lay Board Member
Professor Robert Elkeles RE Secondary Care Doctor Board Member
Dr Tim Fennn TF GP Board Member
Dr Ujjal Sarkar US GP Board Member
Dr Raj Mazumder RM GP Board Member
Dr Pavan Sardana PS GP Board Member
Dr Mike Gocman MG GP Board Member
Rathai Thevananth RT Practice Manager Representative Board Member

In Attendance:
Liz Wise LW Chief Officer (Designate)
Richard Quinton RQ Director of Finance and Commissioning
Aimee Fairbairns AF Director of Service Quality and Integrated Governance
Dr Shahad Ahmed SA Director of Public Health
Ray James RJ London Borough of Enfield Representative
Andrew Williams AW Authorisation Programme Lead
Keith Spratt KS GP Commissioning Lead for Enfield CCG

Minutes:
Gilbert George GG NHS Enfield Clinical Commissioning Group Board Secretary (Interim)

1. INTRODUCTION

1.1 Apologies for Absence:
Dr Anshu Bhagat, GP Board Member
Dr Mohammed Abedi, Medical Director Board Member

1.1.1 There were no declarations of conflicts of interest in relation to items of business on the agenda.
Chair's Introduction and Opening Remarks

The Chair welcomed the Enfield Clinical Commissioning Group (CCG) Governing Body and members of the public.

Before the start of formal business, the Chair was handed a petition from an organisation known as the 38 Degrees. The petition called for CCG to:

- Protect local NHS services and consult patients properly before making changes
- Spend money wisely and don’t do deals with irresponsible private companies
- Adopt policies and a constitution which reflect these values.

The Chair thanked 38 Degrees representatives and confirmed the petition would be reviewed and a response from CCG would be issued in due course.

Minutes of the meeting of 7 November 2012 and Action Notes

The CCG Governing Body APPROVED the minutes as an accurate record of the meeting and NOTED the Action Sheet and requested action number 12/09-3 be removed from the register - action completed.

Matters Arising

There were no matters arising.

Questions from the Public

A number of written and oral questions were submitted and asked by members of the public answers were given orally by the Chair. The questions and CCG’s responses are found in appendices N and O.

OVERVIEW REPORTS

Chair’s Report

The Board NOTED the Chair’s report, which provided a brief update on the Chair’s work programme and appointments to GGB board.
2.2 Chief Officer's (Designate) Report

2.2.1 The Chief Officer gave a short update on current issues in relation to the CCG. Appointments to the following positions within the management structure have been made:

- Medical Director
- Head of Governance and Risk
- Second Lay Member with responsibility for Patient and Public Engagement

2.2.2 The CCG Governing Body:

- **NOTED** the progress being made by Enfield Clinical Commissioning Group.
- **NOTED** the approval of the Terms of Reference for the Health and Wellbeing Board.
- **NOTED** the signing of the Memorandum of Understanding between Enfield Council and Enfield CCG.
- **NOTED** the signing off of the full business case for Barnet and Chase Farm Hospitals by NHS London.
- **NOTED** the signing off of the full business case for North Middlesex University Hospital by HM Treasury.
- **NOTED** the development of a draft Communications and Engagement Strategy.
- **AGREED** to maintain on-going update on progress for the functions to be covered by the Chief Officer (Designate) for NHS Enfield Clinical Commissioning Group.

3. STRATEGY

3.1 Enfield Joint Carers Strategy

3.1.2 The CCG Governing Body **APPROVED** the Enfield Joint Carers Strategy.

4. GOVERNANCE / AUTHORISATION (Andrew Williams)

4.1 Authorisation Report update

4.1.1 Andrew Williams, Authorisation Programme Lead presented an update report on the CCG’s progress through the Authorisation process with the NHS Commissioning Board (NHS CB). The Governing Body was pleased to report that following the NHS CB visit to NHS Enfield CCG on 7 January 2013, and on the basis of the evidence provided, the NHS CB Visit Panel decided to reduce the number of Authorisation criteria rated red from 74 to 15 (out of 119).
4.1.2 The CCG’s considered response to the NHSCB Panel’s Site Visit Letter was being drafted for submission by the deadline of 17 January 2013. Following moderation by the NHSCB and further submission of evidence by the CCG in February, the NHSCB is expected to provide its final decision on 7 March 2013.

4.2 ECCG Constitution

4.2.1 Andrew Williams, Authorisation Programme Lead presented a report summarising the outcomes of the joint working to develop the CCG’s Constitution with the LMC; membership consultation; issues raised by Governing Body members supported by the Authorisation Programme Office; and advice from Beachcroft within the framework of the NHS and Social Care Act 2012 and NHS CB guidance.

4.2.2 Andrew Williams, Authorisation Programme Lead explained that the CCG was required to submit the Constitution agreed by the Governing Body as part of the Authorisation process in February 2013. However, this did not preclude the CCG from making changes before 1 April 2013 in response to the requests made by 38 Degrees, following the Governing Body seeking further advice and considering both the views of the LMC and membership and of 38 Degrees members in Enfield.

4.2.3 Governing Body members noted and approved the principal changes made to the Constitution, as explained in the report, in response to feedback from the membership and advice and guidance, following consideration by Governing Body members at the Executive Group meeting on 19/12/12.

4.2.4 As notified in the report on the Constitution issued with the Governing Body papers, final technical revisions had been made with Beachcrofts and were presented by Andrew Williams in a supplementary report to the Governing Body meeting on 16 January 2013. The Governing Body agreed:

1. to confirm in the Constitution that it is the intention that the CCG Chair be a GP (see next point below);
2. that the arrangements in the Constitution for appointment of a GP Chair of the Governing Body require the GP to first be elected as one of the CCG’s elected Locality Lead GPs, prior to appointment by the Governing Body;
3. that in the Constitution LMC Officers can be eligible to be interviewed and elected as a Governing Body Locality Lead GP and that their role in decision making will be subject to the effective application of the Conflict of Interest Policy.
4. to distribute the approved Constitution to the member practices, to request their confirmation of receipt and of each practice’s named clinical Member Representative and their role within the member practice (as per section 9.1) within the next four weeks;

4.2.5 To avoid an election for all GP Governing Body members commencing at the point of establishment of the CCG - which would be highly de-stabilising for the organisation and its contractual partners – the Governing Body agreed to communicate to the membership and LMC the proposal that elected Governing Body members whose term of office would otherwise end on 31 July 2013, be requested at the February Governing Body meeting to extend this to end on 31 July 2014.
4.2.6 Members APPROVED the Constitution, including the principal changes and revisions in the supplementary report, for application with effect from the establishment of NHS Enfield CCG on 1 April 2013.

4.3 Code of Practice on Openness in the NHS

4.3.1 The ECCG Governing Body RATIFIED the decision by Executive Committee members at its 19 December 2012 meeting, to recommend the adoption of the Code of Practice on Openness in the NHS.

4.4 Standards for Members of NHS Boards and Clinical Commissioning Group Governing Bodies in England

4.4.1 The ECCG Governing Body RATIFIED the decision by Executive Committee Members at its 19 December 2012 meeting, to recommend the adoption of the Standards for Members of NHS Boards and Clinical Commissioning Group Governing Bodies in England.

4.5 Standards of Business Conduct for NHS Staff

4.5.1 The ECCG Governing Body RATIFIED the decision by Executive Committee Members at its 19 December 2012 meeting, to recommend the adoption of the Standards of Business Conduct for NHS Staff.

4.6 Code of Conduct for NHS Managers

4.6.1 The ECCG Governing Body RATIFIED the decision by Executive Committee Members at its 19 December 2012 meeting, to recommend the adoption of the Code of Conduct for NHS Managers.

4.7 Policy for Declaration of Interest and Resolution of Conflict.

4.7.1 The ECCG Governing Body RATIFIED the decision by Executive Committee Members at its 03 January 2013 meeting, to recommend the approval of the Policy for Declaration of Interest and Resolution of Conflict Code of Conduct.

4.8 Gifts, Hospitality and Commercial Sponsorship Policy

4.8.1 The ECCG Governing Body RATIFIED the decision by Executive Committee Members at its 03 January 2013 meeting, to recommend the approval of the Gifts, Hospitality and Commercial Sponsorship Policy.

4.9 Risk Management Strategy

4.9.1 The ECCG Governing Body RATIFIED the decision by Executive Committee Members at its 03 January 2013 meeting, to recommend the approval of the Risk Management Strategy.

4.10 Information Governance Policy

4.10.1 The ECCG Governing Body RATIFIED the decision by Executive Committee Members at its 03 January 2013 meeting, to recommend the approval of the Information Governance Policy.
4.10.2 Governing Body members were informed of the appointment of Dr Abedi Mohammed as the ECCG Caldicott Guardian and Aimee Fairbairns as the Senior Information Risk Owners.

4.11 **E-mail Security Policy**

4.11.1 The ECCG Governing Body RATIFIED the decision by Executive Committee Members at its 03 January 2013 meeting, to recommend the approval of the E-mail Security Policy.

4.12 **Information Security Policy**

4.12.1 The ECCG Governing Body RATIFIED the decision by Executive Committee Members at its 03 January 2013 meeting, to recommend the approval of the Information Security Policy.

5.1 **Quality Report**

5.1.2 The Director of Service Quality & Integrated Governance gave a brief update to members on various quality matters including the quality committee governance and structure; safeguarding, complaints and quality review groups.

5.1.3 Quality Review Groups - It was noted each contract management team has a Clinical Quality Review Group (CQR), for Enfield the CQRs are currently attended by Enfield Clinical Commissioning Group clinicians at Barnet and Chase Farm Hospitals NHS Trust (BCF), North Middlesex University Hospitals NHS Foundation Trust (NMH) and Barnet, Enfield and Haringey Mental Health Trust (BEH) which also includes reporting on Enfield Community Services (ECS) which are provided by BEH. The CQR reports from each trust will be reviewed by the Enfield Quality and Safety Committee.

5.1.4 The Director of Service Quality & Integrated Governance informed members that future quality reports will include risks and performance.

5.2 **Quality Strategy Framework**

5.2.1 The ECCG Governing Body RATIFIED the decision by Executive Committee Members at its 03 January 2013 meeting, to recommend the approval of the Quality Strategy Framework subject to minor amendments.

5.3 **Safeguarding Children Policy**

5.3.1 The ECCG Governing Body RATIFIED the decision by Executive Committee Members at its 03 January 2013 meeting, to recommend the approval of the Safeguarding Children Policy.

5.3.2 Governing Body members noted that this policy will be reviewed by Enfield Local Authority under its collaboration agreement with ECCG.

5.4 **Safeguarding Adults Policy**
5.4.1 The ECCG Governing Body **RATIFIED** the decision by Executive Committee Members at its 03 January 2013 meeting, to recommend the approval of the Safeguarding Adults Policy.

5.4.2 Governing Body members noted that this policy will be reviewed by Enfield Local Authority under its collaboration agreement with ECCG.

5.5 **Mental Capacity and Deprivation of Liberty Policy**

5.5.1 The ECCG Governing Body **RATIFIED** the decision by Executive Committee Members at its 03 January 2013 meeting, to recommend the approval of the Mental Capacity and Deprivation of Liberty Policy.

5.6 **Policy and Procedures for the Reporting, Investigating and Management of Incidents and Serious Incidents**

5.6.1 The ECCG Governing Body **RATIFIED** the decision by Executive Committee Members at its 03 January 2013 meeting, to recommend the approval of the Policy and Procedures for the Reporting, Investigating and Management of Incidents and Serious Incidents.

5.7 **Complaints, Compliments and Concerns Policy**

5.7.1 The ECCG Governing Body **RATIFIED** the decision by Executive Committee Members at its 03 January 2013 meeting, to recommend the approval of the Policy and Procedures for the Complaints, Compliments and Concerns Policy.

6. **Finance & Performance**

6.1 Finance

6.1.1 The Director of Finance and Commissioning presented a report on the CCG’s financial position at Month 8. The month 8 cumulative results show a deficit of £1.898m against a zero budget. The shortfall is primarily made up of acute over-performance and unidentified QIPP. The forecast to the end of the year shows a deficit of £5.038m with acute over-performance £1.87M and unallocated QIPP deficit of £6.107M the key items. These are partially offset by the acute reserve of £5.4m and contingency of £2.4m.

6.1.2 The Vice-Chair (Karen Trew) requested future finance report include information on the balance sheet, cash output indicators and more information on Quality, Innovation, Productivity and Prevention (QIPP) active spend.

6.1.3 Director of Finance and Commissioning noted this request and confirmed this would be the case for future reports.

6.1.4 Members sought assurance on the risk that the CCG would meet its control total due to the gap in the QIPP programme, as well as assurance that the QIPP schemes in place would achieve the levels of savings predicted
6.1.5 Director of Finance and Commissioning reported that control total would be met. The Director also stated that there was monthly analysis of the QIPP schemes in operation, showing exact activity and comparison data; at this point in time there is a degree of confidence that we will be meeting our anticipated QIPP savings.

6.1.6 The Director highlighted that there could be a run rate deficit of £19.2m (run rate is a financial term which relates to future forecasting) next financial year for Enfield CCG. This is based on Enfield PCT’s current spending; the Director stated we will be aiming to close this gap by developing a strong financial plan, supported by a QIPP programme.

6.1.7 The Director also stated it is important to note that run rate is a financial forecasting tool and that other factors may also lead to this estimate being revised. Enfield CCG has a smaller financial allocation than Enfield PCT as many of the functions that PCTs provide are transferring to other new NHS organisations. It is important for financial planning that we undertake forecasting and plan for the worst case financial position, but run rate as with any other financial figures can change month by month. NHS North Central London is providing additional support to help minimise the run rate position before the end of this financial year.

6.1.8 Members noted the contents of the Finance report.

6.2 Performance Report

6.2.1 The Director of Finance and Commissioning presented the performance report covering the following areas:

- Risks
- Acute Contract Performance
- Acute Activity
- Learning Disability and Physical Disability
- Continuing Healthcare
- Key Performance Indicators

6.2.2 Members noted the content of the report and acknowledged the report was work in progress.

6.2.3 The Director indicated future reports would include quality and safety key indicators and that development work was now underway following the appointment of the Head of Performance.

6.2.4 The following requests from members were made for future reports to include:
Karen Trew - Primary Care measures
Mike Gocman - Contract performance
Ray James - Patient satisfaction

[ACTION – 6.2.4]
6.3 Procurement Strategy

6.3.1 The ECCG Governing Body RATIFIED the decision by Executive Committee Members at its 03 January 2013 meeting, to recommend the approval of the Procurement Strategy

7 NHS Enfield – web link:
http://www.enfield.nhs.uk

8. ANY OTHER BUSINESS

8.1 There was no other business.

9. WRITTEN AND ORAL QUESTIONS FROM THE PUBLIC

SEE APPENDIX N & O

10. DATE OF NEXT MEETING

20TH MARCH 2013

Venue To Be Confirmed
These minutes are agreed to be a correct record of the meeting of the Enfield Clinical Commissioning Group Governing Body held on 16 January 2013

Signed:                           Date:
Chair

Signed:                           Date:
Chief Officer (Designate)
<table>
<thead>
<tr>
<th>Meeting Date</th>
<th>Action No.</th>
<th>Minutes Reference</th>
<th>Action Description</th>
<th>Responsibility</th>
<th>Target Date</th>
<th>Progress Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>13/06/2012</td>
<td>06/12-03</td>
<td>3.3.3</td>
<td>To raise with contract leads issues around A&amp;E patient discharge and prescribing and to seek advice on the most effective approach to managing acute trust performance in this respect.</td>
<td>Richard Quinton</td>
<td>Feb-13</td>
<td>The Trust has responded with an action plan which it is in the process of implementing. The plan includes staff training and awareness and internal audits of performance. The Trust presented the findings from the audit at the 05 February 2013 Clinical Quality Review Group (CQRG), demonstrating an improvement to 70%+ letters being despatched within the required timescale and with adequate content.</td>
</tr>
<tr>
<td>12/09/2012</td>
<td>12/09-1</td>
<td>1.1</td>
<td>To update the register to include practice membership for all GP Members and to ensure that the nature of organisations is included in declarations and the register of interest.</td>
<td>Gilbert George / Matt Hopkinson</td>
<td>Mar-13</td>
<td>Work is currently on-going to ensure all declarations are up to date and complete.</td>
</tr>
<tr>
<td>16/01/2013</td>
<td>16/01-1</td>
<td>6.2</td>
<td>To develop the current performance report to include amongst others (Key Performance Indicators in: Quality and Safety; Primary Care; Contract performance; and Patient Satisfaction.</td>
<td>Richard Quinton</td>
<td>Mar-13</td>
<td></td>
</tr>
</tbody>
</table>

**ACTION LOG: Enfield Clinical Commissioning Group Board**
MEETING: NHS Enfield Clinical Commissioning Group Governing Body

DATE: Wednesday 13th February 2013, 3.00 – 4.30pm

TITLE: Chair’s Report

LEAD DIRECTOR/MANAGER: Alpesh Patel, Chair

AUTHOR: Keith Spratt and Andrew Williams on behalf of Alpesh Patel

CONTACT DETAILS: Keith.spratt@nclondon.nhs.uk; Andrew.williams@nclondon.nhs.uk

SUMMARY: This report updates the Board on current issues in relation to Enfield Shadow Clinical Commissioning Group.

SUPPORTING PAPERS: None

RECOMMENDED ACTION: The Governing Body is asked to:
- NOTE the contents of the report
- NOTE the progress of Enfield Clinical Commissioning Governing Body

Objective(s) / Plans supported by this paper: NHS North Central London Commissioning Strategy 2012-15 and Operating Plan 2012-13

Audit Trail: None

Patient & Public Involvement (PPI): None
Equality Impact Assessment: Equality Impact Assessments are undertaken in relation to substantial commissioning changes and will be available where necessary in relation to individual work programmes

Risks: All risks identified are recorded on the Enfield Risk Register and Board Assurance Framework, or available as part of individual work programmes

Resource Implications: Where relevant they are detailed, or available as part of individual work programmes

Next Steps: An updated report will be provided at each Board meeting
1.0 SUMMARY

The purpose of this report is to provide Enfield Clinical Commissioning Group (CCG) Governing Body with information on the work programme of the Chair, working in close liaison with the Chief Officer (Designate) and Board members.

The paper will be updated for each consecutive Board meeting so that progress can be tracked.

2.0 WORK PROGRAMME

The work programme over the period covers the following areas:

- Appointments to CCG Board
- Authorisation update

2.1 APPOINTMENTS TO THE CCG BOARD

- Secondary care nurse – appointment has been made subject to final HR clearance.

2.2 AUTHORISATION UPDATE

2.2.1 Outcome of the NHSCB Site Visit to NHS Enfield CCG

The NHS Commissioning Board (NHSCB) Authorisation Site Visit to NHS Enfield CCG took place on 7 January 2013. The CCG Chair and Chief Officer delivered a presentation and four key lines of enquiry were then followed up in detail by the Panel with groups of CCG Governing Body members, including the Joint Director of Public Health and LBE Director of Health Housing and Adult Social Care, who were supported by the Chief Operating Officer and Contracting Director (NCL CCG’s) from the North Central and East London Commissioning Support Unit.

Feedback from the Panel Chair and members at the end of the visit was both positive and constructive and the CCG’s 74 red rated authorisation criteria prior to the visit were reduced to 15.

2.2.2 Governing Body Membership

Since the last update to the Health and Well Being Board, the following Governing Board members have fully taken up their roles on the Governing Body:

- Professor Robert Elkeles, as secondary care (hospital) doctor

- Teri Okoro, as lay member and patient and public engagement lead

- Angela Dempsey, as Registered Nurse Board member

2.2.3 Outstanding Issues

The CCG’s Moderation Panel Report was received from the NHSCB on 31 January 2013. This report together with our submission in response and additional evidence (to be
uploaded to the NHSCB on-line authorisation system by 20 February) goes to the NHSCB Conditions Panel before a final decision from NHSCB is made. The Moderation Panel checks consistency of judgements made by the Panels, so decisions to change ratings are much more in the hands of the Conditions Panel. The good news is that Moderation Panel:

- Changed the Constitution sign up criteria (1.2c) from Red to Green;
- Identified 5 criteria as key remaining areas for us, inferring that they support the Panel Key Assessor’s recommendations that subject to providing the evidence we said we would (in the Considered Response on 17/01), 9 criteria will be changed for Red to Green

This means that there are now 14 red-rated criteria remaining following the site visit. The key remaining areas after our site visit response are as follows:

3.1.1 B – Further information is required to show the targets for the commissioning intentions to achieve end state and the process that will ensure this happens. Clarity is required regarding current year priorities, 2013/14 commissioning intentions and longer term strategic aims.

3.1.1 C – The CCG needs to clearly set out how it will achieve financial balance and manage within its management allowance and other required constraints.

4.2.1 G – Further evidence is required to demonstrate that the CCG has agreed risk sharing arrangements with neighbouring CCGs.

5.1 A – Further evidence is required to demonstrate that the CCG has agreed collaboration and risk sharing arrangements with neighbouring CCGs.

6.4 G - Further evidence is required to demonstrate that the CCG has appointed a governing body nurse and that once in post, this role assists the capacity and capability in maintaining strategic oversight.

We anticipated the first 4 because nationally the first two (Clear Commissioning & QIPP Plan and Finance and Recovery Plan) are excluded from this stage of the process nationally by NHSCB. This is to allow them to be reviewed by NHSCB area teams - presumably against the NHS Operating Plan requirements - in what is known as the March Review. The second two (NCL CCGs collaboration and risk share agreements) are interdependent with the two above and these are reported separately on the Governing Body Agenda.

Further clarification and advice has been obtained from NHSCB London colleagues to assist in producing our response and submission regarding 6.4 G. This relates to more than the appointment of the Registered Nurse Board member and requires further evidence of the capacity available to the CCG to monitor, assure and improve quality of CCG commissioned services.

The NHSCB Conditions Letter was received on 7 February. Of the 14 criteria:

- 5 are at the lowest level (i) requiring submission of documents approved by the Governing Body since the visit;
- 7 are at level ii where assistance and advice is offered to the CCG by NHSCB London which we have taken up to help enable the CCG to meet these conditions;
2 are at level iii. These are 3.1.1.B and 3.1.1.C above and, as for the large number of CCG’s nationally with these as Red rated criteria, no additional Authorisation submission is required in February and the NHSCB will decide on these in March.

2.2.4 Preparing for Establishment as NHS Enfield CCG on 1 April 2013

The CCG’s response and evidence report will be produced ready for approval by the Chair and Chief Officer at the Authorisation and Transition Programme Board 14 February and submission to NHSCB by 20 February 2013.

The CCG is actively engaged with NHS North Central London PCTs Cluster, the North Central and East London Commissioning Support Unit and NHSCB London in managing the effective transfer and handover of those functions for which the CCG becomes statutorily responsible for commissioning from 1 April 2013.

NHS Enfield CCG remains on track for Establishment with Authorisation on 1 April 2013.

3.0 TERMS OF OFFICE for LOCALITY LEAD GP MEMBERS of the CCG GOVENING BODY

At the 16th January Governing Body meeting it was reported that Locality Lead GP Governing Body members and the Practice Manager Representative either have Terms of Office ending 31 July 2013 or, in the case of Dr Bhagat who was elected and appointed in 2012, three years from his date of appointment. This is due to these appointments being for the shadow CCG during the transitional period from April 2011 to March 2013 as made by the NHS NCL (and NHS Enfield PCT) Chair and Chief Executive. Holding an election at a time when contracts are being negotiated and the CCG organisation is being established presents serious and high risks of distraction and discontinuity for the CCG’s Governing Body’s leadership.

In common with other CCG’s, it was proposed that the existing elected Governing Body members be asked to extend their terms of office at the 13th February Governing Body meeting. For Enfield, it was proposed that those elected members with terms of office ending 31 July 2013, be requested to extend their terms of office to July 2014. The provision in the Constitution for at least one GP to stand down at each Annual General Meeting would remain applicable for 2013/14.

As proposed at the January meeting, this proposal has been communicated to the member practices and LMC in advance of the February meeting to establish whether there are any objections and, if so, to be able to consider these and respond accordingly.

At the time of drafting this report, 1 response had been received from 1 practice. The practice supported the extension of terms of office as proposed. There were no concerns expressed regarding extending the Terms of Office, as proposed.

As requested by Governing Body Locality Lead GPs, a follow up letter has been sent by registered post to each member practice’s named clinical representative.

Any further comments received will be reported verbally at the meeting.
4.0 RECOMMENDATIONS

Subject to any further comments, the CCG’s Governing Body is recommended to:

1. **REQUEST** that elected Locality Lead GP Governing Body members, whose term of office would otherwise end on 31 July 2013, agree to extend this to end on 31 July 2014.
This report updates the Governing Body on current issues in relation to NHS Enfield Clinical Commission Group and wider policy issues and should be read in conjunction with the Head of Finance's paper.

RECOMMENDED ACTION:
The Governing Body is asked to:

• Note the progress being made by Enfield Clinical Commissioning Group.
• Maintain on-going update on progress for the functions to be covered by the Chief Officer (Designate) for NHS Enfield Clinical Commissioning Group.

Objective(s) / Plans supported by this paper: NHS North Central London Commissioning Strategy 2012-15 and Operating Plan 2012-13

Audit Trail: None

Patient & Public Involvement (PPI): None

Equality Impact Assessment: Equality Impact Assessments are undertaken in relation to substantial commissioning changes and will be available where necessary in relation to individual work programmes.
**Risks:** All risks identified are recorded on the Enfield Risk Register and Board Assurance Framework, or available as part of individual work programmes

**Resource Implications:** Where relevant they are detailed, or available as part of individual work programmes

**Next Steps:** An updated report will be provided at each Board meeting
SUMMARY

The purpose of this report is to provide the Governing Body with information on key developments for the CCG, since the last meeting on 7th November 2012.

My report covers the following areas:

• Developing the organisation
• Award of GP Out of Hours Service
• Organisational Form for Barnet and Chase Farm Hospitals
• The Barnet, Enfield and Haringey Mental Health Trust (BEHMHT) – Foundation Trust Application progress
• Joint Services Centre, Ordnance Road
• Update on Change of Hours in Evergreen Walk-in Centre
• Update on the Final Report into Winterbourne View
• Primary Care Strategy - Enfield

DEVELOPING THE ORGANISATION

Since the last Public Governing Body meeting the Clinical Commissioning Group (CCG) has successfully appointed to the following positions within the management structure;

• Interim Head of Performance and Informatics

AWARD OF GP OUT OF HOURS SERVICE

Following a procurement process the Joint Boards of NCL, held on 31st January 2013, have approved the award of a 24 month contract to Barndoc to deliver the GP Out of Hours services for Barnet, Enfield and Haringey CCGs.

ORGANISATIONAL FORM FOR BARNET AND CHASE FARM HOSPITALS

Following Barnet and Chase Farm Trust’s decision that it was not viable as a standalone Foundation Trust, a competitive selection process was undertaken which resulted in the selection of the Royal Free London NHS Foundation Trust as the Trust’s preferred partner.

The Strategic Outline Case, making the case for progressing to a detailed outline business case for the acquisition of Barnet and Chase Farm Trust by the Royal Free London NHS Foundation Trust was approved by the Capital Investment Committee of NHS London at the end of November 2012.

The Royal Free is now working with Barnet and Chase Farm Hospitals and the wider health economy to develop an innovative solution that maximises clinical synergies and delivers patient benefits in a financially sustainable way. The Outline Business Case is due to be submitted to the Trust Development Agency at the end of April 2013, with agreement of the Outline Business Case planned for the end of May 2013.

Parallel to this work, the Royal Free is undertaking the necessary due diligence to be in a position to provide assurance to their Board by the end of February 2013. The Competition
and Co-operation Panel will carry out the first stage of their review between February and March, with the full review expected to continue until July 2013.

Subject to a positive outcome of these pieces of work it is anticipated that the full business case will be completed and agreed by November 2013, with the transaction expected to take place in January 2014.

THE BARNET, ENFIELD AND HARINGEY MENTAL HEALTH TRUST (BEHMHT) - FOUNDATION TRUST APPLICATION PROGRESS

BEHMHT’s Foundation Trust application completed the development stage of the Foundation Trust pipeline process and was submitted by NHS London to the Department of Health in June 2012. Further work is on-going by the Trust to inform NHS London’s updated statement on quality for the NTDA. Following a successful assessment by Monitor, the Trust would be expected to achieve Foundation Trust status during the 2013/14 financial year.

JOINT SERVICES CENTRE, ORDNANCE ROAD, ENFIELD

NHS Enfield CCG and NHS North Central London is working with the London Borough of Enfield to improve the delivery of local primary care services within the Borough. A demand has been identified to provide improved premises within the locality. This has arisen from a combination of predicted population growth, the potential to improve patient registration numbers and generally to improve healthcare in the Enfield Lock area, as well as the condition of the existing Ordnance Road practice premises.

The London Borough of Enfield, NHS Enfield CCG and NHS North Central London have investigated a number of alternative locations for delivery of the new services and after consultation have selected the Ordnance Road library site as the preferred location for development of an integrated scheme. The decision of both parties to back the integrated scheme is supported on the NHS side by completion of a Full Business Case which tests the case for change against policy requirements, value for money considerations and affordability as well as testing or re-testing any alternative options. The Full Business Case has been submitted to NHS London for review and approval. The Council has already approved the scheme and full planning permission has been obtained.

The integrated scheme, when completed, will comprise a purpose built new development comprising of a Library, Community Hall, GP Practice and a Dental Surgery. The proposed GP surgery will replace the practice currently operating from 171 Ordnance Road and provide enlarged practice facilities and the opportunity to deliver an increased level of local services, including out of hospital minor procedures. The Dental Surgery will allow provision of community dental services to the north of the Borough to offer greater efficiencies, service resilience and provision of local services. Opportunities to engage with local dentists to offer specialist services will also be explored.

UPDATE ON CHANGE OF HOURS IN EVERGREEN WALK-IN CENTRE

In advance of the service change, which was introduced on 1st December 2012, a working group was established (which included Local Authority and LINKs representation) to agree an action plan, ensure appropriate communication arrangements
were in place and oversee the change. As part of this work, checks were carried out with local practices to ensure that additional access was being made available by them.

On introducing the new arrangements, a review was conducted at the end of the first weekend which provided assurance that the changes were working appropriately, with some minor issues (primarily around communication) being identified and addressed.

Initially, around 9% of patients attending were unregistered. Those living within Evergreen Surgery’s catchment area were offered registration by the surgery. Others were given a list of local GPs in the area and information on how to obtain assistance in case of difficulty registering.

A further review was undertaken at the end of December (the first month of the new arrangements), where it was noted that the change in operational hours had coincided with one the busiest weekends ever in the Walk-In Centre, with a record 310 patients seen on Sat 29th / Sun 30th. However, this may reflect the fact that there were several bank holidays and the outbreak of Norovirus and flu-like illnesses which have been widely reported in the press.

Some concerns were expressed in early December by North Middlesex University Hospital about an increase in the number of under 18s attending A&E during the week, with the suggestion that many of these were Evergreen patients. A review was immediately undertaken based on analysis of a sample week of data provided. This identified that over a quarter of the patients were not Evergreen patients, and a number of others had attended either out of core weekday hours or at weekends. No evidence was found that a direct link could be made between the service changes and the increased A&E attendances. However, as a trial, the surgery has introduced “under 12s only” sessions to further improve access for acutely ill children, with the intention of providing dedicated access for children who may otherwise have needed to access unscheduled care.

Although it is acknowledged that some patients were unhappy about the change in service, no formal complaints have been received, and the implementation has so far been uneventful.

UPDATE ON THE FINAL REPORT INTO WINTERBOURNE VIEW

The Department of Health published the final report on Winterbourne View on 10 December 2012. The report encompasses the findings from the CQC internal review and outcomes of the 150 inspection visits to learning disabilities services, the Castlebeck Internal Review and the Serious Case Review. Alongside the report a Concordat was published, outlining the commitment to a programme of work by national organisations including the Royal Colleges, Association of Directors of Adult Social Services and the NHS Commissioning Board.

David Nicholson subsequently wrote to PCT Cluster Chief Executives, Local Authority Chief Executives and Directors of Adult Social Services on 10 December 2012, outlining a clear programme of national and local actions to transform care, to ensure that there are local high quality services that reduce the health inequalities suffered by people who have a learning disability or autism and whose behaviour is regarded as challenging.

There are key actions that organisations are now requested to do, and it will take continued joint leadership from NHS and Local Authority organisations to work in an integrated and
collaborative way to make changes happen.

Key National Enablers:
• Transforming care: A national response to Winterbourne View Hospital (DH 2012)
• A mandate from the Government to the NHS Commissioning Board: April 2013 to March 2015 (DH 2012)
• Clinical Commissioning Group Authorisation: Guide for applicants (NHS CB)
• Operating Framework for the NHS in England 2012/13 (DH 2012)
• Clinical Commission Group Commissioning Guidance Everyone counts: Planning for Patients 2013/14 (NHS CB)

Action Required:
• NHS Enfield CCG and the Local Authority need to take account of the Concordat and key actions to ensure that people with learning disabilities and autism receive safe, appropriate high quality care.

• NHS Enfield CCG needs to ensure that handover and transition arrangements are put into place to ensure the CCG have accurate records and clear outlines of future expectations. This should build on the existing work undertaken following Winterbourne View, which included the Safeguarding Assurance Framework and Learning Disability Health Self-Assessment Framework.

PRIMARY CARE STRATEGY - ENFIELD

The Primary Care Strategy continues to introduce specific schemes aimed at improving access, the patient experience and health outcomes. Recently we have started the Minor Ailment Scheme with local pharmacists, the Enhanced Access scheme - with GP training for triage and the COPD project aimed at providing equipment and education for better detection and treatment within primary care.

Local practices have been funded to improve flooring, sinks and access ahead of the new CQC standards and a plan for nurse training is being implemented to support local prescribing and specialist skills.

RECOMMENDATIONS

The Governing Body is asked to:

• Note the progress being made by Enfield Clinical Commissioning Group.
• Maintain on-going update on progress for the functions to be covered by the Chief Officer (Designate) for NHS Enfield Clinical Commissioning Group.
### MEETING:
NHS Enfield Clinical Commissioning Group Governing Body

### DATE:
Wednesday, 13 February 2013, 3.00 – 4.30

### TITLE:
Communications and Engagement Strategy

### LEAD BOARD MEMBER:
Aimee Fairbairns, Director of Service Quality and Integrated Governance

### AUTHOR:
Jacqueline Green, Interim Head of Communications and Engagement

### CONTACT DETAILS:
jackie.green@nclondon.nhs.uk

### Approved By:
Approved by PPE Committee and reviewed by Public Health team, subject to further engagement with key stakeholders

### Review Date:
September 2013

### SUMMARY:
This document sets out the strategic direction for Enfield Clinical Commissioning Group (CCG) communications and engagement and sets out the key actions essential for successful communications and engagement. The strategy will also link to the Business Plan and Organisation Development Plan.

This strategy will encompass: internal communications, media liaison, public affairs, patient and public engagement, clinical stakeholder and partner organisations engagement. Acknowledging that communication is part of everyone’s job, this strategy provides the framework for communication by all in Enfield CCG, so that all communication by us, as individuals, as teams and as an organisation, supports the overall objectives of Enfield CCG.

Delivery of the strategy will be led by Enfield CCG, with additional support from the Commissioning Support Unit.

The aim of the strategy is to ensure that Enfield CCG communicates and engages effectively with its stakeholders, to ensure that their views are used to improve services, to inform the development and review of key policies and processes and to lever change through understanding. The strategy is designed to be an evolving document, which will be built on as future plans develop. Within this strategic framework, bespoke
communications, marketing and engagement plans will be produced as and when required, to support individual initiatives, projects or work streams. Successful engagement with stakeholders is fundamental and therefore it is essential that high quality, robust communications and engagement are embedded throughout the organisation. Through effective communications we can achieve productive and valuable relationships with our key stakeholders, enabling us to excel as commissioners, and to provide the most appropriate healthcare in the most cost effective way.

Initiatives will be developed to enable two-way external and internal communication to become a fundamental part of working with Enfield CCG. Being clear about what information should be made available to whom, whether specific individuals, partner organisations, or community groups, will help with the day-to-day management of the organisation and promote a positive reputation.

One of Enfield CCGs key business objectives is to promote excellence, transform the health and well-being of the local community, reduce health inequalities and promote inclusion. In order to successfully achieve this we must provide opportunities for all members of our local community to tell us how they want their healthcare delivered and to influence decision making. Genuine two-way communication is vital to this process.

In this document, a range of audiences that we need to reach have been identified and the messages that we want to convey and the methods that we will use to communicate these messages have also been defined.

Over and above the identified work, there are a number of key performance indicators within the strategy which will enable us to monitor our success. Underpinning the key performance indicators, clear objectives have also been identified and developed for each stakeholder group. This gives us clarity regarding what successful communication will look like.

The appendices to the strategy comprises: a stakeholder matrix and an action plan, which highlights the key milestones over an initial six month period.

This strategy will provide a proactive programme of work which will deliver excellent communication, both internally and externally. This will allow us to maximise our relationships and understanding for the benefit of patients, carers, staff and stakeholders.

A key factor to consider in delivering the strategy is budget. It is essential that an annual budget be agreed and set aside for communications activity. It is particularly important that communications activity is adequately funded as the current economic climate may mean difficult decisions have to be taken about service delivery. Communications will play a vital role in delivering information regarding changes to service delivery and also in protecting Enfield CCG’s reputation. Any changes to service delivery may result in negative reaction by key audiences, including: media, patient and public groups, local partners and other stakeholders. This will necessitate swift and clear action by the
communications team in order to refute any false or misleading reporting, and to give Enfield CCG’s true position in an open and transparent way.

The strategy contains a high level action plan, a more detailed plan will be developed

SUPPORTING PAPERS:

RECOMMENDED ACTION:
To APPROVE the Communications and Engagement Strategy
To NOTE the Strategy will be subject to evaluation of success to date and strategy refresh in September 2013

Objective(s) / Plans supported by this paper: ECCG Constitution

Through the Communications and Engagement Strategy our main aim is to:

Target our communications efforts where they will be most relevant and effective. Communications activity will be designed to build and maintain a positive image, and get the right information to the right people at the right time. Feedback from all audiences regarding communications activity will be welcomed, encouraged and taken into account.

Patient & Public Involvement (PPI): PPI will be ongoing

Equality Impact Analysis: To be reviewed at PPE Committee to provide additional assurance to the Board

Risks: Enfield CCG will be at significant risk if stakeholders are not communicated with, and engaged with in a sustained and productive manner

Resource Implications: Additional support via SLA with Commissioning Support Unit

Audit Trail: Initial strategy, uploaded for Authorisation purposes, document redrafted focussing on both strategic and operational objectives, particularly over the next six months. Reviewed by PPE Committee and Public Health

Next Steps: Approval by Governing Body and implementation
Enfield Clinical Commissioning Group
Communications and Engagement Strategy

Author: Jacqueline Green, Interim Head of Communications and Engagement

Date: January 2013
<table>
<thead>
<tr>
<th></th>
<th><strong>SUMMARY</strong></th>
<th>Communications and Engagement Strategy</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>RESPONSIBLE PERSON</td>
<td>Head of Engagement</td>
</tr>
<tr>
<td>3</td>
<td>ACCOUNTABLE DIRECTOR</td>
<td>Aimee Fairbairns</td>
</tr>
<tr>
<td>4</td>
<td>APPLIES TO</td>
<td>Internal and external stakeholders</td>
</tr>
<tr>
<td>5</td>
<td>GROUPS / INDIVIDUALS WHO HAVE OVERSEEN THE DEVELOPMENT OF THIS STRATEGY</td>
<td>Alison Mitchell-Hall Rathai Thevananth Karen Trew Jacqueline Green Aimee Fairbairns</td>
</tr>
<tr>
<td>6</td>
<td>GROUPS THAT WERE CONSULTED AND HAVE GIVEN APPROVAL</td>
<td>PPE Committee Public Health</td>
</tr>
<tr>
<td>7</td>
<td>EQUALITY IMPACT ANALYSIS COMPLETED</td>
<td>Strategy screened: 5/2/13 Template completed: 5/2/13</td>
</tr>
<tr>
<td>8</td>
<td>RATIFYING COMMITTEES AND DATE OF FINAL APPROVAL</td>
<td>PPE Committee Enfield Clinical Commissioning Group Governing Body</td>
</tr>
<tr>
<td>9</td>
<td>VERSION</td>
<td>6</td>
</tr>
<tr>
<td>10</td>
<td>AVAILABLE ON</td>
<td>Intranet: Once approved Website: No</td>
</tr>
<tr>
<td>11</td>
<td>RELATED DOCUMENTS</td>
<td>Equality and Diversity Strategy</td>
</tr>
<tr>
<td>12</td>
<td>DISSEMINATED TO</td>
<td>PPE Committee Public Health Communications and Engagement Team</td>
</tr>
<tr>
<td>13</td>
<td>DATE OF IMPLEMENTATION</td>
<td>Once approved by Board</td>
</tr>
<tr>
<td>14</td>
<td>DATE OF NEXT FORMAL REVIEW</td>
<td>September 2013</td>
</tr>
</tbody>
</table>
### DOCUMENT CONTROL

<table>
<thead>
<tr>
<th>Date</th>
<th>Version</th>
<th>Action</th>
<th>Author</th>
<th>Amendments</th>
</tr>
</thead>
<tbody>
<tr>
<td>27/1/13</td>
<td>1</td>
<td>Created</td>
<td>Jacqueline Green</td>
<td></td>
</tr>
<tr>
<td>27/1/13</td>
<td>2</td>
<td>Amended</td>
<td>Aimee Fairbairns</td>
<td>editorial</td>
</tr>
<tr>
<td>29/1/13</td>
<td>3</td>
<td>Amended</td>
<td>Glen Stuart</td>
<td>editorial</td>
</tr>
<tr>
<td>5/2/13</td>
<td>4</td>
<td>Amended</td>
<td>Sonia Amos</td>
<td>editorial</td>
</tr>
<tr>
<td>5/2/13</td>
<td>5</td>
<td>Amended</td>
<td>Teri Okoro</td>
<td>editorial</td>
</tr>
<tr>
<td>5/2/13</td>
<td>6</td>
<td>Amended</td>
<td>Laura Andrews</td>
<td>editorial</td>
</tr>
</tbody>
</table>
## Contents

1. Executive Summary
2. Enfield Context
3. Vision
4. Situational analysis
5. Aims and objectives
6. Audiences, key messages and channels
7. Reputation management
8. Enfield Clinical Commissioning Group Committees
9. Development of communications/engagement function
10. Priority actions
11. Budget
12. Evaluation and key performance indicators
13. Appendices:
   13.1 Stakeholder matrix (to be added)
   13.2 January – August 2013 Action plan
1. Executive summary

This document sets out the strategic direction for Enfield Clinical Commissioning Group’s (CCG) communications and engagement and sets out the key actions essential for successful communications and engagement. The strategy will also link to the Business Plan and Organisation Development Plan.

This strategy will encompass: internal communications, media, reputation management, public affairs, patient and public engagement, clinical stakeholder and partner organisations engagement. Acknowledging that communication is part of everyone’s job, this strategy provides the framework for communication by all in Enfield CCG, so that all communication by us, as individuals, as teams and as an organisation, supports the overall objectives of Enfield CCG.

Delivery of the strategy will be led by Enfield CCG, with additional support from the North and East London Commissioning Support Unit (NEL CSU).

The aim of the strategy is to ensure that Enfield CCG communicates and engages effectively with its stakeholders, to ensure that their views are used to improve services, to inform the development and review of key policies and processes and to lever change through understanding. The strategy is designed to be an evolving document, which will be built on as future plans develop. Within this strategic framework, bespoke communications, marketing and engagement plans will be produced as and when required, to support individual initiatives, projects or work streams. Successful engagement with stakeholders is fundamental and therefore it is essential that high quality, robust communications and engagement are embedded throughout the organisation. Through effective communications we can achieve productive and valuable relationships with our key stakeholders, enabling us to excel as commissioners, and to provide the most appropriate healthcare in the most cost effective way.

The overall aim of good communication and engagement is to get the right information, to the right people, at the right time. By involving stakeholders in decision making and service design, we aim to improve patient experience and health outcomes. In addition, once good relationships have been formed, then resolution of problems can achieved more easily.

Key indicators of our communication and engagement are:

- **Are stakeholders informed?**
  - Do patients/ public know how to access services, get advice and support and how to make a complaint?
  - Do patients/ public know how to make healthy lifestyle choices and where to get support in order to make these choices?
Do patients/public know and understand what improvements are being made and what challenges exist within Enfield CCG and the wider NHS?
Does Enfield CCG provide information in accessible ways?
Do health professionals have the information they need to assist in carrying out their jobs and that helps provide an equitable service?
Do staff know what the aims and objectives are of Enfield CCG and understand their own role within the organisation?

Are stakeholders involved?
- Are the people who access health services and the professionals who provide health services involved in the development of health services in order to provide better quality care and increased productivity?
- Is there wide involvement in developing the strategic direction of Enfield CCG?
- Are we utilising new technologies to reach people?
- Do we have robust two-way communication with our stakeholders?
- Are staff involved in Enfield CCG’s development and helping to improve the quality of services?

Are we influencing?
- Are we raising patient and public aspirations for their own health and that of their families
- Are we allowing patients to participate in, and have control over their healthcare
- Are we influencing our patient/public population to adopt healthier lifestyles?
- Are we influencing healthcare professionals to adopt best practice?
- Are we creating a climate within the community that supports, contributes to, and enables change?

Are people inspired?
- Are we creating a culture where innovation can flourish and ideas are encouraged and acted upon?
- Are we creating a sense of united purpose across the many organisations and individuals we work with?
- Are we succeeding in leading the NHS locally
- Are we encouraging and leading community dialogue about health and healthcare which will support us in improving health outcomes in Enfield?
Initiatives will be developed to enable two-way external and internal communications. Being clear about what information should be made available to whom, whether specific individuals, partner organisations, or community groups, will help with the day-to-day management of the organisation and promote a positive reputation.

Enfield CCG’s key business objectives are to promote excellence, transform the health and well-being of the local community, reduce health inequalities and promote inclusion. In order to successfully achieve this we must provide opportunities for all members of our local community to tell us how they want their healthcare delivered and to influence decision making. Genuine two-way communication is vital to this process.

In this document, a range of audiences that we need to reach have been identified and the messages that we want to convey and the methods that we will use to communicate these messages have also been defined.

Over and above the identified work, there are a number of key performance indicators within the strategy which will enable us to monitor our success. Underpinning the key performance indicators, clear objectives have also been identified and developed for each stakeholder group. This gives us clarity regarding what successful communication will look like.

The appendices to the strategy comprises: a stakeholder matrix and an action plan, which highlights the key milestones over an initial six month period.

This strategy will provide a proactive programme of work which will deliver excellent communication, both internally and externally. This will allow us to maximise our relationships and understanding for the benefit of patients, staff and stakeholders.

A key factor to consider in delivering the strategy is budget. It is essential that an annual budget be agreed and set aside for communications activity. It is particularly important that communications activity is adequately funded as the current economic climate may mean difficult decisions have to be taken about service delivery. Communications will play a vital role in delivering information regarding changes to service delivery and also in protecting Enfield CCG’s reputation. Any changes to service delivery may result in negative reaction by key audiences, including: media, patient and public groups, local partners and other stakeholders. This will necessitate swift and clear action by the communications team in order to refute any false or misleading reporting, and to give Enfield CCG’s true position in an open and transparent way.
2. Enfield Context

Enfield CCG serves 312,000 people and is the capital’s most northerly borough. Of the 32 London boroughs, Enfield is the fifth largest.

Enfield CCG’s role is to commission services that optimise health gain and reductions in health inequalities for local people, with the greatest possible return on investment and best value. It is essential that communications in the wider sense are integral to the commissioning process.

Compared to the average for England the population of Enfield has:

- Higher infant mortality
- Higher childhood obesity rates
- Higher teenage pregnancy rates
- Higher than average population of 0 -14 years
- Higher than average population of over 65 years

The main causes of death in Enfield which exceed the national average relate to diabetes, breast, prostate and cervical cancers.

Enfield CCG has a challenging agenda. Currently we are facing:

- Significant levels of deprivation in the local community
- Diverse ethnicity in local population
- Changes within the NHS
- Financial challenges

In the future we will be facing:

- Demographic and economic change
- Population increase
- Rising expectations
- Public sector finances constrained

2.1 Partnership working

Enfield CCG is the leader of the local health economy, however it cannot commission in isolation. Working with external partners is essential in order to stimulate innovation, improve efficiency, improve service design and therefore optimise health gains and reduce inequalities in the population of Enfield.
2. Vision

Vision

Enfield CCG’s vision for effective communication and engagement is the active involvement of people and communities of Enfield in our decision making and priority setting recognising that patients, carers and service users have valuable expertise and insight which we will use to inform service redesign and commissioning decisions. We will empower communities to develop sustainable approaches to health improvement and health promotion. Successfully implementing this vision will lead to demonstrable improvements in how we work with our local community. Enfield CCG has developed five communication and engagement objectives to support in achieving our vision:

- Establish a clear identity and positive reputation for the CCG and demonstrate its leadership of NHS services (reputation management)
- Develop effective relationships with the CCG’s strategic partners (stakeholder management)
- Engage GPs, other clinical practitioners and CCG staff in the work and development of the organisation (internal communications)
- Develop a patient and public involvement programme that engages people in the commissioning, operation and development of health services (PPE)
- Develop a system for formal consultation that provides information, enables people to easily submit comments and suggestions and properly reflects these comments in any discussion of and decision about options, and feeds back to those consulted once a decision has been taken (statutory duties)

Commissioners will:

- Involve patients, carers and the public in decision making
- Use the insight of patients and carers to improve patient care
- Support patients in decisions about their own health
- Ensure that all the providers we commission services from support our principles

Patients, carers and the public will:

- Understand what services are available and how care is delivered
- Know how decisions are made and how to become active partners in the decision making process
- Know how to get help and support in maintaining healthy lifestyles and managing their own conditions
4. Situational analysis

An analysis of our current situation will assist us in seeing where our communications efforts should be focused. Enfield CCGs situation will change in response to internal and external factors so our situation analysis should be refreshed intermittently and the communications and engagement strategy revised accordingly.

Below is Enfield CCGs current situation and the focus of the communications and engagement strategy will reflect that.

4.1 SWOT

<table>
<thead>
<tr>
<th>Strengths</th>
<th>Opportunities</th>
</tr>
</thead>
<tbody>
<tr>
<td>• High commitment to delivering effective communications and engagement strategy</td>
<td>• Establishment of joint partner working</td>
</tr>
<tr>
<td>• Good relationships with clinical stakeholders</td>
<td>• Development of public website</td>
</tr>
<tr>
<td></td>
<td>• GP appetite for PPGs</td>
</tr>
<tr>
<td></td>
<td>• Motivated staff</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Weaknesses</th>
<th>Threats</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Lack of public awareness of commissioner role</td>
<td>• Limited financial resources</td>
</tr>
<tr>
<td>• New, currently underdeveloped communications and engagement function</td>
<td>• Capacity to deliver when expectations are raised</td>
</tr>
<tr>
<td></td>
<td>• Negativity around BEH clinical strategy may impact on public perception</td>
</tr>
</tbody>
</table>
4.2 Political, Economic, Social, Technological, Legal, Environment (PESTLE)

The political, economic, social, technological, legal and environmental, situation will also impact on Enfield CCG’s strategic direction as external factors will impact on how our business is run and how we communicate with our stakeholders.

As with the situational analysis the PESTLE environment will change and the Communications and Engagement Strategy will be revised as and when that happens in order to reflect this.

Below is the current PESTLE situation:

Political
- NHS funding issues
- NHS changing environment

Economic
- Increasing pressure to deliver more for less
- Recession impacting on morale

Social
- Changing Enfield population
- Diverse population in Enfield
- Pockets of deprivation in Enfield
- Continuing economic downturn

Technological
- Increase in news providers using multi-media
- New technologies as communication tools (Facebook, Twitter, mass texting etc)

Legal
- Equality and human rights laws
- Claim/ blame culture

Environmental
- Increasing partnership working. E.g integration of health and social care
5. Aims and objectives

Through the Communications Strategy our main aim is to:

Target our communications efforts where they will be most relevant and effective. Communications and engagement activity will be designed to build and maintain a positive image, and get the right information to the right people at the right time. Feedback from all audiences regarding communications activity will be welcomed, encouraged and taken into account.

5.1 External communications objectives

- To build a strong image, identity and reputation through the Enfield CCG brand
- To ensure Enfield CCG has a strong, positive external presence and is seen as leader of the local NHS
- To promote the work of Enfield CCG through all relevant channels including the public website, the media, opinion formers and patient and public groups
- To use communications and engagement methods to support change and innovation
- To provide clear, timely information for all stakeholders
- To create an understanding of who our key stakeholder audiences are, and to develop and sustain effective relationships with them
- To promote an understanding of our aims and objectives across all our stakeholder audiences
- To establish genuine two-way communication with all stakeholders
- To promote Enfield CCG as an excellent employer, aiding staff recruitment and retention

5.2 Internal communications objectives

- To consult, engage and involve staff
- To encourage feedback from staff
- To establish two-way communication as standard
- To use communications vehicles to support internal change and innovation
- To promote understanding amongst staff of the organisation’s goals and objectives
- To disseminate policies, protocols and procedures in an easily accessible way
- To promote corporate identity and a sense of ownership amongst staff
6. Audiences key messages and communications channels

This section reviews the range of audiences Enfield CCG will reach, identifies messages we will communicate and the best methods of achieving that. The matrix in Appendix 1 will summarise this information.

Some audiences such as the media and MPs are influencers of other audiences in their own right and therefore will be particularly significant in our communications activity.

Equality and diversity

Equality and diversity will be embedded within communications to all our audiences. In conjunction with the Equality and Diversity Strategy and Equality Delivery System, all audiences, external and internal will be identified and plans put in place to reach them.

In addition, Enfield’s population has specific hard-to-reach groups which include:

- People who cannot read or write
- People who do not speak English as their first language
- Older people
- People who are affected by poverty and deprivation
- People with hearing, speech, visual or physical impairments
- People with learning, communications or cognitive difficulties
- Homeless people
- Working people
- People who are disinterested or disillusioned

All audiences will be considered when either broad or specific communications activity is undertaken.

6.1 Patients and the public

Patients are becoming increasingly more involved, and have more control regarding their care and how it is delivered. The NHS Constitution, published in January 2009, clearly lays out for the patient what should be expected from every NHS contact. It sets out the rights to which each patient is entitled and also their own responsibilities. In recent times patients are far more aware of the level of service they should receive, and it is essential that we excel in service commissioning on their behalf.

Patient engagement should be at the very core of what we do as an NHS commissioner, it is one of the most important aspects of the NHS today.
Our patient and public population should expect:

- Ongoing engagement and consultation
- The opportunity to shape and influence healthcare
- Excellent two way communication
- Ability to feedback and have problems actioned
- Provision of high quality information
- Good performance in annual ratings and achieving national targets
- Favourable media reporting

Patient and public engagement is absolutely essential in giving patients a voice - in how their treatment is delivered and how future services are planned and developed. The communications and engagement strategy will assist in this goal.

Our key messages

- Enfield CCG is the leader of the local NHS
- Enfield CCG commissions healthcare patients can trust
- Enfield CCG is committed to engagement and consultation in order to ensure the views of patients and public influence the commissioning of healthcare
- Enfield CCG is a professional and caring organisation and its focus is on the needs and requirements of its patients
- Feedback and input into the development of patient services is actively sought
- Enfield CCG wants to work in partnership with patients, carers and others

Communication Vehicles

- Clear corporate branding that reinforces the image of a professional organisation with high standards of care and attention to detail
- Easily understood and professionally produced publications
- Up-to-date and informative public website that provides relevant, informative information.
- Patient and public engagement / consultation channels to increase patient participation
- Media releases giving information about improvements to health and healthcare in Enfield
- Use of marketing materials such as posters, leaflets and other information
- Programme of presentations to local people covering a range of topics:
  - Exploration of a patient/public newsletter.
  - Exploration of further development of specific information for students.
6.2 Providers

The opening up of the provider market means that Enfield CCG will communicate and engage with an extensive range of providers.

Key messages

- Enfield CCG will commission the best, most appropriate, most cost effective services for its patient and public population
- Enfield CCG is committed to putting patients first
- Enfield CCG is an experienced commissioner of healthcare
- Enfield CCG wants to work in partnership with Providers and the Local Authority in order to deliver high-quality patient care

Communication and engagement methods

We must take a strategic in our approach to communicating with providers. Communication and engagement methods should include:

- Establishment of regular face-to-face briefings
- Development of extranet site for current and potential providers
- Establishment of regular communications team-to-communications team meetings

6.3 Clinical stakeholders

Clinical stakeholder communication is extremely important. Regular communications channels should be established and feedback encouraged.

Key messages

- Enfield CCG will commission the best, most appropriate, most cost effective services for its patient and public population
- Enfield CCG is committed to positive engagement with clinical stakeholders

Communication Vehicles
Development of extranet site, or hidden area on public website accessible only by NHS staff that will include all relevant information for clinical stakeholders

Clinical stakeholder groups developed across the borough. Bi-monthly meetings to discuss and debate services.

### 6.4 Media

The media is a key influencer of all audiences, including patients and staff. Media reporting can have a dramatic effect on an organisation’s reputation and how audiences perceive that organisation – whether deserved or not. Building good relationships with media can also be of great benefit in the event of a potentially negative media situation. It will afford the opportunity to put our case forward and be heard in defence of an allegation.

The communications team lead on identifying and maximising proactive opportunities for positive media coverage. For each individual story core messages will be developed in line with corporate objectives.

Reactive issues are handled quickly and professionally by the communications team, in consultation with the appropriate senior member of staff. In the event of a serious issue the Governing Body will be briefed and updated as necessary. Upward briefing through the NHS chain would take place regarding serious issues that could have wide impact.

To ensure robust media handling arrangements are in place, it is vital that the Executive Team undergo professional media training with regular refreshers. In addition, the communications team will support all media interviews by preparing briefings for the staff involved.

**Messages**

- Enfield CCG is dedicated to commissioning excellent patient care
- Enfield CCG is an innovative, forward thinking organisation committed to its patients and public
- Enfield CCG is both accessible and accountable to its stakeholders
- Enfield CCG is a committed and caring employer
- Patients trust and value Enfield CCG

**Communications Vehicles**
To build on existing good relationships, particularly with local media
To develop a timetable of strategic, planned, proactive campaigns to promote areas of excellence and innovation
To continue to improve relationships with key commissioning staff in order to facilitate swift resolution of reactive media enquiries

6.5 Key local stakeholders

There are a range of key local stakeholders to whom regular communications updates will be useful. These stakeholders include LINKs/ Health and Wellbeing Committee, local authority, local trusts, local MPs, Local Authority, Overview and Scrutiny Committee, other NHS organisations, local voluntary sector organisations and community, patient and faith groups. Some of these individuals and groups are influencers of local community and Government so it is essential to build good, solid relationships with them.

Appended to this document will be a comprehensive matrix of all stakeholders. This will ensure that we are communicating the right information in a consistent and timely manner.

Key messages

- Enfield CCG is a professional and effective organisation
- Enfield CCG ensures a very high standards of healthcare
- Enfield CCG is focused on the needs of its patients
- Enfield CCG is accountable and accessible to our local population
- Enfield CCG is committed to two-way communication

Communications Vehicles

- Programme of written and face-to-face briefings/meetings
- Exploration of: quarterly emailed newsletter
- Group presentations on current topics

6.6 Staff

Internal communication is an integral part of any organisation, helping to foster good relationships with staff, encouraging recruitment, engagement and retention, high performance, loyalty and promoting a positive corporate image and reputation. There is a duty upon us to ensure that staff are informed and
engaged. Our aim should be not simply to inform staff of developments and initiatives, but to encourage and facilitate their involvement and participation in the decision making process.

To achieve this we will:
- Provide responsive, two-way communication processes to support staff and facilitate a deeper understanding of their own roles, and the organisation’s overall strategic direction
- Ensure staff recognise that communication works both ways and that as well as a right to be kept informed, they also have an obligation to feedback their thoughts and feelings regarding strategic and operational developments
- Ensure that the Chief Officer and Executive Directors are visible and accessible
- Ensure that staff are aware and informed of the NHS Constitution and the pledges made to them

Communication Vehicles

- Core Brief. This should contain high level corporate information and be mandatory at team meetings
- Intranet.
- Weekly e –bulletin
- Posters and marketing for various staff campaigns
- Quarterly Chief Officer Surgery, where nominated staff at all levels and areas of the organisation attend an hour long session. The topic could be chosen by the Chief Officer, or suggested by staff, dependant upon circumstances. This will give staff the opportunity to discuss any corporate issues and receive direct feedback from Chief Officer and opinions from other staff members. Numbers will be limited
- Appropriate information from the monthly Executive and Assistant Directors meetings should be disseminated to other staff via management structure
- Exploration of annual staff conference
- Staff Forum
- Staff feedback mechanism – dedicated email account for staff

6.7 Public website and areas for development

Enfield CCG will continue to enhance and evolve the current public facing website in order to build on our brand. The website design and content will be
regularly reviewed so it remains fit for purpose and meets the demands of our target audience.

Website objectives:

- Easy to locate via online search engines and partner sites
- Written in plain English
- Meet the minimum required Web Content Accessibility Guidelines (WCAG) working towards achieving the highest AAA standard.
- Include comprehensive information and guidance
- Information about our role as leaders of the local NHS, our vision and performance
- Support Enfield CCG’s commitment to engaging with local people, patients and other stakeholders
- Promote healthy living messages
- Host statutory information

6.7.2 Areas for development

Social Media
Over the past few years, social media has become the most popular way for people to communicate, join communities, find and share information online. Sites like Facebook, Twitter, Flickr and YouTube are among the most visited on the web.

NHS organisations are increasingly using social media to engage with online communities to generate exposure to key healthcare messages, news and guidance. Many NHS websites now include social media tools and content.

Enfield CCG will explore tactical use of social media to engage with specific target audiences and promote health and healthcare services. However, this may be ruled out as too labour intensive to gain positive, ongoing results.

Affiliate information sharing
Enfield CCG will ensure, where possible, that key healthcare messages, information and guidance is available on key partner affiliate sites including: NHS Choices, Enfield Council etc
7. Reputation

Corporate brand and identity can be created, but reputation is earned. It can take years to build a good reputation and only hours to destroy it. Reputation enhancement and management is essential for any organisation. Enfield CCG aspires to be the best, and will work hard to achieve this.

Reputation management is the responsibility of everyone who is connected with the organisation, however, good communications activities are key in enhancing an organisation's reputation. A good reputation is built on knowledge and understanding, and these are gained through communication.

Reputation management can be broken down into three areas:

- Reputation enhancement – through proactive promotion of the work of an organisation and through a trusted, visible and recognisable brand
- Issues management – the correct handling of ad hoc issues that could become damaging if not dealt with effectively and in a timely manner
- Crisis management – a crisis can be either organisation specific or wider. An organisation specific crisis is a serious problem that is unique to the organisation. An example would be a serious medical failure. A wider crisis is one where the crisis is wider than the organisation itself. An example of this could be a breakout of a dangerous disease

Reputation can be extremely fragile, once tainted it can take years to repair. That is why it is essential to have a robust and tested emergency communications plan. Effective crisis communication is paramount, both during a major incident or crisis, and beyond. Correct handling of communications at this time can limit or negate damage to reputation. It is essential that a member of the Communications Team continues to be involved in any Emergency Planning/Crisis Management planning.

7.1 Brand and Corporate Identity

Brand is often mistaken merely to be an organisation's name and logo, but it is far more than that. It should outwardly represent an organisation’s core values and should induce positive customer/client feelings about its products or services. It should be fundamental to an organisation’s principles and aid customer/client recognition. The brand should promise, and raise expectations of
a certain level of customer/client satisfaction. It should create within the eyes of its audience a sense that the products or services attached to the brand have qualities and characteristics that make it unique and desirable.

Brand identity is built up over a period of time, accompanied by good marketing, PR, and offering products and services that are valued and trusted. Brand recognition and loyalty are the ultimate goals and the brand should trigger favourable feelings towards the organisation and its services or products.

A good brand should achieve the following:

- Brand identity – how the customer/client perceives the brand
- Brand personality – personality traits of the brand, such as: trustworthiness, excellence and friendliness
- Brand promise – what the customer/client can expect from the interactions with the brand. This can encompass dealing with the organisation’s employees, communications, performance, value for money, as well as the actual service or product
- Brand value – encompasses customer/client loyalty and recruitment and retention of high quality staff to the organisation
- Brand recognition – customer/client immediate identification and understanding of the brand
- Brand loyalty – a customer/client base that receives a high level of satisfaction by opting for a particular brand and consequently chooses that brand over others in the marketplace

We in the NHS are uniquely fortunate in that the NHS is the biggest and the best brand in Britain. Ipsos MORI research shows that it has a 98% recognition rate and 92% patient satisfaction levels.

Our challenge is to ensure that Enfield CCG’s branding achieves recognition of its role as local leader of the NHS and both draws upon and enhances the strengths of the national brand.

To ensure the Enfield CCG brand value is upheld then a comprehensive Corporate Identity and Brand guidelines document must be produced/refreshed for use internally and by external partners with whom we are working jointly. The document should include:

- Correct use of the NHS and Enfield CCG logo (size, positioning, colour options etc)
- Guidance on typefaces style and size
- Templates for posters, corporate literature, PowerPoint slides, newsletters etc

7.2 Media Training
To deal effectively with reputation management in all its forms, it is essential that key senior staff are able to perform well in media interviews. The only effective way of ensuring this will happen is to identify these staff and have them undergo media training. The media training course will encompass both radio and TV interviews in a simulated setting, and training in ‘down the line’ – where the interviewee is in a different studio to the interviewer. It will also cover aggressive, confrontational journalism encountered in a crisis situation.

7.3 Reputation monitoring

A regular media monitoring report will be produced for the Governing Body and Executive Team.

As part of strategic communications planning, this will be developed to become a more robust evaluation tool, which informs proactive planning with the ultimate aim of improving Enfield CCG’s reputation.

7.4 Crisis management

Enfield CCG’s emergency plans must incorporate communications. This will be treated as a priority
8. Enfield CCG Committees

Communications and engagement must be embedded throughout the organisation. One way this can be achieved is for committee chairs to reflect the communications and engagement strategy in the work of each relevant committee.

Committees with delegated authority:

- Risk Management Committee
- Audit Committee
- Quality and Safety Committee
- Patient and Public Engagement Committee
- Financial Recovery and QIPP Committee
- Remuneration and Nomination Committee

There will not be regular attendance at these meetings by a communications and engagement representative, but where a communications issue is identified then a representative will attend.
9. Development of Communications / engagement function

Overview
Engagement makes a crucial contribution to commissioning assurance. Enfield CCG will develop a practical model that will ensure that engagement is embedded into all stages of the commissioning cycle, namely:

- Engaging with communities to identify health needs and aspirations
- Engaging public in decisions about priorities
- Specifying outcomes and procuring services
- Engaging patients in service design and improvement
- Patient-centred procurement and contracting
- Managing demand and performance management
- Capture/ use of patient experience data
- Patient-centred monitoring and performance management

9.1 Delivery

For communications and engagement to work at optimum level it must be strategic and originate from the corporate business plan. It is essential that wide scale public and patient engagement is built into the strategic, corporate communications function.

9.2 LINks/ Healthwatch and Health Overview and Scrutiny Committee (HOSC) and Health and Wellbeing Board

Enfield Local Involvement Network/ Healthwatch/ OSC/ Health and Wellbeing Board will provide a mechanism to ensure that the health services provided in Enfield are relevant to the needs of local people by scrutinising and commenting on commissioning and provision of services.

Enfield CCG will encourage LINk/ Healthwatch/ OSC/ Health and Wellbeing Board to play an active role in monitoring and reviewing health services and be involved in service improvement and development.

9.3 Patient experience and quality monitoring

Enfield CCG, as the commissioner should learn, change and improve services for our patients.

A system of reporting should be implemented to provide commissioning managers with regular information from Providers. The reports should provide
information relating to the nature of the complaints/queries received and what action has been taken to resolve matters.

Dissemination of this information to the appropriate commissioning managers enable commissioners to learn more about patient experiences and give them the opportunity to use the information to drive forward service improvements and inform commissioning decisions.

Surveys
Surveys, including patient and GP surveys are also an invaluable source of feedback concerning how we can learn, and consequently improve as an organisation. There is already a considerable amount of work happening in this area, both nationally and locally, but we should also incorporate this type of communication into our strategic corporate engagement.

9.4 Formal consultation
The National Health Service Act 2006 places a duty on NHS organisations and other bodies to involve and consult patients and the public and other organisations in:

- Planning services
- The development and consideration of proposals for changes in the way services are provided
- Decisions to be made by the NHS organisation affecting the operation of services

Enfield CCG and its NHS partners will work with Enfield Council’s Overview and Scrutiny Committee and the North Central London (NCL) Overview and Scrutiny Committee (JHOSC) to determine when formal consultation is required.

NHS formal consultation should be:

- Open
- Inclusive
- Responsive
- Proactive
- Focused on improvement

When consulting all relevant stakeholders must be included e.g. patients, public, carers, self-help and support groups, user groups and representatives. Some will be harder to reach that others and are easy to overlook. Efforts must be made to
reach these hard to reach groups, who are also referred to as ‘Seldom Heard’ groups.

Actions

- Request a steer from Enfield Council’s Overview and Scrutiny Committee in order to establish if health service developments are considered ‘substantial variation’ and therefore subject to formal consultation
- Ensure the correct stakeholders are being consulted
- Ensure the consultation is open for an appropriate length of time
- Ensure comprehensive feedback is given on the outcome of any consultation

10. Priority actions

- Develop comprehensive stakeholder matrix
- Develop comprehensive media database, including media targeted at specific groups
- Develop existing public website
- Develop existing intranet
- Develop an internal communications plan
- Develop individual stakeholder engagement plans for:
  - Local community
  - GPs
  - NHS partners
  - Other partners
  - MPs
11. BUDGET

Assessment will be made to ensure financial resource is adequate to deliver on expectations.

Example areas requiring budget:

- Annual Report and Accounts
- Publications
- Branded display materials – banner stands etc. These materials are essential and can be used in a variety of ways: back drops for media interviews, events, presentations etc
- Advertising
- Media training. Media training for key staff within the Management Team is essential. With an increased profile comes media attention. It is important to react to media questioning in a measured, calm and confident way, but essential during times of organisational crises
- Photography. Even with an established photo library from time to time addition photography will be needed – Annual Report and Accounts, patient literature and posters for example
- Website/ intranet development
- Strategic programme of patient and public engagement.

Requirements for budget will be assessed taking into account what the Commissioning Support Unit will provide.
12. EVALUATION AND KEY PERFORMANCE INDICATORS

Key Performance Indicators

12.1 External

✓ Production of a comprehensive stakeholder matrix
✓ Development of existing public website and subsequent increase in traffic
✓ Increased positive media coverage
✓ Enhanced relationships with stakeholders
✓ Sustained programme of patient and public engagement
✓ Improvement in patient surveys

12.2 Internal

✓ Staff will demonstrate a greater understanding of the business objectives
✓ Increased awareness of staff opinions by Executive Team
✓ Staff will be motivated
✓ Staff will be willing to support innovation and change
✓ The annual evaluation through the staff survey of the effectiveness of internal communications will show year-on-year improvement

Overall

✓ Activity is brought in on budget and any unbudgeted activity having separate funding arrangements agreed in advance
✓ The same consistency and quality of communications is adopted for both internal and external stakeholders
✓ The communications and engagement strategy is implemented

12.3 Evaluation and measurement

The key performance indicators listed above will be monitored, measured and evaluated in a number of ways:

- Budget is always within agreed limits
- Communications activity is evaluated annually and a report prepared. Evaluation will consist of measuring amount and quality of communications activity
- Stakeholders feedback and good relationships built and maintained
- Media coverage will be measured by column centimetres and whether negative, neutral or positive
- Patient surveys
- Annual staff surveys
### January – July 2013 Action plan

<table>
<thead>
<tr>
<th>Month</th>
<th>Activity - external</th>
<th>Activity - internal</th>
</tr>
</thead>
<tbody>
<tr>
<td>January</td>
<td>• Establish how CSU will be utilised</td>
<td>• Establish how CSU will be utilised</td>
</tr>
<tr>
<td></td>
<td>• Set objectives for Communications Team</td>
<td>• Set objectives for Communications Team</td>
</tr>
<tr>
<td></td>
<td>• Establish fortnightly team meetings with Comms team</td>
<td>• Establish fortnightly team meetings with Comms team</td>
</tr>
<tr>
<td>February</td>
<td>• Develop comprehensive stakeholder matrix</td>
<td>• Assess and sign off handover certificates</td>
</tr>
<tr>
<td></td>
<td>• Develop comprehensive media list</td>
<td>• Communications and Engagement Strategy ratified by ECCG Governing Body</td>
</tr>
<tr>
<td></td>
<td>• Develop comprehensive programme of engagement</td>
<td>• Audit of internal communications and activity to-date</td>
</tr>
<tr>
<td></td>
<td>• Commence relationship building with key stakeholders</td>
<td>• Draft internal communications and engagement plan</td>
</tr>
<tr>
<td></td>
<td>• Development plan for the public website</td>
<td>• Development plan for the intranet</td>
</tr>
<tr>
<td></td>
<td>• Develop calendar with key dates e.g. OSC meetings, Committees etc</td>
<td>• Develop Core Brief and sign off by Exec Team</td>
</tr>
<tr>
<td></td>
<td>• Contribute to BEH Clinical Strategy implementation</td>
<td>• Identify staff re intranet responsibilities</td>
</tr>
<tr>
<td></td>
<td>• Develop generic communications e-mail account for external enquiries</td>
<td>• Development of weekly e-bulletin</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Launch of dedicated staff questions email account</td>
</tr>
<tr>
<td>March</td>
<td>• Develop ECCG Corporate Identity guidelines</td>
<td>• Launch bi-weekly Core Brief</td>
</tr>
<tr>
<td></td>
<td>• Develop relationships with</td>
<td>• Establish Chief Officer/ Director’s face-to-face staff</td>
</tr>
<tr>
<td>Month</td>
<td>Activities</td>
<td></td>
</tr>
<tr>
<td>-------</td>
<td>------------</td>
<td></td>
</tr>
</tbody>
</table>
| April | - Media training for Chief Executive/ Directors  
- Ongoing engagement work  
- Chief Executive ‘staff breakfast surgery’ (quarterly)  
- Issue Core Brief |
| May   | - Ongoing engagement work  
- Ongoing media work  
- Issue Core Brief |
| June  | - Ongoing engagement work  
- Ongoing media work  
- Chief Officer/ Director’s face to face staff briefing  
- Issue Core Brief |
| July  | - Evaluation of work to date regarding external stakeholders  
- Strategy will be reviewed from the evaluation and the work plan completed for the next 12 months  
- Evaluation of work to date regarding external stakeholders  
- Strategy will be reviewed from the evaluation and the work plan completed for the next 12 months  
- Issue Core Brief |
North Central London Equality Impact Analysis (EQIA) screening

**Proposal Title: Communications and engagement strategy**

<table>
<thead>
<tr>
<th>Author /editor/assessors</th>
<th>At least one of the people carrying out an EQIA must be the person responsible for the policy/function/service</th>
<th>Jacqueline Green, Interim Head of Communications and Engagement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Partners/decision-makers/ implementers</td>
<td>Identify who else will need to be involved. This can be decision-makers, frontline staff implementing the policy, partner/parent organisations, etc.</td>
<td>Review by PPE Committee</td>
</tr>
<tr>
<td>Start date</td>
<td>The EQIA should be started prior to policy/service development or at the design stages of the review and continue throughout the policy development/review. For an existing policy/service, any changes identified have to be implemented.</td>
<td>February 2013</td>
</tr>
<tr>
<td>End date</td>
<td>The EQIA will need to inform decision-making so the date should take this into account.</td>
<td>Review September 2013</td>
</tr>
<tr>
<td>Due regard, proportionality and relevance in relation to the following characteristics</td>
<td>Has due regard been given to equality (i.e. promote equality of opportunity between communities, eliminate discrimination that is unlawful, promote positive attitudes towards communities) for this proposal/policy/function? Due regard has two linked elements: proportionality and relevance. The weight given to equality should therefore be proportionate to its relevance to a particular function. The greater the relevance of a function/policy/proposal to equality, the greater regard that should be paid. Where it is concluded that the policy is not relevant for an EQIA, this should be recorded here with the reasons and evidence.</td>
<td>The communications and engagement strategy is designed to be inclusive of all groups.</td>
</tr>
<tr>
<td>- Gender including gender reassignment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Race/ethnicity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Disability</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Age</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Religion or belief</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Pregnancy and maternity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Sexual orientation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Deprivation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>----------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Proposal/policy/function/service aims</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| Consider:  
  - Why is the proposal/policy/function/service needed?  
  - What does NCL hope to achieve by it?  
  - How will NCL ensure that it works as intended?  
  - Who benefits?  
  - Who doesn't benefit and why not?  
  - Who should be expected to benefit and why don't they? |
| It is essential that a comprehensive communications and engagement strategy is developed and implemented. It will benefit all stakeholders. |

<table>
<thead>
<tr>
<th>Evidence gaps</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identify what evidence is available and set it out here. This includes evidence from involvement and consultation. Identify where there are gaps in the evidence and set out how these will be filled.</td>
</tr>
<tr>
<td>As a new organisation ECCG’s communications and engagement strategy will aim to deliver evidence and fill any gaps</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Involvement &amp; consultation</th>
</tr>
</thead>
</table>
| What involvement and consultation has been done in relation to this (or a similar) policy or function, and what are the results?  
What involvement and consultation will be needed and how will it be undertaken?  
Report any results. |
| PPE Committee  
Public Health  
Further consultation to be implemented with patient groups |

<table>
<thead>
<tr>
<th>Addressing the impact</th>
</tr>
</thead>
</table>
| **Outcome 1: No major change:** the EQIA demonstrates the policy/change is robust and there is no potential for discrimination or adverse impact  
**Outcome 2: Adjust the policy:** the EQIA identifies potential problems or missed opportunities. Adjust the policy to remove barriers or better promote equality.  
**Outcome 3: Continue the policy:** the EQIA identifies the potential for adverse impact or missed opportunities to promote equality. Clearly set out the justifications for continuing with it. The justification must be in line with the duty to have due regard. For the most relevant policies, compelling reasons will be needed.  
**Outcome 4: Stop and remove the policy:** the policy shows actual or potential unlawful discrimination. |
<p>| Outcome 1 |</p>
<table>
<thead>
<tr>
<th>Title of Proposal: Communications and engagement strategy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Will the proposal's outcomes differ according to which protected characteristics people have?</td>
</tr>
<tr>
<td>Race</td>
</tr>
<tr>
<td>No</td>
</tr>
<tr>
<td>Evidence</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Are there any consequences or evidence of any negative impact upon the protected characteristics?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Race</td>
</tr>
<tr>
<td>No</td>
</tr>
<tr>
<td>Evidence</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Does the proposal positively impact on the protected characteristics? E.g. Opportunities, access, choice, language, information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Race</td>
</tr>
<tr>
<td>No</td>
</tr>
<tr>
<td>Evidence</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Is there any potential that any part of the proposal could discriminate, directly or indirectly? If so can it be justified?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Race</td>
</tr>
<tr>
<td>No</td>
</tr>
<tr>
<td>Evidence</td>
</tr>
</tbody>
</table>
Is the proposal likely to affect relations between any protected characteristics e.g. because it is seen as favouring particular groups or denying opportunities to another?

<table>
<thead>
<tr>
<th>Evidence</th>
<th>Evidence</th>
<th>Evidence</th>
<th>Evidence</th>
<th>Evidence</th>
<th>Evidence</th>
<th>Evidence</th>
<th>Evidence</th>
<th>Evidence</th>
</tr>
</thead>
</table>

No No No No No No No No 0 0 0

Is the proposal likely to affect relations between any protected characteristics and what would be the impact if it does?

Risk Scoring

<table>
<thead>
<tr>
<th>Likelihood</th>
<th>Negligible (1)</th>
<th>Minor (2)</th>
<th>Moderate (3)</th>
<th>Major (4)</th>
<th>Catastrophic (5)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rare (1)</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Unlikely (2)</td>
<td>2</td>
<td>4</td>
<td>6</td>
<td>8</td>
<td>10</td>
</tr>
<tr>
<td>Possible (3)</td>
<td>3</td>
<td>6</td>
<td>9</td>
<td>12</td>
<td>15</td>
</tr>
<tr>
<td>Likely (4)</td>
<td>4</td>
<td>8</td>
<td>12</td>
<td>16</td>
<td>20</td>
</tr>
<tr>
<td>Almost Certain (5)</td>
<td>5</td>
<td>10</td>
<td>15</td>
<td>20</td>
<td>25</td>
</tr>
</tbody>
</table>

1-3 Low Risk 4-6 Moderate Risk 8-12 High Risk 15-25 Extreme Risk

Multiply this impact [1-5] by the likelihood [1-5] to get your priority rating

<table>
<thead>
<tr>
<th>Key</th>
<th>Risk Level</th>
<th>Action &amp; Timescales</th>
</tr>
</thead>
<tbody>
<tr>
<td>Red</td>
<td>15 - 25</td>
<td>Immediate action must be taken to manage the risk. Further control measures should be put into place, which will have the effect of reducing either the impact or the likelihood or both to at least a score 8-15. A number of new or strengthened control measures may be required. The risk must be included on the Significant Risk Register.</td>
</tr>
<tr>
<td>Amber</td>
<td>8 - 12</td>
<td>Efforts should be made to reduce the risk, but the costs of prevention should be carefully measured and weighed against the impact. Establish more precisely the likelihood of harm / the extent of financial loss as a basis for determining the need for improved control measures. Consider also other risks affecting the same objective(s)</td>
</tr>
<tr>
<td>Green</td>
<td>1 - 6</td>
<td>On or below this level a risk is usually acceptable. Existing controls should be monitored and adjusted if minimal time &amp; cost involved. No further action or additional controls are required. Consideration may be given to a more cost-effective solution or improvement.</td>
</tr>
</tbody>
</table>

Three Year Action Plan

<table>
<thead>
<tr>
<th>Equality Strand</th>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
<th>Why/Am</th>
<th>Outcome Measure</th>
<th>Who/Lead</th>
<th>Resources</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender (inc. reassignment)</td>
<td>Age</td>
<td>Disability</td>
<td>Sexual Orientation</td>
<td>Religion/Belief</td>
<td>Deprivation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>--------------------------</td>
<td>-----</td>
<td>------------</td>
<td>--------------------</td>
<td>----------------</td>
<td>-------------</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

N.B These exercises are subjective and should be carried by a team with one person who is the author or responsible for the proposal.
MEETING: NHS Enfield Clinical Commissioning Group Governing Body
DATE: Wednesday, 13 February 2013, 3.00 - 4.30
TITLE: Equality and Diversity Strategy
LEAD BOARD MEMBER: Aimee Fairbairns, Director of Service Quality and Integrated Governance
AUTHOR: Jacqueline Green, Interim Head of Communications and Engagement
CONTACT DETAILS: jackie.green@nclondon.nhs.uk
Approved By: Approved by PPE Committee and reviewed by Public Health team, subject to further engagement with key stakeholders
Review Date: September 2013

SUMMARY:
Equality and Diversity is at the heart of the NHS strategy. Equality is about creating a fair society where everyone has the same opportunity to access services, influence decision making and shape change. Creating an environment where no one is unfairly disadvantaged.

Enfield Clinical Commissioning Group is committed to promoting equality, diversity and human rights for service users and staff. Enfield CCG’s approach is to tackle inequalities, remove barriers, value diversity and adhere to the human rights principals of respect, dignity and autonomy. The strategy acknowledges the many different groups facing various barriers on the grounds of race, gender, transgender, disability, age, religion, sexual orientation and economic, social and educational background. It also acknowledges the impact of migration and the added challenges to the delivery of this vision, particularly within healthcare commissioning.

Enfield Clinical Commissioning Group want to involve local people in the creation of a robust, evolving strategy, that ensures that we commission the right healthcare services, delivered by well trained staff and meets the equality duties set out in the Equality Act 2010. A programme of wide-scale engagement will be developed, emanating from the development of a comprehensive stakeholder matrix. All stakeholders will be included in the programme – internal and external – however efforts will be concentrated on forming relationships with seldom heard groups.

A full performance review of the strategy, and resulting action plans will be executed after six months and the following learning used to inform and improve the ongoing
The Equality Act came into force in 2010 and ensures all public organisations are consistent in approach to equality. Public sector equality duties are as follows:

- Eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under the Act
- Advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it
- Foster good relations between persons who share a relevant protected characteristic and persons who do not share it

The protected characteristics are:

- Age
- Disability
- Gender reassignment
- Marriage and civil partnership
- Maternity and Paternity
- Race
- Sexual equality
- Sexual orientation
- Religion and belief

**SUPPORTING PAPERS:**

**RECOMMENDED ACTION:**
To **APPROVE** the Equality and Diversity Strategy
To **NOTE** the Strategy will be subject to evaluation of success to date and strategy refresh in September 2013

Objective(s) / Plans supported by this paper: ECCG Constitution
- Quality, fairness, dignity, respect and equality for all of our staff during their employment cycle and experience within the CCG
• Address health inequalities, improve the wellbeing of patients and service users and ensure that our procurement/ outsourcing and commissioning are underpinned by equality and human rights principles which meet the needs of our local population

**Patient & Public Involvement (PPI):** PPI will be intensive and ongoing

**Equality Impact Analysis:** be reviewed at PPE Committee to provide additional assurance to the Board

**Risks:** Enfield CCG will be at significant risk if equality and diversity is not recognised internally and externally and a robust EDS delivered throughout

**Resource Implications:** To be assessed

**Audit Trail:** Initial strategy, uploaded for Authorisation purposes, document redrafted focusing on both strategic and operational objectives, particularly over the next six months. Reviewed by PPE Committee and Public Health

**Next Steps:** Approval by Governing Body and implementation. Equality Delivery System developed and implemented.
Enfield Clinical Commissioning Group

Equality and Diversity Strategy
<table>
<thead>
<tr>
<th></th>
<th>SUMMARY</th>
<th>Equality and Diversity Strategy</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>RESPONSIBLE PERSON</td>
<td>Head of Engagement (Jacqueline</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Green – interim)</td>
</tr>
<tr>
<td>3</td>
<td>ACCOUNTABLE DIRECTOR</td>
<td>Aimee Fairbairns</td>
</tr>
<tr>
<td>4</td>
<td>APPLIES TO</td>
<td>Internal and external stakeholders</td>
</tr>
<tr>
<td>5</td>
<td>GROUPS / INDIVIDUALS WHO HAVE OVERSEEN THE DEVELOPMENT OF THIS STRATEGY</td>
<td>Alison Mitchell-Hall</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Rathai Thevananth</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Karen Trew</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Jacqueline Green</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Aimee Fairbairns</td>
</tr>
<tr>
<td>6</td>
<td>GROUPS THAT WERE CONSULTED AND HAVE GIVEN APPROVAL</td>
<td>PPE Committee</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Public Health</td>
</tr>
<tr>
<td>7</td>
<td>EQUALITY IMPACT ANALYSIS COMPLETED</td>
<td>Strategy screened: 5/2/13</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Template completed: 5/2/13</td>
</tr>
<tr>
<td>8</td>
<td>RATIFYING COMMITTEES AND DATE OF FINAL APPROVAL</td>
<td>PPE Committee</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Enfield Clinical Commissioning</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Group Governing Body</td>
</tr>
<tr>
<td>9</td>
<td>VERSION</td>
<td>11</td>
</tr>
<tr>
<td>10</td>
<td>AVAILABLE ON</td>
<td>Intranet: Yes (once approved)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Website: Yes (once approved)</td>
</tr>
<tr>
<td>11</td>
<td>RELATED DOCUMENTS</td>
<td>Communications and Engagement</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Strategy</td>
</tr>
<tr>
<td>12</td>
<td>DISEMINATED TO</td>
<td>PPE Committee</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Public Health</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Communications and Engagement</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Team</td>
</tr>
<tr>
<td>13</td>
<td>DATE OF IMPLEMENTATION</td>
<td>Once approved by Board</td>
</tr>
<tr>
<td>14</td>
<td>DATE OF NEXT FORMAL REVIEW</td>
<td>September 2013</td>
</tr>
<tr>
<td>Date</td>
<td>Version</td>
<td>Action</td>
</tr>
<tr>
<td>------------</td>
<td>---------</td>
<td>-----------------------------------------------</td>
</tr>
<tr>
<td>09/10/12</td>
<td>1</td>
<td>Created</td>
</tr>
<tr>
<td>17/10/12</td>
<td>2</td>
<td>Updated following internal review</td>
</tr>
<tr>
<td>30/10/12</td>
<td>3</td>
<td>Updated following Governing Body review</td>
</tr>
<tr>
<td>05/12/12</td>
<td>4</td>
<td>Updated following Governing Body review</td>
</tr>
<tr>
<td>12/12/12</td>
<td>5</td>
<td>Updated following Governing Body review</td>
</tr>
<tr>
<td>28/01/13</td>
<td>6</td>
<td>Updated following Head of Communications and Engagement review</td>
</tr>
<tr>
<td>27/1/13</td>
<td>7</td>
<td>Amended</td>
</tr>
<tr>
<td>29/1/13</td>
<td>8</td>
<td>Amended</td>
</tr>
<tr>
<td>5/2/13</td>
<td>9</td>
<td>Amended</td>
</tr>
<tr>
<td>5/2/13</td>
<td>10</td>
<td>Amended</td>
</tr>
<tr>
<td>5/2/13</td>
<td>11</td>
<td>Amended</td>
</tr>
</tbody>
</table>
Contents

1. Executive Summary

2. The Protected Characteristics

3. Enfield Context
   3.1. Enfield CCGs principle objectives
   3.2. Enfield CCGs equality and diversity objectives

4. Our E&D Duties

5. Enfield Vision and Aims

6. Situational Analysis
   6.1. SWOT
   6.2. PESTLE

7. Equality Delivery System
   7.1 The four EDS goals

8. Priorities for Action

9. Evaluation and Key Performance Indicators

Appendices
Appendix I
Equality Objectives 2013-14

Appendix II
Action plan February 2013 – August 2013 (to be added)
1. Executive Summary

Equality and Diversity is at the heart of the NHS strategy. Equality is about creating a fair society where everyone has the same opportunity to access services, influence decision making and shape change. Creating an environment where no one is unfairly disadvantaged.

Enfield Clinical Commissioning Group is committee to promoting equality, diversity and human rights for service users and staff. Enfield CCG’s approach is to tackle inequalities, remove barriers, value diversity and adhere to the human rights principals of respect, dignity and autonomy. The strategy acknowledges the many different groups facing various barriers on the grounds of race, gender, transgender, disability, age, religion, sexual orientation and economic, social and educational background. It also acknowledges the impact of migration and the added challenges to the delivery of this vision, particularly within healthcare commissioning.

Enfield Clinical Commissioning Group want to involve local people in the creation of a robust, evolving strategy, that ensures that we commission the right healthcare services, delivered by well trained staff and meets the equality duties set out in the Equality Act 2010. A programme of wide-scale engagement will be developed, emanating from the development of a comprehensive stakeholder matrix. All stakeholders will be included in the programme – internal and external – however efforts will be concentrated on forming relationships with seldom heard groups.

A full performance review of the strategy, and resulting action plans will be executed after six months and the following learning used to inform and improve the ongoing work.

2. The Protected Characteristics

The Equality Act came into force in 2010 and ensures all public organisations are consistent in approach to equality. Public sector equality duties are as follows:

- Eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under the Act
- Advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it
- Foster good relations between persons who share a relevant protected characteristic and persons who do not share it

The protected characteristics are:

- Age
- Disability
• Gender reassignment
• Marriage and civil partnership
• Maternity and Paternity
• Race
• Sexual equality
• Sexual orientation
• Religion and belief

3. Enfield Context

Enfield is the capital’s most northerly borough and is home to a diverse community. At mid – 2011 the population of Enfield was estimated to be 312,500 (ONS 2011) making Enfield the fourth largest of the 32 London boroughs. The most demographically distinguishing feature about Enfield is its combination of particular ethnic groups. Levels of deprivation vary considerably across the borough, wards in the east of the borough have been identified as ranking in the worst 10% of England. Conversely, areas in the west of the borough have been identified amongst the least deprived areas of England (Enfield Borough Profile 2012).

In general the health of people in Enfield is similar to the England average and life expectancy is above the national average. However, compared to the average for England the population of Enfield has:

• Higher infant mortality
• Higher childhood obesity rates
• Higher teenage pregnancy rates
• Higher than average population of 0 -14 years
• Higher than average population of over 65 years

People in the most deprived part of Medway suffer more ill health and live on average 8.8 years for men and 10 years for women less than the least deprived. The main causes of death in Enfield which exceed the national average relate to diabetes, breast, prostate and cervical cancers.

Enfield CCG has a challenging agenda. Currently we are facing:

• Significant levels of deprivation in the local community
• Diverse ethnicity in local population
• Changes within the NHS
• Financial challenges

In the future we will be facing:

• Demographic and economic change
• Population increase
• Rising expectations
• Public sector finances constrained

3.1 Enfield CCGs principal objectives

• To continue to improve the health and wellbeing of the local population by focusing on preventative services, reducing health inequalities and enabling the population to take responsibility for their own health

• To ensure the provision of high quality, efficient health services for the population, within available resources, recognising that Enfield faces considerable financial pressures

• To facilitate integration between health and social care services

• To ensure good quality, safe healthcare in all settings

• To create an Enfield strategy that is clinically led, draws on evidence and uses innovative, radical solutions to deliver the best possible care to patients and their carers within allocated resources

• To focus on education and development support to clinicians to improve care and ensure that high quality services are delivered

• To commission quality, efficient and effective health services for the people of Enfield

3.2 Enfield CCGs equality and diversity objectives

• Quality, fairness, dignity, respect and equality for all of our staff during their employment cycle and experience within the CCG

• Address health inequalities, improve the wellbeing of patients and service users and ensure that our procurement/ outsourcing and commissioning are underpinned by equality and human rights principles which meet the needs of our local population
4. **Our E&D Duties**

Through the adoption of the NHS Equality Delivery System, Enfield CCG aims to demonstrate to the people we serve how we are meeting the three aims of the Equality Duty:

- Eliminate unlawful discrimination, harassment and victimisation
- Advance equality of opportunity between different groups
- Foster good relations between different groups

Enfield CCG will meet the requirements of the Specific Duties of the Equality Act by publishing quality information, gathered as part of the Equality Delivery System (EDS), self assessment annually and work with local people and equality stakeholders to grade the CCGs performance against the four goals of EDS. The findings of the grading will identify the CCGs equality objectives - this work has already been carried out for 2012 by Enfield PCT and the CCG will adopt these where they would be relevant for the CCG to meet its public sector equality duty. Enfield CCG will identify its equality objectives for the next year following engagement with local people from the protected groups.

The four goals:
- Better health outcomes for all
- Improved patient access and experience
- Empowered, engaged and included staff
- Inclusive leadership at all levels

5. **Enfield Vision and Aims**

**Vision**

Enfield CCGs vision is that of an organisational culture and environment where equal opportunity is everyone’s business. Enfield CCG aims to deliver efficient and effective high quality integrated health and social care in order to improve the health and wellbeing of the population of Enfield and reduce health equalities in the borough.

**Aims**

As a new organisation Enfield CCG has the opportunity to liberate itself from old opinions and negative attitudes. We have the prospect of building meaningful and productive relationships with all groups across the borough of Enfield, allowing both the organisation and it’s population to grow together.
This is obviously a long-term ambition and has to be taken slowly in order to garner solid and long-lasting results.

While being a responsible and accountable organisation, in its own right, it is important that we don’t work in isolation. A joined-up and streamlined approach to reaching all our harder to reach equality groups would be most effective, in order to avoid ‘pockets’ of excellence. The move to integrate health and social care is a positive one and this ideology is something we should carry through to all areas. In that way our service users should experience the same, equitable treatment across organisational boundaries. For example, one key demographic for Enfield is a higher than average younger and older population. There are likely to be more complex health and social care needs across both of these groups and therefore they may have varying levels of experience.

With our staff at Enfield CCG we must have a programme of activity that embeds equality and diversity throughout the organisation. Initially staff may view this as yet another thing to do/ think about, on an increasingly long list of tasks, however, it is vital that considering and acting upon any impact upon equality groups becomes second nature. Equally, our staff must be treated in a fair and equitable way within the work environment.

Our staff must be helped and supported to understand the importance of personalisation, fairness and diversity, not only when planning and commissioning services; but also when working together. If staff enjoy an environment where they can thrive, this will have a great impact upon how our services will be commissioned and monitored.

**Our aims should be to:**

- Deliver services that are easily accessible to all
- Deliver services where no one person is prioritised over another, except in the cases of clinical need
- Ensure staff are fully supported in order to deliver fair and equitable services
- Ensure staff work in an environment that supports and embraces diversity
- Provide forums for the local population of Enfield to have a voice
6. Situational Analysis

6.1 Swot Analysis

<table>
<thead>
<tr>
<th>Strengths</th>
<th>Opportunities</th>
</tr>
</thead>
<tbody>
<tr>
<td>• High commitment to delivering effective equality and diversity strategy</td>
<td>• Establishment of joint partner working</td>
</tr>
<tr>
<td>• Good relationships with clinical stakeholders</td>
<td>• Development of public website</td>
</tr>
<tr>
<td></td>
<td>• GP appetite for PPGs</td>
</tr>
<tr>
<td></td>
<td>• Motivated staff</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Weaknesses</th>
<th>Threats</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Lack of public awareness of commissioner role</td>
<td>• Limited financial resources</td>
</tr>
<tr>
<td>• Underdeveloped internal communications function</td>
<td>• Capacity to deliver when expectations are raised</td>
</tr>
<tr>
<td></td>
<td>• Negativity around BEH clinical strategy may impact on public perception</td>
</tr>
</tbody>
</table>

6.2 Political, Economic, Social, Technological, Legal, Environment (PESTLE)

The political, economic, social, technological, legal and environmental, situation will also impact on Enfield CCG’s strategic direction as external factors will impact on how our business is run and how we communicate with our stakeholders.

As with the situational analysis the PESTLE environment will change and the E&D Strategy will be revised as and when that happens in order to reflect this.

Below is the current PESTLE situation:

Political
• NHS funding issues
• NHS changing environment

Economic
• Decreasing pressure to deliver more for less
• Recession impacting on morale
Social
- Changing Enfield population
- Diverse population in Enfield
- Pockets of deprivation in Enfield
- Continuing economic downturn

Technological
- Increase in news providers using multi-media
- New technologies as communication tools (Face Book, Twitter, mass texting etc)

Legal
- Equality and human rights laws
- Claim/ blame culture

Environmental
- Increasing partnership working. E.g integration of health and social care

7. Equality Delivery System (EDS)

The Equality and Delivery System is designed to support NHS commissioners and providers to deliver better outcomes for patients and communities and better working environments for staff, which are personal, diverse and fair.

The EDS is a tool that can be used to review performance and identify future priorities and actions. It offers local and national reporting mechanisms.

Enfield CCG has decided to use the Equality Delivery System because it will help us to embed equalities in mainstream business.

At the heart of the EDS is a set of 18 outcomes grouped into four goals. These outcomes focus on the issues of most concern to patients, carers, communities, NHS staff and Governing Bodies/ Boards. It is against these outcomes that performance is analysed, graded and action determined.

7.1 The four ED goals

- Better health outcomes for all
- Improved patient access and experience
- Empowered, engaged and included staff
- Inclusive leadership at all levels
8. Priorities for Action February – August 2013

External audiences

- Develop comprehensive stakeholder matrix, including influence and importance. Including:
  - Community groups (faith, BLGT, disability, age, race etc)
  - Pressure groups
  - NHS partners
  - Local MPs
  - Local authority
  - Voluntary section organisations
  - OSC
  - LINks/ Health and Wellbeing Boards

- Identify seldom heard groups and group leaders

- Commitment to consult any groups that may be disadvantaged by any proposals

- Comprehensive E&D section on the public website

- Develop and deliver community engagement plan in conjunction with the Communications and Engagement Strategy

- Identify print and broadcast media that is targeted to specific diverse groups

- Piggy back E&D messages onto existing communications vehicles

Internal audiences

- Mandatory staff training around E&D

- Ensure staff are aware of and correctly using EQIA

- Comprehensive E&D section on the intranet

- Incorporate E&D messages into any staff briefings from CO/ Executive Team

- Incorporate E&D messages into new staff induction sessions
9. Evaluation and Key Performance Indicators

Key Performance Indicators

Overall

✓ A high-level of patient satisfaction reported
✓ Service planning and delivery have equality and diversity embedded throughout
✓ The Equality and Diversity Strategy and EDS is successfully implemented

9.1 External

✓ Production of a comprehensive stakeholder matrix
✓ Public website E&D pages achieves high-level of traffic
✓ Increased positive media coverage
✓ Enhanced relationships with stakeholders
✓ Programme of patient and public engagement with seldom heard groups
✓ Improvement in patient surveys results from seldom heard groups

9.2 Internal

✓ Staff will demonstrate a greater understanding of the equality and diversity objectives
✓ Increased awareness of staff opinions by Executive Team will show year-on-year improvement regarding equality and diversity issues

9.3 Evaluation and measurement

The key performance indicators listed above will be monitored, measured and evaluated in a number of ways:

- Activity is evaluated every six months and a report prepared. Evaluation will consist of measuring amount and quality of engagement activity including user feedback
- Stakeholders will be keen to engage with Enfield CCG
- Media coverage will be measured by column centimetres and whether negative, neutral or positive
- Patient surveys
- Annual staff surveys
<table>
<thead>
<tr>
<th>Objective 1</th>
<th>Action</th>
<th>Expected Outcome and Timescale</th>
<th>Measure of Success</th>
</tr>
</thead>
<tbody>
<tr>
<td>Better health outcomes for all:</td>
<td>Ensure Equality Impact Analysis are undertaken on any policy revisions, service/team/directorate change</td>
<td>All new policies/policy revisions, service/team/directorate change have had an EQIA completed</td>
<td>All policies, functions, proposals would have had an EQIA</td>
</tr>
<tr>
<td></td>
<td>Publish completed Equality Impact Analysis on ECCG website</td>
<td>All EQIAs have been published</td>
<td>All completed EQIAs published on website</td>
</tr>
<tr>
<td></td>
<td>Review the quality of EQIAs and make recommendations for improvement by setting up an external review group made up of community groups with an interest in one or more of the equality strands.</td>
<td>Review group set up</td>
<td>All recommendations from audit have clear implementation plans and achievement is monitored</td>
</tr>
<tr>
<td></td>
<td>Audit a percentage of the papers that go to the Governing Body for approval to see if EQIAs have been appropriately completed and make recommendations for improvements.</td>
<td>Report to Patient and Public Engagement (PPE) Committee</td>
<td>Managers trained on EQIA</td>
</tr>
<tr>
<td></td>
<td>Provide further training on EQIAs to improve their quality</td>
<td>Report to PPE Committee EQIA</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Master classes</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Progress to be reviewed on an annual basis/1st review due September 2013</td>
<td></td>
</tr>
<tr>
<td>Objective 2</td>
<td>Action</td>
<td>Expected Outcome and Timescale</td>
<td>Measure of Success</td>
</tr>
<tr>
<td>-------------</td>
<td>--------</td>
<td>--------------------------------</td>
<td>--------------------</td>
</tr>
<tr>
<td><strong>Improved patient access and experience:</strong></td>
<td>Commission hospitals to improve access to healthcare for people with a learning disability, and people on the autism spectrum through inclusion in the Mental Health Commissioning Strategy</td>
<td>Undertake a range of actions including the provision of care plans and accessible information for learning disabled and patients on the autistic spectrum.</td>
<td>People with learning disability have ready access to healthcare. Access to healthcare for people with a learning disability improved.</td>
</tr>
<tr>
<td></td>
<td>Some suggestions on actions that would deliver against this domain:</td>
<td></td>
<td>Staff trained to competently and sensitively handle people with a learning disability</td>
</tr>
<tr>
<td></td>
<td>1. Uptake on IAPT</td>
<td>People with autism are included with people with learning disability in their access to healthcare</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2. Access to maternity services</td>
<td>Reported on quarterly by the Trusts that adopt it</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3. Increase in GP appointments in primary care</td>
<td>Progress to be reviewed on a quarterly basis/1st review due September 2013.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>4. Set up effective and representative PPGs</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>5. Develop a DOS on the ECCG website</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Rationale:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1 and 2 are areas highlighted for improvement in Context statement</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>3 links to primary care strategy / HWB sub cte work</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>4 and 5 within Comms and Engagement strategy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Objective 3</td>
<td>Action</td>
<td>Expected Outcome and Timescale</td>
<td>Measure of Success</td>
</tr>
<tr>
<td>-------------</td>
<td>--------</td>
<td>--------------------------------</td>
<td>-------------------</td>
</tr>
<tr>
<td>Empowered, engaged and well supported staff:</td>
<td>Improve the data about our staff to identify patterns of potential discrimination and publish this data in the next Annual Equality Report.</td>
<td>To undertake self assessment of data about our staff and Governing Body members. Identify potential data gaps and to close or narrow them. Publish staffing data in the Annual Equality report through the intranet and external websites Mandatory training and annual appraisal process including PDPs</td>
<td>Data collection methods improved the capture of information</td>
</tr>
</tbody>
</table>

- Data gaps identified. Process in place to eliminate or reduce gaps
- Staff data published
- Publish data as per statutory requirement September 2013
<table>
<thead>
<tr>
<th>Objective 4</th>
<th>Action</th>
<th>Expected Outcome and Timescale</th>
<th>Measure of Success</th>
</tr>
</thead>
</table>

**Robust Organisational Governance**

<table>
<thead>
<tr>
<th>Objective</th>
<th>Action</th>
<th>Expected Outcome and Timescale</th>
<th>Measure of Success</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improve the range of information we have about patients in protected groups and how this is used.</td>
<td>Commissioning plans demonstrate where patient information has informed decision making (as above)</td>
<td>Equality monitoring is taking place.</td>
<td>Implementation of the EDS demonstrating that 4 or more protected groups have been consulted</td>
</tr>
<tr>
<td>Disaggregate data to ensure a full understanding of the impact of services across the protected groups</td>
<td>A reduction in inequalities in relation to access</td>
<td></td>
<td>Publish equality objectives and annually report on positive outcomes demonstrating an upward indicator</td>
</tr>
<tr>
<td>Create an understanding of inequalities to service delivery and identify existing barriers</td>
<td>Equality measures are incorporated into all provider contractual and procurement arrangements. Ensure robust contract management processes are in place to drive quality services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inclusion of appropriate contractual terms and conditions to comply with the Equality Act 2010</td>
<td>Locality based governance arrangements are recognised and work</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Set up the requisite governance structure to ensure equality performance, monitor and reporting on compliance</td>
<td>Progress to be reviewed on an annual basis/1st review due September 2013.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Objective 5 Patient and Public Engagement**

<table>
<thead>
<tr>
<th>Action</th>
<th>Expected Outcome and Timescale</th>
<th>Measure of Success</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>The CCG has a robust engagement</td>
</tr>
<tr>
<td>Build strong relationships with diverse groups and communities to understand their needs, priorities and experiences.</td>
<td>Proactively engage with service users and residents in community social housing in areas of high deprivation. Engaging with locally excluded groups and communities, such as the homeless and gypsy/traveller. Develop appropriate communications and engagement plans that recognise the value of community feedback. Using technology and techniques best suited to different population groups. Develop strategies in line with local partners e.g. local authorities, health and wellbeing boards LINKS/Health watch, voluntary and third sector organizations. Proactively engage in the development of JSNAs and joint health and wellbeing strategies to integrate commissioning and work in shared governance and processes with local authorities. Set up engagement forums with patient representatives for all major care pathway, service redesign work streams and systems. Actively communicate commissioning decisions and respond to feedback. Arrangements for handling complaints and concerns raised with the CCG deliver outcomes equivalent to those set out in the statutory framework for complaints handling.</td>
<td>All protected groups involved in engagement and consultation processes. Planned events/consultations. Communities feel engaged and empowered as communications become more meaningful. Joint planned events across health and social care. Active patients in partnership groups engaged in the development of key documents and plans. Progress to be reviewed on an annual basis/1st review due September 2013.</td>
</tr>
<tr>
<td>Objective 6</td>
<td>Action</td>
<td>Expected Outcome and Timescale</td>
</tr>
<tr>
<td>------------</td>
<td>-----------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Improved Self Management Programmes</td>
<td>Develop the following targeted prevention, early intervention and self management programmes</td>
<td>Diabetes Awareness and Peer Education for BME communities</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Targeted approach to deliver stop smoking programmes BME Men and Young gay men</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Improve Cervical Screening uptake amongst lesbians and younger women</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Develop an integrated care system - provide better coordinated care, identify and support more vulnerable patients and deliver more equitable and superior health outcomes</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Focus on children’s services and school nursing - support mothers and families, resulting in a better start for children, reduce later ill health.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Programmes demonstrate, increases in take up, with prevalence decreasing over time, national and local target being met and where possible exceeded, patient experience survey demonstrate increased confidence and self management. Decrease in hospital admissions. Improve mental health - develop a single point of access for professionals, resulting in improved engagement and patient experience and reduction in length of stay. We aim to reduce health inequalities by focussing on more deprived wards</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Progress to be reviewed on an annual basis/1st review due September 2013</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Objective 7</strong></td>
<td><strong>Action</strong></td>
<td><strong>Expected Outcome and Timescale</strong></td>
</tr>
<tr>
<td>----------------</td>
<td>------------</td>
<td>-----------------------------------</td>
</tr>
<tr>
<td><strong>Improved Access to Services</strong></td>
<td>Improve access to and provide a patient centred approach to delivering primary and community services: Provide a self-referral process to IAPT (Impact Access Psychological Therapy) services, recruit and train bilingual IAPT counsellors. Improve uptake of mental health service by young gay men. Identify areas of low uptake or non-access to services particularly where there is a high prevalence of certain conditions such as Diabetes, Cancer and Stroke and screening programmes such as childhood immunisation, programmes, cervical, breast and bowel cancer screening. Work with communities and local health advocates to co-design outreach activities to address priority areas of low uptake e.g. teenage pregnancy rates, childhood immunisation for MMR booster at age 5. Improve Awareness of maternity and other healthcare services around Female Genital Mutilation.</td>
<td>Patients health needs are assessed, and resulting services provided, in appropriate and effective ways.</td>
</tr>
<tr>
<td><strong>Objective 8</strong></td>
<td><strong>Action</strong></td>
<td><strong>Expected Outcome and Timescale</strong></td>
</tr>
<tr>
<td>----------------</td>
<td>------------</td>
<td>-----------------------------------</td>
</tr>
<tr>
<td><strong>Inclusive Leadership at all levels</strong></td>
<td>Ensure robust equality and diversity analysis is integral in the staff transition programme&lt;br&gt;Develop effective communication and engagement plan to promote staff participation in the Equality Delivery System for themselves and service users&lt;br&gt;Include session on Equality, diversity and Culture and values into staff training to support the improvement of staff survey results&lt;br&gt;Ensure CCG identify Competent Equality, Diversity and Human rights Leadership that can consistently deliver&lt;br&gt;Ensure CCG identify Competent Equality, Diversity and Human rights Leadership that can consistently deliver&lt;br&gt;Identification of E&amp;D champions and meaningful role for them; promotion / engagement / training around the organisation’s vision and values; undertaking a staff survey and acting on feedback</td>
<td>Staff feel consulted and engaged in the transition process. Feedback suggests that staff feel fairly treated as evidenced by robust impact assessment and ultimately the right individuals get the right jobs.&lt;br&gt;CCG’s able to evidence that through the collection and user of staff profiling data that staff from all protected groups have equity in the level of personal development&lt;br&gt;The CCG workforce planning assesses the overall capability and capacity within its existing workforce to deliver the Equality Human Rights outcomes set out in the authorisation workbook, EDS and the NHS Outcomes Framework.&lt;br&gt;Progress to be reviewed on an annual basis/1st review due March 2013&lt;br&gt;EDHR Specialist to support the CCG by providing strategic visioning, leadership and operational delivery competence e.g.&lt;br&gt;· Be able to respond to diverse and changing community needs&lt;br&gt;· Apply robust equalities analysis to service planning and improvement</td>
</tr>
</tbody>
</table>
# North Central London Equality Impact Analysis (EqIA) screening

## Proposal Title: Equality and diversity strategy

<table>
<thead>
<tr>
<th>Author /editor/assessors</th>
<th>At least one of the people carrying out an EQIA must be the person responsible for the policy/function/service</th>
<th>Jacqueline Green, Interim Head of Communications and Engagement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Partners/decision-makers/ implementers</td>
<td>Identify who else will need to be involved. This can be decision-makers, frontline staff implementing the policy, partner/parent organisations, etc.</td>
<td>Review by PPE Committee</td>
</tr>
<tr>
<td>Start date</td>
<td>The EQIA should be started prior to policy/service development or at the design stages of the review and continue throughout the policy development/review. For an existing policy/service, any changes identified have to be implemented.</td>
<td>February 2013</td>
</tr>
<tr>
<td>End date</td>
<td>The EQIA will need to inform decision-making so the date should take this into account.</td>
<td>Review September 2013</td>
</tr>
<tr>
<td>Due regard, proportionality and relevance in relation to the following characteristics</td>
<td>Has due regard been given to equality (i.e. promote equality of opportunity between communities, eliminate discrimination that is unlawful, promote positive attitudes towards communities) for this proposal/policy/function?</td>
<td>The equality and diversity strategy is designed to be inclusive of all groups.</td>
</tr>
<tr>
<td>• Gender including gender reassignment</td>
<td>Due regard has two linked elements: <strong>proportionality and relevance</strong>. The weight given to equality should therefore be proportionate to its relevance to a particular function. The greater the relevance of a function/policy/proposal to equality, the greater regard that should be paid. Where it is concluded that the policy is not relevant for an EQIA, this should be recorded here with the reasons and evidence.</td>
<td></td>
</tr>
<tr>
<td>• Race/ethnicity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Disability</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Age</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Religion or belief</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Pregnancy and maternity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Sexual orientation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Deprivation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
</tbody>
</table>
| **Proposal/policy/function/service aims** | **Consider:**  
- Why is the proposal/policy/function/service needed?  
- What does NCL hope to achieve by it?  
- How will NCL ensure that it works as intended?  
- Who benefits?  
- Who doesn’t benefit and why not?  
- Who should be expected to benefit and why don’t they? | **It is essential that an equality and diversity strategy is developed and implemented. It will benefit all stakeholders.** |
| **Evidence gaps** | **Identify what evidence is available and set it out here. This includes evidence from involvement and consultation. Identify where there are gaps in the evidence and set out how these will be filled.** | **As a new organisation ECCG’s communications and engagement strategy will aim to deliver evidence and fill any gaps, alongside the Equality Delivery System** |
| **Involvement & consultation** | **What involvement and consultation has been done in relation to this (or a similar) policy or function, and what are the results?**  
**What involvement and consultation will be needed and how will it be undertaken?**  
**Report any results.** | **PPE Committee**  
**Public Health**  
**Further consultation to be implemented with patient groups** |
| **Addressing the impact** | **Outcome 1: No major change:** the EQIA demonstrates the policy/change is robust and there is no potential for discrimination or adverse impact  
**Outcome 2: Adjust the policy:** the EQIA identifies potential problems or missed opportunities. Adjust the policy to remove barriers or better promote equality  
**Outcome 3: Continue the policy:** the EQIA identifies the potential for adverse impact or missed opportunities to promote equality. Clearly set out the justifications for continuing with it. The justification must be in line with the duty to have due regard. For the most relevant policies, compelling reasons will be needed  
**Outcome 4: Stop and remove the policy:** the policy shows actual or potential unlawful discrimination. | **Outcome 1** |
<table>
<thead>
<tr>
<th>Title of Proposal:</th>
<th>Equality and Diversity Strategy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Race</td>
<td>Gender (including gender reassignment)</td>
</tr>
<tr>
<td>Will the proposal’s outcomes differ according to which protected characteristics people have?</td>
<td>No</td>
</tr>
<tr>
<td>Are there any consequences or evidence of any negative impact upon the protected characteristics?</td>
<td>No</td>
</tr>
<tr>
<td>Does the proposal positively impact on the protected characteristics? E.g. Opportunities, access, choice, language, information</td>
<td>No</td>
</tr>
<tr>
<td>Is there any potential that any part of the proposal could discriminate, directly or indirectly? If so can it be justified?</td>
<td>No</td>
</tr>
</tbody>
</table>
Is the proposal likely to affect relations between any protected characteristics e.g. because it is seen as favouring particular groups or denying opportunities to another?

<table>
<thead>
<tr>
<th>Evidence</th>
<th>Evidence</th>
<th>Evidence</th>
<th>Evidence</th>
<th>Evidence</th>
<th>Evidence</th>
<th>Evidence</th>
<th>Evidence</th>
<th>Evidence</th>
<th>Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>0</td>
</tr>
</tbody>
</table>

Is the proposal likely to affect relations between any protected characteristics and what would be the impact if it does?

### Risk Scoring

<table>
<thead>
<tr>
<th>Likelihood</th>
<th>Impact (consequence/severity) of hazard being realised</th>
</tr>
</thead>
<tbody>
<tr>
<td>Negligible (1)</td>
<td>Minor (2)</td>
</tr>
<tr>
<td>Rare (1)</td>
<td>1</td>
</tr>
<tr>
<td>Unlikely (2)</td>
<td>2</td>
</tr>
<tr>
<td>Possible (3)</td>
<td>4</td>
</tr>
<tr>
<td>Likely (4)</td>
<td>10</td>
</tr>
<tr>
<td>Almost Certain (5)</td>
<td>25</td>
</tr>
</tbody>
</table>

### Key

<table>
<thead>
<tr>
<th>Risk Level</th>
<th>Action &amp; Timescales</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Red</strong></td>
<td>15 - 25 Immediate action must be taken to manage the risk. Further control measures should be put into place, which will have the effect of reducing either the impact or the likelihood or both to at least a score 8-15. A number of new or strengthened control measures may be required. The risk must be included on the Significant Risk Register.</td>
</tr>
<tr>
<td><strong>Amber</strong></td>
<td>8 - 12 Efforts should be made to reduce the risk, but the costs of prevention should be carefully measured and weighed against the impact. Establish more precisely the likelihood of harm / the extent of financial loss as a basis for determining the need for improved control measures. Consider also other risks affecting the same objective(s)</td>
</tr>
<tr>
<td><strong>Green</strong></td>
<td>1 - 6 On or below this level a risk is usually acceptable. Existing controls should be monitored and adjusted if minimal time &amp; cost involved. No further action or additional controls are required. Consideration may be given to a more cost-effective solution or improvement.</td>
</tr>
</tbody>
</table>

### Three Year Action Plan

<table>
<thead>
<tr>
<th>Equality Strand</th>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
<th>Why/Am</th>
<th>Outcome Measure</th>
<th>Who/Lead</th>
<th>Resources</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Race</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gender (inc. reassignment)</td>
<td>Age</td>
<td>Disability</td>
<td>Sexual Orientation</td>
<td>Religion/Belief</td>
<td>Deprivation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>----------------------------</td>
<td>-----</td>
<td>------------</td>
<td>-------------------</td>
<td>-----------------</td>
<td>-------------</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

N.B These exercises are subjective and should be carried by team with one person who is the author or responsible for the proposal.
The Clinical Commissioning Groups (CCGs) in North London are committed to agreeing and taking forward a programme of collaboration on commissioning and on other appropriate developments. The Collaboration Agreement is now ready for CCG Governing Body approval and the collaboration work programme taken forward. The Collaboration Agreement covers a number of key elements:

- The core Collaboration Agreement document that highlights the advantages to CCG collaboration and suggests principles that could be used to inform how and when CCGs could collaborate;
- A collaborative agreement for contracting work;
- A collaboration work programme;
- Terms of reference for the North London Clinical Commissioning Board.

A financial risk sharing agreement will also form a key component of the Collaboration Agreement. Significant progress has been made on developing it. The CCGs are still awaiting further clarification from the NHS Commissioning Board on 13/14 financial allocations, and once these are confirmed the financial risk share agreement will be finalised and sent to individual CCGs for approval in the near future.
RECOMMENDED ACTION:
The Governing Body is asked to:
- **APPROVE** on the North London CCG Collaboration Agreement and work programme;
- **NOTE** the progress in developing the NCL CCG’s collaborative risk share agreement and that this will be reported separately for approval by the Governing Body;
- **APPROVE** the collaboration arrangements for contracting;
- **NOTE** the Terms of Reference for the North London Clinical Commissioning Board.

Objective(s) / Plans supported by this paper:

<table>
<thead>
<tr>
<th></th>
<th>Enable the people of Enfield to live longer fuller lives by tackling the significant health inequalities that exist between communities</th>
<th>Yes - Duty to reduce Inequalities</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>Provide children with the best start in life</td>
<td>Yes - Duty to reduce Inequalities</td>
</tr>
<tr>
<td>3</td>
<td>Ensure the right care in the right place, first time</td>
<td>Yes – Duty to promote Innovation</td>
</tr>
<tr>
<td>4</td>
<td>Deliver the greatest value for money for every NHS pound</td>
<td>Yes - Duty to ensure efficiency and effectiveness</td>
</tr>
<tr>
<td>5</td>
<td>Commission care in a way which delivers integration between health, primary, community and secondary care and social care services</td>
<td>Yes – Duty to promote integration</td>
</tr>
</tbody>
</table>

Patient & Public Involvement (PPI):

There has been no specific PPI work in drawing up the CCG Collaboration Agreement. However, it should be noted that patients and the public will be involved in relevant elements of the collaborations work programme.

Equality Impact Analysis:  N/A

Risks:

The key risk is that the CCG is unable to secure in full it’s commissioning intentions and contracting brief due to the negotiation of agreed contracting outcomes within the collaborative arrangements with other CCGs. This may be offset by gains achieved by contracting with a single provider as collaborative CCG commissioners. There is a dispute resolution procedure included within the agreement, which Chief Officers are working together to implement.

Resource Implications:

Most of the human resources to deliver the Collaboration Agreement work programme will come from the CSU, as part of the core offer. In addition there will be the requirement for CCG Chief Officers to sponsor and lead some of the work programme. Some collaboration work programme areas will require more
management input and this is still to be scoped (i.e. work on the future provider landscape). Potential resource implications arise from the agreement of risk share arrangements which will be reported separately to the Governing Body for approval.

Audit Trail:

The collaboration agreement has been discussed during December 2012 and January 2013 at the fortnightly meeting of the north London CCG Chief Officers’ meeting. It was also discussed at the January 10th 2013 meeting of the North London Clinical Commissioning Board.

Next Steps:

Approval of the Collaboration Agreement by all 5 North London CCG Governing Body meetings.

Alpesh Patel will represent NHS Enfield CCG at The North London Clinical Commissioning Board. The collaborative contracting teams are in place for the current 2013/14 contracting round. The Financial Recovery and QIPP Committee has oversight of the effectiveness of the operational arrangements for collaboration co-ordinated by the Finance and Commissioning Directorate.

1. INTRODUCTION

The Clinical Commissioning Groups (CCGs) in North London are committed to agreeing and taking forward a programme of collaboration on commissioning and on other appropriate developments. The Collaboration Agreement is now ready for CCG Governing Body approval and the collaboration work programme to be taken forward. The Collaboration Agreement covers a number of key elements:

- The core Collaboration Agreement document that highlights the advantages to CCG collaboration and suggests principles that could be used to inform how and when CCGs could collaborate;
- A financial risk sharing agreement;
- A collaborative agreement for contracting work;
- A collaboration work programme;
- Terms of reference for the North London Clinical Commissioning Board

There is a long tradition of both NHS commissioners and providers collaborating together to benefit patient care. It is a natural step for CCGs, as the new NHS statutory bodies that will be responsible for commissioning most services for local people, to also continue with collaborative arrangements. In the document ‘Towards Establishment: Creating responsive and accountable CCGs’, there is an emphasis on CCGs developing appropriate robust collaborative arrangements between themselves and other organisations. Furthermore, collaboration requirements are also listed in ‘Clinical Commissioning Group authorisation: Draft Guide for applicants’, where there are a number of domains where there is a clear expectation for CCGs to formally enter into collaboration arrangements.
CCG Approval of the Collaboration Agreement

The Collaboration Agreement was developed from a series of meetings and discussions of North London CCG Chairs, Chief Officers, Chief Finance Officers and senior Commissioning Support Unit Colleagues. It is essential that each individual CCG signs up to and approves the Collaboration Agreement. The CCG Governing Body meetings are advised to focus on reviewing the main elements of the Collaboration Agreement that together make up the totality of it. These are as follows:

Standard sections of the Collaboration Agreement (Appendix 1) – There are a number of standard sections that have been co-created locally. These include: principles of joint working, benefits of collaboration, governance, dispute resolution and the process for joining and leaving the Collaboration Agreement.

The draft collaboration agreement was reviewed at the Executive Group meeting on 19 December and included in Governing Body members Authorisation Briefing Packs.

Financial Risk Sharing Agreement (Appendix 2) - It is proposed that CCGs have in place financial risk sharing arrangements from April 2013. There are many reasons why collaboration and risk sharing arrangements need to be in place:

- Uncertainty regarding the level of CCG budgets;
- Agreed collaborative/financial risk sharing arrangements between CCGs are required in order to achieve authorisation;
- To manage fluctuations in high cost/low volume activity;
- To fund the transitional costs arising from agreed local NHS strategies; and
- To fund ‘invest to save’ initiatives in order to deliver transformational change.

Collaborative Contracting Agreement (Appendix 3) - Across the 5 CCGs in North Central London, the total value of all contracts excluding non-clinical services is around £2.5bn, covered by around 6,000 contracts (see Appendix 3). From 1st April contracts relating to services that will be commissioned by public health or the National Commissioning Board will not be the responsibility of the CCGs. However, that will still leave around two thirds (by value) of contracts for services that will remain with the CCGs.

With limited resources to deliver commissioning responsibilities, it is sensible for CCGs to consider collaborative working arrangements, which is also a requirement for authorisation. It is also sensible for CCGs to seek working relationships that give them appropriate levels of control over the areas of greatest risk.

The collaborative contracting arrangements were reviewed with the CCG Governing Body at the Executive Group meeting on 3 January 2013 and included in Governing Body members Authorisation Briefing Packs.
Collaboration Agreement work programme (Appendix 1) – This highlights the financial risk sharing and contracting agreements, but also describes a range of other work that the CCGs plan to collaborate on.

North London Clinical Commissioning Board (Appendix 4) - The North London Clinical Commissioning Board will have delegated responsibilities from CCG Governing Bodies to set the strategic priorities, direction and provide leadership to the programme of collaboration between North London CCGs and others if appropriate. It will assess the opportunities for CCG collaboration, and if suitable, arrange for them to be taken forward. It will enable mutual support and advice to CCG Chairs and Chief Officers across a wide range of common areas that the CCGs will need to address. It will be a forum where the response to national and local strategies or initiatives can be discussed and how member CCGs intend to respond individually and collaboratively to them. Governing Body members are requested to note these terms of reference.

2. Next Steps
Following approval of the Collaboration Agreement by the five CCGs in North London Approval of the Collaboration Agreement by all 5 North London CCG Governing Body meetings work will continue to progress the collaboration work programme elements. There will also be regular updates on progress on the collaboration work programme provided to Governing Body meetings.

Alpesh Patel will be a member of the North London Clinical Commissioning Board, as Chair of NHS Enfield CCG, as will Liz Wise, as Chief Officer.
NORTH LONDON CCGs –

DRAFT COLLABORATIVE COMMISSIONING AGREEMENT

Viii 23rd January 2013
1. PARTIES TO THE AGREEMENT
The members of this CCG Collaboration Agreement are:
   Barnet CCG
   Camden CCG
   Enfield CCG
   Haringey CCG
   Islington CCG

2. BACKGROUND
The CCGs participating in this Collaboration Agreement wish to collaborate on:
   Financial risk sharing agreement (Appendix 2);
   Collaborative commissioning agreement; (Appendix 3)
   Collaborative work programme (pages 5-11);
   North London Clinical Commissioning Board (Appendix 4).

3. PRINCIPLES
To benefit from the advantage of CCG collaboration, and to determine whether it is useful to collaborate or not, the following principles of collaboration are suggested for the NL CCGs to endorse:

   • The CCGs should have a positive and trusting relationship to base their collaboration on.
   • There must be approval from the individual CCG Governing body to sign up to the Collaboration Agreement, and the collaboration work programme will be described in this agreement.
   • Use local judgement and knowledge to help determine if the specific collaboration work element would be beneficial.
   • Collaboration does not require all five CCGs working together. There will be occasions when two or more CCGs collaborate, but not all five. There will also be occasions when the collaboration includes working with CCGs from outside the NL area.
   • The Collaboration Agreement needs to be flexible and responsive. There will be work that is currently not known about, that CCGs will need to respond to and that taking a collaborative approach would be beneficial. The Collaboration Agreement needs to be able to include these new developments as they arise.
   • The CCG collaboration needs to ensure a strong and consistent clinical focus. It needs to ensure that the views of constituents, patients and other stakeholders on clinical issues are fed into the work programme and influence outcomes where appropriate.
   • The governance set up to take forward the Collaboration Agreement must not duplicate existing CCG governance arrangements.
   • The Collaboration Agreement seeks to maximise the leverage that CCGs coming together to collaborate brings.
   • There will be regular updates and highlight reports to the individual CCG Governing Body members that are signed up to the Collaboration Agreement.
   • There must be a clear rationale for the collaboration.
   • There must be tangible benefits and outputs resulting from CCG collaboration.
   • CCG collaboration must contribute to the aim of enabling high quality, accessible, safe and value for money services.
   • Resources that CCGs put into the Collaboration Agreement work programme should be fair and split on an equitable basis (this includes money and staffing).
A clear and transparent governance process should form part of the CCG Collaborative Agreement, and members should work to the rules of this agreement. This must include how decisions about collaboration projects and initiatives are taken, delegated authority from CCG Governing Bodies to individuals or committees and dealing with disputes.

The priorities for CCG collaboration should be set collectively and by the mutual agreement of the CCGs signing up to the Collaboration Agreement.

The CCGs should carry out an annual evaluation of their Collaboration Agreement and its work programme. This review should be presented to the each member Governing Body for information.

4. FUNCTIONS OF THE COLLABORATIVE

There is a long tradition of both NHS commissioners and providers collaborating together to benefit patient care. It is a natural step for CCGs, as the new NHS statutory bodies that will be responsible for commissioning most services for local people, to also continue with collaborative arrangements. In the document ‘Towards Establishment: Creating responsive and accountable CCGs’, there is an emphasis on CCGs developing appropriate robust collaborative arrangements between themselves and other organisations. Furthermore, collaboration requirements are also listed in ‘Clinical Commissioning Group authorisation: Draft Guide for applicants’, where there are a number of domains where there is a clear expectation for CCGs to formally enter into collaboration arrangements.

The advantages to CCG collaboration have been highlighted by the NHS Commissioning Board as:

Clinical improvement:
- Consistent, evidence based pathway development
- Effective and consistent performance management, clinical governance and risk management
- Service integration
- Ability to better manage strategic change

Efficiency:
- Leverage with providers
- Keeping transaction costs low
- Sharing (potentially scarce) expertise and capacity
- Manage relationships and responses more collectively i.e. NHS CB, NHS Property Services etc.

Resilience and risk management:
- Enabling diversity in CCG configuration and size
- Managing financial risks
- Managing regulatory and legal change
- Managing extended absence
<table>
<thead>
<tr>
<th>Collaboration Area</th>
<th>Commentary</th>
<th>Proposed CCG Lead</th>
<th>CSU Role</th>
<th>Governance Issues</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Financial risk sharing</strong></td>
<td>CCG Chief Finance Officers and CSU Senior Finance staff have devised a draft Financial Risk Sharing framework. Significant progress on this has been made to date. However, the CCGs are still awaiting further clarification from the NHS Commissioning Board on 13/14 financial allocations, and once these are confirmed the financial risk share agreement will be finalised and sent to individual CCGs for approval in the near future.</td>
<td>Richard Quinton</td>
<td>Harry Turner</td>
<td>CCG sign up to the Financial risk Sharing Framework with need individual CCG Governing Body approval.</td>
</tr>
<tr>
<td><strong>13/14 Contract negotiation and setting round</strong></td>
<td>There is a strong track record of NHS commissioners in NCL working together, and with lead and associate roles in contract negotiations and holding of agreed contracts. Work is already well under way on the 13/14 contract negotiation and setting round.</td>
<td>There will be individual CCG leads for each contract.</td>
<td>The CSU will draft the documentation for the CCGs to use with their contracts.</td>
<td>The CCG negotiation team rep (GP or Director) to have delegated decision and approval authority during contract negotiation. However, final proposed deal on the contract to be signed off by the CCG Governing Body or F&amp;P Committee.</td>
</tr>
<tr>
<td><strong>Care pathways</strong></td>
<td>It is mutually beneficial for providers and commissioners alike for care pathways to be similar. If providers are asked to do slightly different things for each commissioner making operational the required service can be difficult and also it could end up with commissioners needing to pay more for the differences. The improved value for money harmonised care pathways brings is better for patients and gives them a more equitable experience.</td>
<td>CCG Directors of Commissioning A lead CCG to be identified to lead for all major care pathways, with reps from other CCGs as appropriate.</td>
<td>CSU to review the care pathways and to lead the coordination of the process; including re-drafting of care pathways and report writing etc.</td>
<td>Final care pathways to be signed off by the CCG Governing Body or other committee.</td>
</tr>
<tr>
<td>Collaboration Area</td>
<td>Commentary</td>
<td>Proposed CCG Lead</td>
<td>CSU Role</td>
<td>Governance Issues</td>
</tr>
<tr>
<td>---------------------</td>
<td>------------</td>
<td>------------------</td>
<td>----------</td>
<td>-------------------</td>
</tr>
<tr>
<td>Emergency planning and On-call, Pressure surge management</td>
<td>As statutory organisations all CCGs must have emergency plans in place. These plans would look very similar across NCL and could very easily be produced collaboratively. This approach would help create a ‘whole system’ approach and have economy of scale benefits. One CCG could take the lead for Emergency Planning (Haringey) and could be the NCL CCG link CCG with the NCB. Each CCG could contribute to funding an Emergency Planning Manager who could be hosted in one CCG. This approach would be similar to the current NCL arrangements for emergency planning where the approach is common across the five PCTs in NCL. The Emergency Planning Manager under the supervision of the Haringey Chief Officer could develop the Emergency Plan. A NCL Emergency Planning Group chaired by the Haringey Chief Officer could meet and have CCG representatives as appropriate.</td>
<td>Sarah Price</td>
<td>Sylvia Kennedy</td>
<td>The CCG reps on the emergency planning groups to have delegated decision and approval authority. However, final care pathways to be signed off by the CCG Governing Body or other Committee.</td>
</tr>
<tr>
<td>Winter planning</td>
<td>CCGs will be required to develop and implement winter plans. An approach similar to that suggested for emergency planning could be adopted. The winter planning could also include a collaborative approach to the seasonal flu campaign (patients and staff), as well as the Public Health Cold Weather plan. Winter planning needs extremely close links with Public Health and these needs to be protected as part of the transition work. Close links on winter planning will need to be made with the</td>
<td>Sarah Price</td>
<td>Sylvia Kennedy</td>
<td></td>
</tr>
<tr>
<td>programes, new care standards etc.) and service delivery and taking a collaborative response.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Collaboration Area</td>
<td>Commentary</td>
<td>Proposed CCG Lead</td>
<td>CSU Role</td>
<td>Governance Issues</td>
</tr>
<tr>
<td>---------------------</td>
<td>-------------</td>
<td>-------------------</td>
<td>----------</td>
<td>-------------------</td>
</tr>
<tr>
<td>Unscheduled Care work stream</td>
<td>111 There is a shared provider for the 111 pilot in NCL. It makes sense for one CCG to lead for 111 on behalf of the others. The CSU will support the monitoring of the contract, but it will be good to have CCG involvement with this; particularly GPs. The future of 111 needs to be CCG led and a 111 group could be led by a CCG with the CSU supporting. This group could also lead future 111 specification re-design and procurement work. OOH It could also include GP OOH. From 1st April 2013 CCGs will be responsible for commissioning of GP OOH for GP practices, which have opted of providing the service. Although there may be more than one provider of OOH in NCL which might make this more complex. Unscheduled Care This work stream area will also seek to rationalize the number of committees and groups in North London that are involved in the unscheduled care commissioning performance monitoring agenda. The aim will be to move to having fewer groups that for unscheduled care to ensure a whole system approach to commissioning and monitoring and that support CCG collaboration. Evaluation of unscheduled should be a part of the CCG collaboration work programme.</td>
<td>NCL CCGs Sponsors - Alison Blair/Dr Raj Mazumder</td>
<td>Helen Brown, SRO CSU coordinates 111 performance monitoring and a 111 strategic group. Also OH Contracts and Performance Monitoring lead to be appointed</td>
<td>The 111 Group could to have delegated decision and approval authority to monitor the SLA. Any new specification it worked up or tendering proposals would need to be approved by the individual CCG Governing Body or other committee. Lead CCG representatives could have delegated approval and decision making for day to day issues, but any major decisions would need to be agreed by each CCG Governing Body or full CCG if appropriate.</td>
</tr>
<tr>
<td>Quality work</td>
<td>Continued regular meetings between all CCGs • Management of CQRG – paper circulated that adopts a “Host CCG” model with CCG officers chairing their home meetings along with clinical input from the home GP leads. • Support from both the CSU contracting and quality teams to facilitate this. • Recognised the need for a standard approach to managing CQRGs</td>
<td>Alison Blair</td>
<td>CSU PoD Quality lead to support this collaboration work programme</td>
<td>This work collaboration work programme would report into the relevant Quality Committee of every individual CCG.</td>
</tr>
<tr>
<td>Collaboration Area</td>
<td>Commentary</td>
<td>Proposed CCG Lead</td>
<td>CSU Role</td>
<td>Governance Issues</td>
</tr>
<tr>
<td>--------------------</td>
<td>------------</td>
<td>------------------</td>
<td>----------</td>
<td>-------------------</td>
</tr>
</tbody>
</table>
| Opportunities for further collaboration | • Operational areas for collaboration being considered are currently being worked on but include:  
• Serious incident, reporting, recording, investigating and analysis (both operationally and form an assurance perspective)  
• Complaints handling (similar to SIs)  
• Infection Control (again similar to Sis)  
• There is an opportunity for collaboration between committees as well as officers with joint assurance being sought (particularly on the three issues above) and the lessons learned from CQRG process  
• The proposal here would be to hold a one off joint quality committee in early 13/14 to look at our understanding of some of the areas outlined above.  
• From this we will take a view about whether there is added value in making these meetings a permanent part of the assurance cycle  
• This should not be a duplication of what may be required in terms of Quality Surveillance networks which will be established (probably) by the NCB  
• Francis – will inevitably recommend significant change within the system and we could respond to this collectively. | | | |
<p>| Equality and diversity | CCGs looking into feasibility of sourcing this service. Approach would need to be informed by collaboration principles in terms of resources put into this by each CCG. One CCG could host a post on behalf of the others | CCG host to be identified | N/A | An NCL group could be set up to devise and oversee the E&amp;E work programme. It could have delegated approval and decisions making authority. It could report to each Governing Body or a sub-committee. Any |</p>
<table>
<thead>
<tr>
<th>Collaboration Area</th>
<th>Commentary</th>
<th>Proposed CCG Lead</th>
<th>CSU Role</th>
<th>Governance Issues</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>major decisions that are required could be agreed by the individual CCG Governing Body.</td>
</tr>
<tr>
<td>Information governance</td>
<td>As above</td>
<td>As above</td>
<td>Liaison with CSU on data exchange issues i.e. data warehouse, analytics</td>
<td>As above</td>
</tr>
<tr>
<td>NHS Property Services and LIFT Co’s</td>
<td>One CCG could be the link with NH Property Services. There are a number of areas that NHS Property Services will have a local role (i.e. transfer of PCT premises to new landlords, new GP premises etc.). It is not clear what the CCG role is in LIFT Co’s and what the future of these companies is. Currently there are PCT senior managers on the Board of each LiFT Co. If required this could be taken over by CCGs. Each CCG will need to have an identified premises lead.</td>
<td>John Morton</td>
<td>Tony Hoolaghan</td>
<td>Lead could have delegated approval and decision making for day to day issues, but any major decisions would need to be agreed by each CCG Governing Body or full CCG if appropriate.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Potential Future Collaboration Areas</th>
</tr>
</thead>
<tbody>
<tr>
<td>Collaboration Area</td>
</tr>
<tr>
<td>---------------------</td>
</tr>
<tr>
<td>Primary care strategy implementation</td>
</tr>
</tbody>
</table>
**Potential Future Collaboration Areas**

<table>
<thead>
<tr>
<th>Collaboration Area</th>
<th>Commentary</th>
<th>Proposed CCG Lead</th>
<th>CSU Role</th>
<th>Governance Issues</th>
</tr>
</thead>
</table>
| Service and provider changes support | The current work on the BEH Clinical Strategy might be a useful model to help work out how collaboration on future major service re-design might work. The main provider landscape issues at the moment are as follows:  
  - Barnet Enfield and Haringey Clinical Strategy (Liz Wise)  
  - Royal Free Hospital and of Barnet and Chase Farm Hospital acquisition (John Morton)  
  - Whittington Hospital FT application (Alison Blair)  
  - Barnet and Enfield Mental Health Trust FT application (Liz Wise)  
  - RNOH FT application (John Morton)  

It is noted that these issues impact on a number of CCGs and would benefit from collaboration. It is also noted that it is likely the CCGs would need to bring in additional management help to support taking them forward depending on how they play out. | As opposite | CSU to support on range of elements of the work programme. | It is likely that there would be a programme board overseeing this work and some sub-groups reporting in (finance, needs assessment, patient involvement etc.) The programme Board could have delegated approval for decision making on its work programme, but all of its major proposals would need to be approved by the full CCG and Governing Body. |
6. NORTH LONDON CLINICAL COMMISSIONING BOARD
The North London Clinical Commissioning Board will set the strategic priorities, direction and provide leadership to the programme of collaboration between North London CCGs and others if appropriate. It will assess the opportunities for CCG collaboration, and if suitable, arrange for them to be taken forward. It will enable mutual support and advice to CCG Chairs and Chief Officers across a wide range of common areas that the CCGs will need to address. It will be a forum where the response to national and local strategies or initiatives can be discussed and how member CCGs intend to respond individually and collaboratively to them.

Appendix 4 gives the Terms of Reference for the North London Clinical Commissioning Board.

7. INFORMATION AND REPORTING
The progress of the Collaboration Agreement will be regularly reviewed by the North London Clinical Commissioning Board and the CCG Chief Officers’ Meeting. The CCGs will carry out an annual evaluation of their Collaboration Agreement and its work programme. This review should be presented to the each member Governing Body for information.

8. OBLIGATIONS OF EACH PARTY
It is proposed that the North London Clinical Commissioning Board are given the delegated approval by each CCG Board to set the priorities for the Collaboration Agreement work programme. It would provide overall strategic clinical and senior management leadership to the work programme as well as agree new opportunities for collaboration.

In taking forward specific elements of the Collaboration Agreement work programme, there needs to be clarity as to how decisions are made in relation to taking forward these collaboration work programme projects and initiatives. It is important to note that CCGs can not delegate or share their liability for their respective statutory function. However, CCGs can delegate the exercise of any function to a committee or sub-committee of the CCG or its Governing Body or to any member or employee. This means that the CCG could delegate decision making on projects and initiatives that are within the Collaborative Agreement work programme to a committee made up of the member CCGs signed up to the Collaboration Agreement.

However, it is important to get the balance right in terms of when the CCG might wish to delegate decision making, and it is proposed that the way in which decision making is dealt with for collaborative work is done on a case by case basis. One of the following approval or decision making scenarios will be used for each individual collaborative work programme area:

- Requires approval or decision making from entire CCG
- Approval or decision making delegated to the Governing Body or one of it sub-committees
- Approval or decision making delegated to a CCG member or employee

It is proposed that the North London Clinical Commissioning Board would decide which level of approval or decision making governance is required for each specific Collaboration Agreement work programme area. The Collaboration Agreement will not include the full details of the work programme, as this will need to be iterative and responsive.
The role of the North London Clinical Commissioning Board will be to ensure that these collaborations are achieving the benefits and outcomes listed in the Collaboration Agreement.

The following steps need to be put on place to provide the governance:

In order to support CCG collaboration it is proposed that a North London Clinical Commissioning Board is established to lead and take forward CCG collaboration.

14. **DISPUTE RESOLUTION**
   The CCGs in dispute should aim to resolve the dispute themselves. CCGs will not be able to dispute any commissioning decision taken by an individual CCG. If the CCGs cannot agree, they should escalate the issue to the North London Clinical Commissioning Board which will make suggestions on how to resolve the issue. The Board will meet within 10 working days of having been asked to resolve a dispute.

   If the North London Clinical Commissioning Board cannot settle the dispute, the ‘independent party’ that is used to settle the dispute is a CCG Collaborative Commissioning Forum from another part of London. If the independent mediator cannot get the CCGs to sign up to its recommended resolution, it will issue a binding one that the CCGs involved will adhere to.

15. **COMMISSIONING SUPPORT**
   The Clinical Commissioning Groups (CCGs) in North London are committed to agreeing and taking forward a programme of collaboration on commissioning and on appropriate projects. North and East London Commissioning Support Unit are expected to support and help make successful this collaboration work. CCG collaboration work will require the CSU to work flexibly, sometimes working with one CCG that is leading on a work programme area on
behalf of others. CCG collaborative working should also enable economies of scale in CSU support.

The approach to collaborative contracting is given in Appendix 3.

16. LEAVING OR JOINING THE COLLABORATIVE
16.1 A new CCG may join the Collaborative subject to (this does not apply to January 2013, but to subsequent years):
   i. all of the existing CCG members support their joining;
   ii. that they participate in specific elements of the collaboration work programme as agreed by all existing members;
   iii. for the financial risk sharing element new CCGs must be identified by 31st December and the other CCGs must confirm by 31st January whether they can join or not;
   iv. that the CCG is not being administered by the NHS CB because of performance or authorisation concerns;
   v. signing the Collaborative Commissioning Agreement and having it approved at a Governing Body or other appropriate local CCG fora.

16.2 Any of the parties may cease to be a party of this Agreement subject to:
   I. for the financial risk share element, CCGs can only step put of the arrangement on 31st March and must give a minimum of 3 months notice that they do not intend to take part in the risk sharing agreement from 1st April of new financial year;
   II. Giving notice. The minimum notice period is 6 months for all collaboration work programme areas;
   III. Evidence that the Governing Body or other relevant CCG for a have approved the decision to withdraw from the Collaborative Commissioning Agreement.

18. COUNTERPARTS
This Agreement may be executed in any number of counterparts, each of which will be regarded as original, but all of which together shall constitute one agreement binding all the Parties, notwithstanding that all Parties are not signatories to the same counterpart.

<table>
<thead>
<tr>
<th>CCG Name and Authorised Officer</th>
<th>Signature</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Barnet</td>
<td></td>
<td></td>
</tr>
<tr>
<td>John Morton</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Camden</td>
<td></td>
<td></td>
</tr>
<tr>
<td>David Cryer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Enfield</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Liz Wise</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Haringey</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sarah Price</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Islington</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alison Blair</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Tony Hoolaghan  
23 January 2013
Enfield Clinical Commissioning Group

Agenda Item: 4
Paper Ref: 4.1- App Hi

<table>
<thead>
<tr>
<th>MEETING:</th>
<th>NHS Enfield Clinical Commissioning Group Governing Body Meeting</th>
</tr>
</thead>
<tbody>
<tr>
<td>DATE:</td>
<td>Wednesday 13th February 2013, 3.00-4.30 pm</td>
</tr>
<tr>
<td>TITLE:</td>
<td>Governance Policies for Governing Body's approval</td>
</tr>
<tr>
<td>LEAD BOARD MEMBER:</td>
<td>Aimee Fairbairns, Director of Service Quality and Integrated Governance</td>
</tr>
<tr>
<td>AUTHOR:</td>
<td>Aimee Fairbairns, Director of Service Quality and Integrated Governance</td>
</tr>
</tbody>
</table>
| CONTACT DETAILS: | Aimee.Fairbairns@nclondon.nhs.uk  
Andy.Nuckcheddee@nclondon.nhs.uk |

**SUMMARY:**

This summary report relates to the recommended adoption of the following policies:

- Policy for the Development of Policies and Procedural Documents;
- Data Protection Policy;
- Internet Policy;
- Information Sharing and Disclosure Policy; and
- Information Lifecycle Management Policy.

In working towards authorisation a full range of policies and procedures have already been adapted and endorsed for approval through the Enfield CCG’s sub-committees and the Executive Committee.

These policies have all been amended from existing North Central London policies and the Executive Committee has reviewed, commented on and endorsed for approval the policies listed in this report.

Where appropriate these policies have also been reviewed and amended by the relevant sub-committees of the Governing Body and will be reviewed again within the first year of the establishment of the CCG.
If or when minor changes are required and in keeping with the Policy on for the Development of Policies and Procedural Documents requirements these policies can be reviewed and amended by the relevant sub-committees.

Any significant changes within local, regional and or national policy that impact on any policy approved by the Governing Body will be effected accordingly and for the Governing Body’s approval.

These policies and the framework are all required for the registration with the information commissioner and as part of the CCG’s requirements for information governance.

SUPPORTING PAPERS:
Policy on for the Development of Policies and Procedural Documents
Data Protection Policy
Internet Policy
Information Sharing and Disclosure Policy
Information Lifecycle Management Policy

RECOMMENDED ACTION:
The Governing Body members are asked to:

- Accept the recommendation from the Executive Committee to adopt the policies listed in this report;
- Note that during the transition period and towards authorisation Enfield CCG is in the process of reviewing amending, approving and adopting a full suite of policies and procedures which will become operational as from 1st April 2013; and
- ECCG will ensure policies and procedures meet legislative, national policy and regulatory requirements.

Objective(s) / Plans supported by this paper:
As part of NHS Enfield Commissioning Group’s statutory responsibilities and commitment to the delivery of the key objectives, policies need to be approved, mobilised and in place. It is also important to ensure that policies are reviewed and updated as and when appropriate.

Patient & Public Involvement (PPI): Not identified

Equality Impact Analysis: No negative impact identified
Risks: Capacity and transition with mitigations in place and recorded on the corporate risk register.

Resource Implications: As part of organisational and staff development there will be time and resource implications. These will be addressed as part of the on-going organisational development plan.

Audit Trail: All Policies have a unique reference number, review date and the Committee responsible for overseeing their review and implementation.

Next Steps:

- During transition, NHS Enfield CCG will continue to work to NHS North Central London’s policies and procedures;
- Post transition, after 1st April 2013, NHS Enfield CCG will utilise the locally adopted policies. These will be reviewed in a timely manner to ensure that they continue to meet the requirements of the newly constituted CCG; and
- All ECCG Policies will be posted on the website.

The listed policies have been reviewed by the Executive Committee members on 30th January 2013.
**Policy for the Development and Management of Procedural Documents**

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>SUMMARY</strong></td>
<td>This policy sets out the principles by which the Enfield Clinical Commissioning Group will develop, manage and review all policies and associated documentation.</td>
</tr>
<tr>
<td><strong>RESPONSIBLE PERSON:</strong></td>
<td>Director of Service Quality and Integrated Governance</td>
</tr>
<tr>
<td><strong>ACCOUNTABLE DIRECTOR:</strong></td>
<td>Director of Service Quality and Integrated Governance</td>
</tr>
<tr>
<td><strong>APPLIES TO:</strong></td>
<td>All staff employed within ECCG</td>
</tr>
</tbody>
</table>
| **GROUPS/ INDIVIDUALS WHO HAVE OVERSEEN THE DEVELOPMENT OF THIS POLICY:** | Director of Service Quality and Integrated Governance  
Head of Governance and Risk |
| **GROUPS WHICH WERE CONSULTED AND HAVE GIVEN APPROVAL:** | Executive Committee |
| **EQUALITY IMPACT ANALYSIS COMPLETED:** | Policy Screened  
Template completed |
| **RATIFYING COMMITTEE(S) & DATE OF FINAL APPROVAL:** | Executive Committee - 30th January 2013  
ECCG Governing Body - 13th February 2013 |
| **VERSION:** | 2 |
| **AVAILABLE ON:** | Intranet  
Website |
<p>| <strong>RELATED DOCUMENTS:</strong> | ECCG Risk Management Strategy |
| <strong>DISSEMINATED TO:</strong> | All staff in ECCG |
| <strong>DATE OF IMPLEMENTATION:</strong> | April 2013 |
| <strong>DATE OF NEXT FORMAL REVIEW:</strong> | March 2014, or sooner if there are changes to legislation etc. that impact on this policy and procedure |</p>
<table>
<thead>
<tr>
<th>Date</th>
<th>Version</th>
<th>Action</th>
<th>Author</th>
</tr>
</thead>
<tbody>
<tr>
<td>10/01/13</td>
<td>1</td>
<td>Document Creation</td>
<td>Alison Mitchell-Hall</td>
</tr>
<tr>
<td>24/01/13</td>
<td>2</td>
<td>Updated following internal review</td>
<td>Alison Mitchell-Hall</td>
</tr>
<tr>
<td>30/01/2013</td>
<td>3</td>
<td>Updated from the Executive Committee meeting</td>
<td>Andy Nuckcheddee</td>
</tr>
<tr>
<td>SECTION NO.</td>
<td>TITLE</td>
<td>PAGE NO.</td>
<td></td>
</tr>
<tr>
<td>------------</td>
<td>----------------------------------------------</td>
<td>----------</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Legal Basis of Enfield CCG Policies &amp; Terminology</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Board Reservation of &amp; Scheme of Delegation for Policy Approval</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Role of Governing Body Sub-committees, Accountable Executives &amp; Policy Owners</td>
<td>7</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Duties of Policy Owners/custodians</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Engagement in the Review Process</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Policies within the CCG’s Core Business</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Policy Repository, Access &amp; Archiving: Role of Board Secretary</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Defining Procedures Subsidiary to Policies</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Managing Policy Implementation &amp; Training and Auditing Policies</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>ECCG Format for Policies</td>
<td>11</td>
<td></td>
</tr>
<tr>
<td>Appendix A</td>
<td>Policy Front Sheet</td>
<td>13</td>
<td></td>
</tr>
<tr>
<td>Appendix B</td>
<td>Document Information</td>
<td>14</td>
<td></td>
</tr>
<tr>
<td>Appendix C</td>
<td>Equality Impact Assessment Tool</td>
<td>15</td>
<td></td>
</tr>
</tbody>
</table>
1. Legal Basis of Enfield CCG Policies & Terminology

1.1 Enfield Clinical Commissioning Group (ECCG) Governing Body will develop a range of policies and procedures to enable the organisation to deliver its functions and duties. This policy will clearly define the requirements for the development and management of policies and other documents.

1.2 ECCG has defined its high level functions in the Constitution that it has adopted. Annex 3 Section 7.1 of the Constitution (version 1.2) states:

The CCG will from time to time agree and approve Policy statements/procedures which will apply to all or specific groups of staff employed by the CCG. The decisions to approve such policies and procedures will be recorded in an appropriate CCG minute and will be deemed where appropriate to be an integral part of the CCG’s SOs.

1.3 In developing policies the ECCG Governing Body will take into account of:

- Primary legislation – for instance, the Health and Social Care Act 2012 and The Equality Act 2010;
- Secondary guidance – The Functions of Commissioning Groups (DH, Gateway ref 17005, June 2012); and
- Formal guidance – not applicable for this policy.

1.4 New or fully revised policies will be produced either by the ECCG’s operational teams or by the relevant CCG Sub-committee, as set out in the schedule of delegation within this policy at Section 2 and must be submitted for approval and ratification by the CCG Governing Body.

1.5 Until March 2014, all policies and key procedural documents that are reviewed and adopted by the ECCG Governing Body will be managed and reviewed in accordance with this policy, and future approval may be delegated to the relevant sub-committee of the Governing Body.

1.6 The ECCG Governing Body and employees will adopt the standard definitions of documents across the organisation

1.7 Explanation of Terms

- A ‘strategy’ sets out a plan of action to meet specific goals. Strategies will usually be developed to support and implement long term or organisational goals, and will be approved by the ECCG Governing Body;
- A ‘policy’ is a comprehensive statement that sets out the ECCG position and governing principles with regard to a specific area of work. A ‘policy’ must be followed by all staff, and is enforceable by management. It may include instructions that must be followed, or prohibit certain behaviour. No member is authorised to deviate from Trust policy in all but the most extreme circumstances. Deviation from a particular procedure within a policy can occur and such circumstances are described in the paragraph below.
A ‘procedure’ is a recommended way of working for staff to follow, usually based on evidence of good practice. Procedures are contained within policy documents, usually as an appendix. A member of staff may depart from a ‘procedure’ only where they: 1) feel it is an inappropriate procedure to follow in the particular and usually extraordinary circumstances they face; (2) can provide and record documentary evidence to show that the procedure is not appropriate, or that an alternative approach should be taken; and (3) have authority to depart from that procedure by management approval through a formal variation request to the Accountable Executive.

A ‘guideline’ is a document that provides guidance for practitioners and others in their clinical or managerial decision-making. It allows choices to be made about how standards are achieved and about appropriate actions or behaviour in a given circumstance. From time to time, a practitioner may deviate from a guideline in a patient’s best interest. It is important that the rationale for any variation or deviation from a specific guideline is documented in the appropriate records.

1.8 The glossary of terminology is not universal and other agencies may use different terminologies. For example, the word “protocol" is in wide use within the NHS, both in terms of clinical procedures & inter-agency agreement. Similarly, the word “policy” has been widely used within NHS organisations and often applied to matters that are (within this terminology) “procedures”.

For the purposes of ECCG policy development, management & review, a protocol will be regarded as a type of procedure or a Standard Operating Procedure.

2. Board Reservation of & Scheme of Delegation for Policy Approval

(Board approved Scheme of Reservation and Delegation for Policy Approval)

2.1 All key Financial Policies and key governance frameworks such as Financial Orders and Financial Standing Instructions will be approved and ratified by:

- the Governing Body; and
- have effect as incorporated into the CCG’s Constitution.

2.2 Policies and Procedures relating to Procurement will be:

- developed and approved by the Finance Recovery and QIPP Committee.
- reviewed by the Audit Committee and
- approved and ratified by the Governing Body and
- have effect as incorporated into the CCG’s Constitution.

2.3 Financial procedures and any subsequent amendments will be:

- approved by the Finance Recovery and QIPP Committee; and
- reviewed and approved by the Audit Committee.

2.4 Policies relating to Risk Management will be:

- developed and reviewed by the Quality and Safety Committee;
- approved by the Executive; and
- approved and ratified by the Governing Body.
2.5 Human Resource & Organisational Development Policies applying to all groups of staff will be:

- approved by the Executive; and
- approved and ratified by the Governing Body,

2.6 Policies requiring substantial external consultation or engagement with key stakeholders, and which are likely to attract media attention will be approved and ratified by the Governing Body.

2.7 The responsibility for policy review will be delegated to an ECCG Governing Body’s Sub-committee as in the schedule below. The Sub-committees will have the delegated authority and responsibility to review and make recommendations to the Governing Body for adoption or ratification of policies. During the transition period and first year of operation of the ECCG, the Governing Body should make recommendations which determine that amendments or revision of the policy can be delegated to the relevant sub-committees.

<table>
<thead>
<tr>
<th>Sub Committee</th>
<th>Policy Area Delegated</th>
</tr>
</thead>
<tbody>
<tr>
<td>Executive</td>
<td>All policies associated with Human Resources, Emergency Planning, Corporate Governance (including Business Continuity and Legal Framework), Sustainability and Organisational Development</td>
</tr>
<tr>
<td>Quality and Safety</td>
<td>All policies associated with Risk Management, Safeguarding, Information Governance, Health and Safety and associated legislation, Complaints and Compliments; Patient Safety (including incident &amp; Serious Incident reporting), Being Open, Clinical Effectiveness and Audit, Infection Control</td>
</tr>
<tr>
<td>Public and Patient Engagement</td>
<td>All policies associated with Communications and Engagement, Choice, Equality, Diversity and Human Rights</td>
</tr>
<tr>
<td>Finance Recovery &amp; QIPP Committee</td>
<td>Financial transactions or accounting processes, Scheme of Delegation, Financial Standing Instructions, Standing Orders, Counter-Fraud Policy, Legal Claims</td>
</tr>
<tr>
<td>Audit Committee</td>
<td>All policies associated with Procurement (including competition disputes), Standards of Business Conduct, Counter-Fraud Policy, Internal and External Audit Process</td>
</tr>
</tbody>
</table>

2.8 In discharging its responsibilities, the ECCG Executive Committee will adopt a “portfolio” approach in which individual Executive Director will be accountable for policy
development within their specific Directorates. In terms of policy development, management & review these portfolios are summarised below:

<table>
<thead>
<tr>
<th>Executive</th>
<th>Policy area &amp; Accountability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chief Officer</td>
<td>Organisational Policy Development and Review</td>
</tr>
<tr>
<td></td>
<td>Corporate Governance Framework and Handbook</td>
</tr>
<tr>
<td></td>
<td>Nolan Principles</td>
</tr>
<tr>
<td></td>
<td>Accountability Framework</td>
</tr>
<tr>
<td></td>
<td>Constitution</td>
</tr>
<tr>
<td></td>
<td>Declaration of Interests Health &amp; Safety</td>
</tr>
<tr>
<td></td>
<td>Emergency Planning &amp; Business Continuity</td>
</tr>
<tr>
<td></td>
<td>Sustainable Development</td>
</tr>
<tr>
<td></td>
<td>Human Resources &amp; Organisational Development</td>
</tr>
<tr>
<td></td>
<td>Information Technology and Management</td>
</tr>
<tr>
<td>Chief Finance Officer</td>
<td>Financial Management &amp; Accounting</td>
</tr>
<tr>
<td></td>
<td>Counter-Fraud</td>
</tr>
<tr>
<td></td>
<td>Security Management</td>
</tr>
<tr>
<td></td>
<td>Procurement &amp; Contracts</td>
</tr>
<tr>
<td></td>
<td>Provider Performance</td>
</tr>
<tr>
<td>Director of Service Quality &amp;</td>
<td>Risk Management</td>
</tr>
<tr>
<td>Integrated Governance</td>
<td>Information Governance</td>
</tr>
<tr>
<td></td>
<td>Safeguarding (Children and Adults)</td>
</tr>
<tr>
<td></td>
<td>Patient Safety (including incident &amp; Serious Incident reporting)</td>
</tr>
<tr>
<td></td>
<td>Clinical Quality and Safety</td>
</tr>
<tr>
<td></td>
<td>Communications &amp; Engagement</td>
</tr>
<tr>
<td></td>
<td>Equality &amp; Diversity</td>
</tr>
<tr>
<td>Medical Director</td>
<td>Caldicott Guardian</td>
</tr>
<tr>
<td></td>
<td>Research and Development</td>
</tr>
<tr>
<td></td>
<td>Education and Training</td>
</tr>
<tr>
<td></td>
<td>Clinical Engagement</td>
</tr>
</tbody>
</table>

2.9 A schedule of policies and allocation /review dates will be maintained by the Board Secretary.

3. **Role of Governing Body Sub-committees, Accountable Executives & Policy Owners**

3.1 The Governing Body Sub-committee chairs will maintain a standing agenda item for “Policy Review and Updates” and with the assistance of the Board Secretary, plan agendas to ensure that all policies associated with and relevant to that Committee are reviewed in a timely manner.

3.2 The Accountable Executive will identify an appropriate person as the policy owner. The policy owner will be responsible for the development, implementation and review of the policy and will possess the appropriate competence, experience and authority in order to achieve this.

3.3 The Governing Body Sub-committees will recommend to the Governing Body the review period for each policy associated with that Committee.
3.4 The Accountable Executive will advise the policy owner/custodian of the appropriate approval process and ensure that the policy is discussed and recorded at a full meeting of the Sub-committee in the presence of the policy owner/custodian.

3.5 The Chair of the Governing Body Sub-committees will report the key points of the discussion and recommendations (in an appropriate level of detail) to the ECCG Governing Body in Part 1 meeting.

3.6 The Sub-committees' secretary will ensure that the latest approved version of a policy is provided in the required format to the Board Secretary and recorded in the ECCG central register, under configuration control.

3.7 The Board Secretary will ensure that the document is fully compliant with the ECCG requirements before being placed on the website.

3.8 Where the policy owner/custodian is unable to complete the work of review prior to the expiry date, they will notify both the Chair of the relevant Sub-committee and their line manager (if different).

3.9 The Accountable Executive will be responsible for reporting this delay to the Executive and the Board Secretary, and proposing to the Sub-committee chair any interim extension to the policy if required.

3.10 Where the policy is delegated to the Executive, then any delay in the review process and the proposal for interim extension must be notified to the Chair of the Governing Body, together with the proposal for managing the delay.

4. Duties of Policy Owners/custodian

4.1 The policy owner/custodian will be responsible for the drafting and review of the policy, in collaboration with appropriate and knowledgeable members of the ECCG, ensuring that it is compliant with legislation, regulations, national guidance or evidence-based practice and fit for purpose.

4.2 The policy owner/custodian will also identify any requirement for review as the result of emerging national or regional guidance, policy or legislation changes.

4.3 The policy owner/custodian will identify the target audience for a policy and the stakeholders, including patients, carers and partner organisations that need to be involved in development or review of a particular policy.

4.4 The policy owner/custodian will complete an Equality Impact Assessment and discuss any issues arising with the Accountable Executive and Sub-committee chair before submitting the draft policy for approval.

4.5 The policy owner/custodian will complete the Policy Approval Checklist (Alison, will this be appended) and submit with the draft policy for approval;

4.6 The policy owner/custodian will complete an Implementation and Training Plan to identify actions that need to be taken, and by whom, to ensure proper awareness and application of the policy. This may include a range of issues such as:
  - the requirement to incorporate into mandatory training, or team training;
4.7 The policy owner/custodian will commence any scheduled review no less than 3 months prior to the expiry date in order to ensure that necessary stakeholder engagement and approvals can be achieved before the expiry date. If the work cannot be achieved within this timeframe then the policy owner should notify their line manager and the Accountable Executive.

4.8 Where minor amendments to policy are required, the policy owner/custodian will amend the document and notify the Accountable Executive and Sub-committee chair, which may choose to endorse the amendments to the policy. A maximum of three amendments can be made within the life of the policy without a formal review.

4.9 The policy owner will notify the Board Secretary of all employees whose work may be affected by any minor revisions to the policy and also, purpose and reasoning behind the required changes.

4.10 Where a policy owner or custodian has left his or her position, the Accountable Executive will inform the relevant Sub-Committee chair and agree the most appropriate course of action.

5. Engagement in the Review Process

5.1 Policies will have a clear target audience and will be developed in conjunction with the relevant stakeholders, including patient groups and third party organisations, if appropriate.

5.2 The Accountable Executive and policy owner/custodian will identify the requirement for the policy to be maintained, developed or revised by linking it to changes in relevant primary and secondary legislation and national guidance.

5.3 As a minimum, each policy must be reviewed at least once every three years. New policies will be reviewed after one year.

5.4 The policy owner/custodian will define the stakeholder map for each policy, and consider the implications of the proposed policy under the Equality Act 2010 to ensure that people or organisations that need to take account of the policy are included in the development or review process. This may include representatives from:

- Patients and service users, including carers and those defined as having protected characteristics;
- Member practices;
- Staff Union representatives;
- Commissioning Support Unit staff;
- Any Providers where applicable

5.5 The policy owner and will ensure that each individual participant within the review has fully considered whether they have a conflict of interest that must be declared, in accordance with the ECGC Declaration of Interests Policy. In the event of any doubt or concern, the policy owner/custodian will inform the Accountable Executive of the facts of the issues which
may give rise to a conflict of interest.

5.6 The role of patient and/or carer representatives in the review of policy will be clearly defined, and support given to ensure the views of vulnerable groups are adequately represented.

6. Policies within the CCG’s Core Business

6.1 The policy owner will liaise with the relevant ECCG members and staff, the Commissioning Support Unit or other relevant organisations to incorporate the policy into contracts where applicable and agree the relevant monitoring or audit plan.

6.2 The ECCG Governing Body will agree a core suite of policies that must be incorporated into the specification for any clinical procurement, and the Operational Executive Committee will agree a standardised means of evaluating the tender responses against those requirements.

6.3 The Lead Commissioner on any procurement project will identify any additional policy or legislation that affects a specific planned procurement, and the evaluation of that requirement.

7. Policy Repository, Access & Archiving: Role of Board Secretary

7.1 All relevant policies lodged in the central register will be published on the ECCG’s website as per the requirements of Freedom of Information Act. All policies will be made accessible to all staff working within the CCG via the staff intranet.

7.2 The Board Secretary, in conjunction with the policy owner/custodian, will contact all staff and Governing Body Members to advise of the publication of a new or revised policy, and to remind each individual employee of their responsibility to familiarise themselves with the policy.

7.3 If a policy has passed its review date, and the Executive has not agreed an extension date, will be removed from public display on the website until a revised policy has been approved for publication

7.4 Only the Board Secretary (or nominated deputy) will liaise with the CCG’s Communications Manager in ensuring that relevant policies can be published or removed from the CCG’s website in accordance with the content of this policy.

7.5 Once a policy has been replaced or been removed if it is no more applicable to the CCG, it will be placed in an electronic archive maintained in accordance with NHS Litigation Authority’s Risk Management Standards and Department of Health’s Retention of Records standards by the Board Secretary or nominated deputy.
8. Defining Procedures Subsidiary to Policies

8.1 In general, detailed procedures that are subsidiary to ECCG policies should not be incorporated within the policy documents, nor created as separate policy documents.

8.2 Where the policy owner/custodian and approving Sub-committee agree that it is in the public interest to publish a procedure that is in place to enable the policy to be delivered, this should not be included in the main body of the document, except in summary form, but included either as:

- an appendix to the policy; and
- a hyperlink to another website.

8.3 Where the procedure specific to department’s day-to-day operations task, then it should be referred to within the policy as a Standard Operating Procedure (SOP) and the SOP maintained and updated within the department concerned. (e.g. a financial accounting procedure)

8.4 Where the procedure for applying the policy is expected to be followed across multiple organisations, then those organisations will be required to include both the policy and procedure in the appropriate section or schedule of any contract, multi-agency agreement or “transfer of funding” document or for instance, a multi-agency agreement or memorandum of understanding on Information Sharing.

9. Managing Policy Implementation & Training and Auditing Policies

9.1 The policy owner/custodian will consider with stakeholders the most appropriate implementation plan for any new or substantially revised policy. In doing this they will identify who will be responsible for any action within or across organisations, and agree with that individual a reasonable timescale.

9.2 The policy owner/custodian will identify the associated resources necessary to achieve effective implementation of relevant policy. If a policy requires additional specialist resource (such as facilitators for workshops, training or legal advice) then, approval for additional funding must be sought from the Finance Department.

9.3 The policy owner/custodian will agree with the relevant approving Committee a dissemination and training plan where there has been substantial change to the policy, or where the application of the policy is seen through audit or observation to be deficient.

9.4 The Accountable Executive will identify with the Operational Executive any resources or funding required implementing a policy.

9.5 The policy owner will be required to monitor or audit the implementation plan at an agreed date and provide feedback to the Accountable Executive.

9.6 The Accountable Executive and policy owner will be required to attend and report to the relevant Sub-committee the outcome of any audit of the policy.
10. ECCG Format for Policies

10.1 Each ECCG Policy will be allocated a unique identifier, using the Policy Tracker set out below:

(Alison, I will suggest that we use the NHSLA document Appendix A Checklist for formatting policies)- Please see attachment in email.

- ECCG/Policy area/Year approved/unique policy number

10.2 Policy documents will be produced in Arial font and have a paginated index

10.3 All pages will be numbered

10.4 Abbreviations may be used, but full details must be given in the first instance followed by the abbreviation in brackets.

10.5 The front sheet for all policies will be as set out in Appendix A to this policy (see this front sheet for example)

10.6 A Document Information Summary will be included, as set out in Appendix B

10.7 All policies will be informed by an Equality Impact Analysis which will consider the effect of the policy on the organisation and population that it serves.
### APPENDIX A – Policy Front Sheet

<table>
<thead>
<tr>
<th><strong>MEETING:</strong></th>
<th>NHS Enfield Clinical Commissioning Group Governing Body</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>DATE:</strong></td>
<td></td>
</tr>
<tr>
<td><strong>TITLE:</strong></td>
<td></td>
</tr>
<tr>
<td><strong>LEAD DIRECTOR/MANAGER:</strong></td>
<td></td>
</tr>
<tr>
<td><strong>AUTHOR:</strong></td>
<td></td>
</tr>
<tr>
<td><strong>CONTACT DETAILS:</strong></td>
<td></td>
</tr>
</tbody>
</table>

**SUMMARY:**


**SUPPORTING PAPERS:**


**RECOMMENDED ACTION:**

The Board is asked to:


**Objective(s) / Plans supported by this paper:**


**Audit Trail:**


**Patient & Public Involvement (PPI):**


**Equality Impact Assessment:**


**Risks:**


**Resource Implications:**


**Next Steps:**
## POLICY TITLE

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>SUMMARY</td>
</tr>
<tr>
<td>2</td>
<td>RESPONSIBLE PERSON:</td>
</tr>
<tr>
<td>3</td>
<td>ACCOUNTABLE DIRECTOR:</td>
</tr>
<tr>
<td>4</td>
<td>APPLIES TO:</td>
</tr>
<tr>
<td>5</td>
<td>GROUPS/ INDIVIDUALS WHO HAVE OVERSEEN THE DEVELOPMENT OF THIS POLICY:</td>
</tr>
<tr>
<td>6</td>
<td>GROUPS WHICH WERE CONSULTED AND HAVE GIVEN APPROVAL:</td>
</tr>
</tbody>
</table>
| 7 | EQUALITY IMPACT ANALYSIS COMPLETED:  
   | Policy Screened  
   | Template completed |
| 8 | RATIFYING COMMITTEE(S) & DATE OF FINAL APPROVAL: |
| 9 | VERSION: |
| 10 | AVAILABLE ON:  
   | Intranet  
   | Website |
| 11 | RELATED DOCUMENTS: |
| 12 | DISSEMINATED TO: |
| 13 | DATE OF IMPLEMENTATION: |
| 14 | DATE OF NEXT FORMAL REVIEW: |

### DOCUMENT CONTROL

<table>
<thead>
<tr>
<th>Date</th>
<th>Version</th>
<th>Action</th>
<th>Amendments</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>


### Enfield Clinical Commissioning Group Equality Impact Analysis (EQIA) screening

**Proposal Title:** Policy for the Development and Management of Procedural Documents

<table>
<thead>
<tr>
<th><strong>Author /editor/assessors</strong></th>
<th>At least one of the people carrying out an EQIA must be the person responsible for the policy/function/service</th>
<th>Andy Nuckcheddee, Interim Head of Governance &amp; Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Partners/decision-makers/ implementers</strong></td>
<td>Identify who else will need to be involved. This can be decision-makers, frontline staff implementing the policy, partner/parent organisations, etc</td>
<td>Reviewed by Executive Committee</td>
</tr>
<tr>
<td><strong>Start Date</strong></td>
<td>The EQIA should be started prior to policy/service development or at the design stages of the review and continue throughout the policy development/review. For an existing policy/service, any changes identified have to be implemented.</td>
<td>February 2013</td>
</tr>
<tr>
<td><strong>End date</strong></td>
<td>The EQIA will need to inform decision-making so the date should take this into account</td>
<td>March 2014</td>
</tr>
</tbody>
</table>
| **Due regard, proportionality and relevance in relation to the following characteristics** | Has due regard been given to equality (i.e. promote equality of opportunity between communities, eliminate discrimination that is unlawful, promote positive attitudes towards communities) for this proposal/policy/function?  
*Due regard has two linked elements: proportionality and relevance. The weight given to equality should therefore be proportionate to its relevance to a particular function.* | Please refer to completed EQIA assessment tool |
| • Gender including gender reassignment |  |
| • Race/ethnicity |  |
| • Disability |  |
| • Age |  |
- Religion or belief
- Pregnancy and maternity
- Sexual orientation
- Deprivation

<table>
<thead>
<tr>
<th>Proposal/ policy/function/service aims</th>
<th>Consider:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>- Why is the proposal/policy/function/service needed?</td>
</tr>
<tr>
<td></td>
<td>- What does ECCG hope to achieve by it?</td>
</tr>
<tr>
<td></td>
<td>- How will ECCG ensure that it works as intended?</td>
</tr>
<tr>
<td></td>
<td>- Who benefits?</td>
</tr>
<tr>
<td></td>
<td>- Who doesn’t benefit and why not?</td>
</tr>
<tr>
<td></td>
<td>Who should be expected to benefit and why don’t they?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Evidence gaps</th>
<th>Identify what evidence is available and set it out here. This includes evidence from involvement and consultation. Identify where there are gaps in the evidence and set out how these will be filled</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>None currently identified</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Involvement &amp; consultation</th>
<th>What involvement and consultation has been done in relation to this (or a similar) policy or function, and what are the results? What involvement and consultation will be needed and how will it be undertaken? Report any results.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>CCG Executive Committee</td>
</tr>
</tbody>
</table>

| Addressing the impact | Outcome 1: No major change: the EQIA demonstrates the policy /change is robust and there is no potential for discrimination or adverse impact |
|                       | Outcome 2: Adjust the policy: the EQIA identifies potential problems or missed opportunities. Adjust the policy to remove barriers or better promote equality. |
|                       | Outcome 3: Continue the policy: the EQIA identifies the potential for adverse impact or missed opportunities to promote equality. Clearly set out the justifications for continuing with it. The justification must be in line with the duty to have due regard. For the most relevant policies, compelling reasons will be needed. |
|                       | Outcome 4: Stop and remove the policy: the policy shows actual or potential unlawful discrimination. |
|                       | Outcome1 |
BEFORE USING THIS POLICY ALWAYS CHECK THAT YOU ARE USING THE MOST RECENT VERSION

DATA PROTECTION POLICY

| 1. SUMMARY | This Policy defines the requirements for complying with the Data Protection Act 1998 within Enfield Clinical Commissioning Group (including local presences) and hosted organisations. |
| 2. RESPONSIBLE PERSON: | Head of Governance and Risk |
| 3. ACCOUNTABLE DIRECTOR | Aimee Fairbairns – Director of Service Quality and Integrated Governance |
| 4. APPLIES TO: | All staff |
| 7. EQUALITY IMPACT ANALYSIS COMPLETED: | Policy Screened | Template completed |
| 8. GROUPS/INDIVIDUALS WHO HAVE OVERSEEN THE DEVELOPMENT OF THIS POLICY: | Caldicott Guardian
Director of Service Quality and Integrated Governance
Head of Governance and Risk |
| 9. GROUPS WHICH WERE CONSULTED AND HAVE GIVEN APPROVAL: | Executive Committee |
| 10. RATIFYING COMMITTEE (S) & DATE OF FINAL APPROVAL: | Executive Committee- 30th January 2013
ECCG Governing Body- 13th February 2013 |
<p>| 11. VERSION: | 2 |
| 12. AVAILABLE ON: | Intranet X Website |
| 13. RELATED DOCUMENTS: | Freedom of Information Policy, Complaints Procedure, Copying Letters to Service Users Policy, E-mail Policy, , Data Quality Policy, Information disclosure guidelines, Information Governance Policy, Information Management Strategy, Internet Service Policy, Information Lifecycle Management Policy, Risk Management Strategy: Incident Policy and Serious Incident Policy, Staff Code of |</p>
<table>
<thead>
<tr>
<th></th>
<th>Confidentiality</th>
</tr>
</thead>
<tbody>
<tr>
<td>14.</td>
<td><strong>DISSEMINATED TO:</strong></td>
</tr>
<tr>
<td>15.</td>
<td><strong>DATE OF IMPLEMENTATION:</strong></td>
</tr>
<tr>
<td>16.</td>
<td><strong>DATE OF NEXT FORMAL REVIEW:</strong></td>
</tr>
</tbody>
</table>
Document Control

<table>
<thead>
<tr>
<th>Date</th>
<th>Version</th>
<th>Action</th>
<th>Author</th>
</tr>
</thead>
<tbody>
<tr>
<td>11/01/13</td>
<td>1</td>
<td>Drafted - NCL Policy amended for adoption within ECCG</td>
<td>Alison Mitchell-Hall</td>
</tr>
<tr>
<td>23/01/12</td>
<td>2</td>
<td>Updated following internal review</td>
<td>Alison Mitchell-Hall</td>
</tr>
<tr>
<td>30/01/12</td>
<td>3</td>
<td>Updated following Executive Committee</td>
<td>Andy Nuckcheddee</td>
</tr>
<tr>
<td>SECTION NO.</td>
<td>TITLE</td>
<td>PAGE NO.</td>
<td></td>
</tr>
<tr>
<td>------------</td>
<td>----------------------------------------------</td>
<td>----------</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Introduction</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Policies statement</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Scope of this policy</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Who this policy applies to</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>4.1</td>
<td>Staff (including temporary staff)</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>4.2</td>
<td>Responsibilities of Employees</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>4.3</td>
<td>Managers</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Definitions used in this policy</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Recommendations for Independent Contractors</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Initiation, development and review of the policy</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Risk rating of the policy</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Data Protection Act Risks and Awareness</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>Specific Policy Requirements</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>Dissemination</td>
<td>16</td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>Implementation of this Policy</td>
<td>16</td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>Appendix 1- Equality Impact Assessment</td>
<td>19-21</td>
<td></td>
</tr>
</tbody>
</table>
1. Introduction.

1.1 The Data Protection Act 1998 (the Act) entitles every living person the right to apply for access to information held on them by an organisation. Such information is referred to as ‘personal data’ by the Act. Enfield Clinical Commissioning Group (ECCG) equivalent to ‘personal data’ is ‘person identifiable data’. This Policy sets out the requirements for complying with the Act in the collection, storage, processing and destruction of personal data.

1.2 The Act does not have any provisions for access to the health records of the deceased. Access under these circumstances is governed by the Access to Health Records Act 1990. The personal representative (executor or administrator of the estate) of the deceased or any person who may have a claim arising out of the patient’s death may apply for access. Access will not be allowed if the patient indicated while alive that they did not wish their details to be given to a particular person.

1.3 Access to information that is not deemed to be ‘personal’ may be subject to the Freedom of Information Act 2000, the requirements for which are set out in the Freedom of Information Policy.

1.4 ECCG has a legal obligation to comply with all appropriate legislation in respect of data, information and IT Security, including in this case the Act. It also has a duty to comply with guidance issued by the Department of Health, the NHS Executive, and other advisory groups to the NHS.

1.5 This Policy reflects the findings and Judgement made by the Court of Appeal, 8th December 2003 (the so-called Durant Judgement) which clarified a number of issues arising from the interpretation and implementation of the Act. In particular, this judgement provided clear guidelines on what constitutes personal data, the limitations upon individuals seeking such information, and the need for organisations not to overburden themselves in seeking to comply with the Act. As a consequence, this Policy adopts a pragmatic but compliant approach to the Act taking into account the advice given by the Information Commissioner and the methodical insight provided by the Court of Appeal.

1.6 Any changes to this Policy will largely be driven by any legislative changes, changes in legal interpretation (by a law court) or by any changes in its implementation announced by NHS Connecting for Health. Where NHS Connecting for Health announce such changes, this Policy will be updated immediately and the changes will be communicated, where relevant, to staff.

1.7 All staff and third-parties will be expected to comply with this Policy in full.

2. Policies statement

2.1 The Policy is intended to achieve the following Information Governance objectives via the Act’s eight Principles:

- **Confidentiality** – access to data and information must be confined to only to those users with a specific authority to view the data. The
processing of any access requests for personal data must not lead to unauthorised confidentiality compromises;

- **Integrity** – ECCG data and information must be complete and accurate, and protected from unauthorised modification. All systems, assets and networks must be operated in a manner to ensure that there is no unauthorised or accidental modification of data and systems as a result of any deliberate or accidental misuse;

- **Availability** – information must be available and delivered to the right person at the right time it is needed. ECCG must also ensure that it is able to respond to appropriate data requests from patients in a timely manner; and

- **Accountability** – users will be held responsible for their collection, use and processing of personal data. ECCG will ensure that, where appropriate, there is sufficient accountability for use and processing of personal data. An audit trail of all personal data access requests will be maintained.

3. **Scope of this policy**

3.1 This Policy is applicable to all ECCG (including local presences) and hosted organisations IT and IS computer systems, databases, facilities and networks. It is also applicable to third-party IT and IS computer systems, databases, facilities and networks that are employed to provide services to ECCG.

3.2 This Policy applies to all ECCG information and data, stored in relevant IT and IS systems and paper-based record systems that are comparable in structure to a computer system. This Policy applies to all sites used by the organisation and applies to all those having access to information, either on site or remotely. This includes, but is not limited to: staff employed by the organisation; those engaged in duties for the organisation under a letter of authority, honorary contract or work experience programme; volunteers and any other third party such as contractors, students or visitors.

3.3 The Policy is also applicable to patient images such as still or moving images, for example X-rays, video recordings, photographs, etc. Staff should be aware that these images are subject to the Data Protection Act and may be requested as part of a subject access request. If digital/video images are part of the case note then they are subject to the Caldicott Principles and have to be retained accordingly and stored securely. Audio recordings should be treated in a similar manner to digital images.

4. **Who this policy applies to.**

4.1 **Staff (including temporary staff)**
All staff employed by ECCG have a responsibility to ensure that:

- They work to the most up to date and relevant corporate and local Information Security policies; and

- They work to the most up to date and relevant Information Governance policies.
4.2 **Responsibilities of Employees**
All staff are responsible for carrying out their duties in line with the policies, to note new or amended policies and to contribute to policy development as necessary.

4.3 **Managers**
All staff with a supervisory role have a responsibility to ensure that:
- All staff have been shown how to access this Policy on the Intranet policy library;
- Local induction of newly employed staff includes being made aware of the relevant policies and how it impacts their own roles; and
- Policies that they are responsible for are reviewed appropriately on an ongoing basis and are disseminated and implemented within services as directed.

5. **Definitions used in this policy**

**Asset**
Any information system, computer or programme owned by the organisation.

**Authorisation**
The granting or denying of access rights to network resources, programmes or processes.

**Caldicott**
A set of standards developed in the NHS for the collection, use and confidentiality of patient-related information.

**Data Controller**
A person who determines the purposes for which, and the manner in which, personal information is to be processed. This may be an individual or an organisation and the processing may be carried out jointly or in common with other persons.

**Data processor**
A person who processes personal information on a data controller’s behalf. Anyone responsible for the disposal of confidential waste is also included under this definition.
Data subject
This is the living individual who is the subject of the personal information (data). A set of standards developed in the NHS for the collection, use and confidentiality of patient-related information.

Internet
A global system connecting computers and computers networks. The computers are owned separately by a range of organisations, government agencies, companies and educational institutes.

Information Governance Toolkit
A series of requirements, produced jointly by the Department of Health and NHS Connecting for Health.

Network
A system of interconnected computers which allows the exchange of information network connection. An individual’s access to the network usually involves password checks and similar security measures.

Notifications
Notification is the process by which a data controller’s processing details are added to a register. Under the Data Protection Act, every data controller who is processing personal information needs to notify unless they are exempt. Failure to notify is a criminal offence. Even if a data controller is exempt from notification, they must still comply with the data protection principles.

Personal data
Personal data means information about a living individual who can be identified from that information and other information which is in, or likely to come into, the data controller’s possession.

Person Identifiable Data (PID)
PID may be defined as data that contains sufficient information to relate the data to a specific patient.

Processing
Processing, within the context of this Policy means obtaining, recording or holding the data or carrying out any operation or set of operations on data.

Software
Computer programmes sometimes also called applications.

Subject access request
Under the Data Protection Act, individuals can ask to see the information about themselves that is held on computer and in some paper records. If an individual wants to exercise this subject access request right, they need to write to ECCG.
6. **Recommendations for Independent Contractors**

As all staff and third-parties are expected to comply with this and other policies, there are no additional recommendations.

7. **Initiation, development and review of the policy**

This Policy meets all relevant requirements in its initiation, development and review.

8. **Risk rating of the policy**

All policies are required to possess an appropriate risk rating calculated by use of the organisation’s risk-rating matrix. This Policy has been given a risk rating of LOW. If PID or personal data were released to the wrong individual following a request under the Act, there would be a risk of adverse national publicity. Thus the risk impact score is Major (4). However, as all requests will be managed by the Head of Governance and Risk, the likelihood of this occurring is rare (1). This risk is not expected to occur, except for in exceptional circumstances given existing controls. Dissemination of this Policy to all staff involved in handling any data also serves to significantly reduce the likelihood of this risk occurring.

9. **Data Protection Act Risks and Awareness**

9.1 All staff and other users including third-parties collecting, storing, processing and destroying personal data, must be aware of the following risks and issues:

- **Reputational Risk** – any errors in the collection, storage, processing and destruction of personal data or any errors in meeting data requests from patients could have an adverse impact upon the reputation of ECCG. The confidence that ECCG currently enjoys from the NHS Executive, patients and other key stakeholders could be seriously undermined by any misuse of personal data;

- **Patient Distress** – disclosure of personal data or other patient details could lead to severe stress and trauma for our patients as information on, for example, any medical conditions could be sent to the wrong users. Patients could take legal action against ECCG further undermining public confidence. Some four principal patient risks have been identified by the Data Sharing Review, 11 July 2008, conducted at the request of the Prime Minister:

  1) **Indignity** – unnecessary exposure of facts/suspicions, for example, disclosure of a medical condition that may cause embarrassment;

  2) **Injustice** – stigmatisation resulting from wrongly disclosed information, leading to loss or denial of, for example, employment, training or credit;

  3) **Inappropriate Treatment** – unwarranted interventions by agencies into the lives of individuals or their families, for example with
draconian action being taken by mental health or child protection workers based on misinterpreted/un-contextualised data; and

4) **Ineffective Service Delivery** – because, for example, individuals do not trust agencies sufficiently to provide full and accurate information as required.

- **Legal & Regulatory Risk** – any errors in the handling of personal data could result in action being taken against ECCG by the Information Commissioner if it is deemed that breaches of the Act have occurred. In addition, the Information Commissioner, as a result of changes to the Criminal Justice Act 2008, now has the power to impose fines of up to £500,000 upon organisations and individuals who are aware of information risks but have not taken reasonable care and appropriate steps to mitigate those risks. Any legal and regulatory action against NHS North Central London would be publicised and highly damaging to confidence;

- **The NHS Care Record Guarantee** – the NHS has published a ‘Guarantee’ on how it handles patient data including the duties of keeping records confidential, secure and accurate. Unauthorised access or modification of any patient data would breach such ‘guarantees’;

- **Human Rights Breaches** – in a Landmark Judgement, the European Court of Human Rights found that in the case of *I v Finland*, a patients’ Right to Family Life was breached after a hospital was found not to have maintained sufficient confidentiality of ‘I’s medical records. Failures in maintaining the confidentiality of patient data could be interpreted by a Court of Law as a breach of a patients’ Human Rights by the Trust;

- **Staff Awareness** – staff involved in any stage of handling personal data must fully understand and comply with this Policy and all other relevant policies. Staff must understand that they may be liable for any such loss, and that any breaches of this or any other policy may result in disciplinary action including dismissal. Staff must also be aware that they may be held personally liable by the Information Commissioner, and could face fines of up to £500,000;

- **Third-party Awareness** – any user or third-party handling personal data on behalf of ECCG must comply with this Policy and all other relevant policies. Where third-parties do not comply with this Policy or any other relevant policy, ECCG will reserve the right to terminate all current contractual agreements with immediate effect. Third-party providers and their staff must also be aware that they may be held personally liable for any non-compliance with their statutory requirements by the Information Commissioner and could face fines of up to £500,000
10. Specific Policy Requirements

General Responsibilities

10.1 The Chief Officer has overall responsibility for meeting the requirements of the Act and this Policy. The implementation of and compliance with this Policy is delegated to the Head of Governance and Risk.

10.2 The Head of Governance and Risk, within the context of this Policy, will have operational responsibility for:

- Maintaining Data Protection Act 1998 Notifications;
- Implementing staff awareness and training programmes;
- Facilitating the process of ‘Subject Access Requests’ and meeting such requests;
- Act as the initial point of contact for any data protection issues which may arise within ECCG and;
- Ensuring that all relevant databases are registered in accordance with the Act’s requirements and that these registrations are reviewed on a regular basis.

The Eight Data Protection Act Principles

10.3 There are eight Data Protection Act Principles that define the policy requirements. These are:

- **Principle 1** – Personal data shall be processed fairly and lawfully;
- **Principle 2** – Personal data shall be obtained for one or more specified and lawful purposes and shall not be further processed in any manner incompatible with that purpose or those purposes;
- **Principle 3** – Personal data shall be adequate, relevant and not excessive in relation to the purpose or purposes for which they are processed;
- **Principle 4** – Personal data shall be accurate and, where necessary, kept up to date;
- **Principle 5** – Personal data processed for any purpose or purposes shall not be kept longer than is necessary for that purpose or purposes;
- **Principle 6** – Personal data shall be processed in accordance with the rights of data subjects under this Act;
• **Principle 7** – Appropriate technical and organisational measures shall be taken against unauthorised or unlawful processing of personal data and against accidental loss or destruction of or damage to personal data; and

• **Principle 8** – Personal data shall not be transferred to a country or territory outside the European Economic Area (EEA) unless that country or territory ensures an adequate level of protection for the rights and freedoms of data subjects in relation to the processing of personal data.

### Principle 1

10.4 Principle 1 states that personal data shall be processed fairly and lawfully.

10.5 This Principle introduces the requirement that, as part of fair processing, personal data will not be processed unless at least one of the conditions in Schedule 2 of the Act is met and in the case whereby sensitive data is to be used, at least one condition in Schedule 3 of the Act is also met.

10.6 For Schedule 2, the processing of personal data, the relevant conditions are:

- (4) The processing is necessary in order to protect the vital interests of the data subject; and
- (5)(c) for the exercise of any functions of the Crown, a Minister of the Crown or a Government Department.

10.7 For Schedule 3, the processing of sensitive data, the relevant conditions are:

- (8)(1) The processing is necessary for medical purposes and is undertaken by –
  - (a) a health professional; or
  - (b) a person who in the circumstances owes a duty of confidentiality which is equivalent to that which would arise if that person were a health professional.

10.8 For the above, ‘medical purposes’ includes the purposes of preventative medicine, medical diagnosis, medical research, the provision of care and treatment and the management of healthcare services – all relevant activities that ECCG undertakes.

### Principle 2

10.9 Principle 2 states that personal data shall be obtained for one or more specified and lawful purposes and shall not be further processed in any manner incompatible with that purpose or those purposes.

10.10 Personal information about living individuals, which is obtained, held and/or processed on any medical health systems must be registered with the Office of the Information Commissioner.

10.11 The introduction of new processes, hardware and software could result in ECCG breaching the Principles of the Data Protection Act 1998 and other associated legislation. Therefore it is necessary that any changes arising from the implementation of new systems is assessed for compliance.
10.12 It is vitally important that all proposed changes to ECCG systems and processes are able to maintain the confidentiality, integrity and accessibility of information, and that any additional Notifications that may be required are duly undertaken.

10.13 Failure to keep the Notification up to date, as a result of any new health systems could result in a breach of the Act and possible criminal prosecution.

**Principle 3**

10.14 This Principle states that personal data shall be adequate, relevant and not excessive in relation to the purpose or purposes for which they are proposed.

10.15 This Principle governs what is collected, entered, and held on medical health systems and what information can be disclosed from those systems.

10.16 This Principle also governs the Data Fields that can be legitimately used.

10.17 The Personal data that can be legitimately used are:

- Name;
- Demographic details;
- Date of Birth; and
- NHS Number.

10.18 The Sensitive data that can be legitimately used, after obtaining explicit consent, if it is deemed necessary for the purpose of identifying or keeping under review the existence or absence of equality or opportunity of treatment between persons of different racial, ethnic origin or any other factor with a view to enabling such equality to be promoted or maintained are:

- Racial or Ethnic origin; and
- Physical, Mental Health or Condition.

**Principle 4**

10.19 This Principle states that personal data shall be accurate, and where necessary, kept up to date.

10.20 Accuracy of information will be achieved by implementing validation routines. The validation routines will be system specific and details will be provided of these validation processes to the system/information users.

10.21 Staff who are responsible for inputting data into the ECCG systems are responsible for:

- Quality;
• Accuracy;
• Timeliness; and
• Completeness of the data.

10.22 Staff will be required to check with patients that the information held by ECCG is kept up to date by, for example, asking patients attending appointments to validate the information held.

10.23 Staff information should also be checked for accuracy on a regular basis, either by the relevant Manager or the HR Department.

**Principle 5**

10.24 This Principle states that personal data processed for any purpose or purposes shall not be kept longer than is necessary for that purpose or those purposes.

10.25 All records and information held by ECCG are affected by this Principle regardless of the media that may be used to store such data. The Information Lifecycle Management Policy details the policy requirements further for record and media management.

**Principle 6**

10.26 This Principle states that personal data shall be processed in accordance with the rights of data subjects under this Act.

10.27 Individuals have a right to know if a Data Controller (CSU) processes information about them and if that is the case:

- To receive a description of the personal data;
- The purpose for which it is being processed;
- To be notified of the recipients or classes of recipients to whom it may be disclosed; and
- to have the information communicated to them in an intelligible form, the personal data itself and any information as to its source.

10.28 ECCG does not have to supply the information unless they have received:

- A request in writing;
- The fee being charged (not exceeding the prescribed maximum) with a fee of £10.00 for Access Fee (for computerised data only); a minimum £10.00 fee for photocopying (up to 40 pages, then 25 pence per page) plus postage by recorded delivery and £10.00 per film for supplying copies of x-ray films and scans.;
• Under Data Legislation the maximum charge is £50.00 and those requesting data should be advised of the exact fee once the records have been copied; and

• Additional information reasonably requested to be satisfied of the identity of the person making the request and locate the information.

10.29 Individuals can ask for all information held. In practice, consideration should be given to whether any clarification on the information being sought is required.

10.30 The response must be acted upon promptly but in any case within 40 days once preconditions are filled.

10.31 If the personal data requested involves disclosing information about third-parties, consideration must be given to whether it will have to be removed or anonymised in compliance with all the principles.

10.32 Where the request cannot be complied with without disclosing data that relate to another individual, from which that individual can be identified, i.e. cannot be anonymised, then ECCG is not obliged to comply unless:

• The ‘other’ individual has given their consent; and

• It is reasonable in all the circumstances to comply without the consent of the individual.

10.33 In determining whether it would be reasonable to disclose the information without the consent of the individual, ECCG must look at:

• Any duty of confidence owed to the individual; and

• Any steps taken by ECCG to gain the consent of the individual;

• Whether the individual is capable of giving consent; and

• any express refusal of consent of the other individual.

10.34 The information must be supplied in permanent form unless it is impossible or would involve a disproportionate effort, or the Data Subject says otherwise.

10.35 If any of the information is intelligible, for example codes or abbreviations are used, appropriate explanation must be given.

10.36 Where ECCG receives repeated but identical requests for data from the same originator, ECCG need not comply with the multiple requests unless a reasonable time interval has passed.

10.37 In determining what exactly is a ‘reasonable time period’, consideration will be given to the nature of the data and the frequency with which the data is altered.
10.38 The information supplied should be what is held at the date of the request but may include deletions or additions since that date, provided that they would have been made regardless of the request.

10.39 At the present time, the Access to Health Records Act 1990 remains to provide access rights to relatives or those who may have a claim to deceased patient records.

10.40 ECCG will ensure the complaints procedures are reviewed to take account of complaints which may be received because of a breach or suspected breach of the Data Protection Act 1998. Individuals have a right to seek compensation for any breach of the Act, which may cause them damage and/or distress.

**Principle 7**

10.41 This Principle states that appropriate technical and organisational measures shall be taken against unauthorised or unlawful processing of personal data and against accidental loss or destruction of, or damage to, personal data.

10.42 ECCG Information Security Policy outlines the technical and organisational measures that are to be taken against unauthorised or unlawful processing of personal data and against accidental loss or destruction of, or damage to, personal data.

10.43 When processing is carried out by a ‘Data Processor’ on behalf of ECCG as ‘Data Controller’ they will have complied with Principle 7 when the processing is carried out under a contract that will be made and evidenced in writing and include compliance with ECCG Information Security Policy.

10.44 The Data Processor is only to act under instructions of the ‘Data Controller’ and the contract will require the Data Processor to comply with obligations equivalent to those imposed on the Data Controller by the 7th Principle.

10.45 ECCG will take all reasonable steps to ensure that the Data Processor is complying with Principle 7 and that the Data Processor gives appropriate guarantees against non-compliance, i.e. indemnity for any of the Principles breached within the Act.

**Principle 8**

10.46 Principle 8 states that Personal data shall not be transferred to a country or territory outside the EU unless that country or territory ensures an adequate level of protection for the rights and freedoms of data subjects in relation to the processing of personal data.

10.47 Personal data (including PID) which is to be transmitted or sent to countries outside of the EU must comply with the Principles of the Act.

10.48 Transfers of this kind must be discussed with, and approval obtained from the Head of Governance and Risk as the levels of protection for the information may not be as comprehensive as those in the UK.
11. Dissemination

11.1 This Policy will be available via the ECCG Intranet.

11.2 An approach to dissemination of this Policy has been agreed whereby all relevant staff will be notified, by email, of the location and nature of this Policy.

12. Implementation of this Policy.

12.1 The Head of Governance and Risk will be responsible for receiving, processing and responding to all data access requests made via this Act. The Head of Governance and Risk will ensure that all staff involved in handling personal data will be made aware of their obligations via appropriate staff awareness initiatives.

12.3 This Policy is, and will continue to be, supported by a framework of additional policies, technical standards, operational procedures and guidance, to ensure that information governance requirements are understood and met throughout the organisation. As stated previously, these will be updated, where necessary following additional risk and gap analysis studies.
Appendix 1

Enfield Clinical Commissioning Group Equality Impact Analysis (EQIA) screening

Proposal Title: Data Protection Policy

<table>
<thead>
<tr>
<th>Author /editor/assessors</th>
<th>At least one of the people carrying out an EQIA must be the person responsible for the policy/function/service</th>
<th>Andy Nuckcheddee, Interim Head of Governance &amp; Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Partners/decision-makers/ implementers</td>
<td>Identify who else will need to be involved. This can be decision-makers, frontline staff implementing the policy, partner/parent organisations, etc…</td>
<td>Reviewed by Executive Committee</td>
</tr>
<tr>
<td>Start Date</td>
<td>The EQIA should be started prior to policy/service development or at the design stages of the review and continue throughout the policy development review. For an existing policy/service, any changes identified have to be implemented.</td>
<td>February 2013</td>
</tr>
<tr>
<td>End date</td>
<td>The EQIA will need to inform decision-making so the date should take this into account</td>
<td>Review March 2014</td>
</tr>
<tr>
<td>Due regard, proportionality and relevance in relation to the following characteristics</td>
<td>Has due regard been given to equality (i.e. promote equality of opportunity between communities, eliminate discrimination that is unlawful, promote positive attitudes towards communities) for this proposal/policy/function? Due regard has two linked elements: proportionality and relevance. The weight given to equality should therefore be proportionate to its relevance to a particular function. The greater the relevance of a function/policy/proposal to equality, the greater regard that should be paid. Where it is concluded that the policy is not relevant for an EQIA, this should be recorded here with the reasons and evidence.</td>
<td>Please refer to completed EQIA assessment tool Worksheet in K ECCG AUTHORISATI...</td>
</tr>
</tbody>
</table>
  * Gender including gender reassignment
  * Race/ethnicity
  * Disability
  * Age
  * Religion or belief
  * Pregnancy and maternity
| Proposal/ policy/function/service aims | Consider:  
• Why is the proposal/policy/function/service needed?  
• What does ECCG hope to achieve by it?  
• How will ECCG ensure that it works as intended?  
• Who benefits?  
• Who doesn't benefit and why not?  
Who should be expected to benefit and why don’t they? | It is important that the CCG has a policy that provides safeguards for maintaining Confidentiality. |
| Evidence gaps | Identify what evidence is available and set it out here. This includes evidence from involvement and consultation. Identify where there are gaps in the evidence and set out how these will be filled | None currently identified |
| Involvement & consultation | What involvement and consultation has been done in relation to this (or a similar) policy or function, and what are the results?  
What involvement and consultation will be needed and how will it be undertaken? Report any results. | CCG Executive Committee |
| Addressing the impact | **Outcome 1: No major change:** the EQIA demonstrates the policy/change is robust and there is no potential for discrimination or adverse impact  
**Outcome 2: Adjust the policy:** the EQIA identifies potential problems or missed opportunities. Adjust the policy to remove barriers or better promote equality.  
**Outcome 3: Continue the policy:** the EQIA identifies the potential for adverse impact or missed opportunities to promote equality. Clearly set out the justifications for continuing with it. The justification must be in line with the | Outcome1 |
duty to have due regard. For the most relevant policies, compelling reasons will be needed.

**Outcome 4: Stop and remove the policy:** the policy shows actual or potential unlawful discrimination.
INFORMATION LIFECYCLE MANAGEMENT (RECORDS MANAGEMENT) POLICY

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>SUMMARY</td>
<td>This Policy defines the Information Lifecycle Management (ILM) requirements for Enfield Clinical Commissioning Group records (including local presences) and hosted organisations</td>
</tr>
<tr>
<td>2.</td>
<td>RESPONSIBLE PERSON:</td>
<td>Head of Governance and Risk</td>
</tr>
<tr>
<td>3.</td>
<td>ACCOUNTABLE DIRECTOR</td>
<td>Aimee Fairbairns – Director of Service Quality and Integrated Governance</td>
</tr>
<tr>
<td>4.</td>
<td>APPLIES TO:</td>
<td>All staff</td>
</tr>
<tr>
<td>7.</td>
<td>EQUALITY IMPACT ANALYSIS COMPLETED:</td>
<td>Policy Screened</td>
</tr>
<tr>
<td>8.</td>
<td>GROUPS/INDIVIDUALS WHO HAVE OVERSEEN THE DEVELOPMENT OF THIS POLICY:</td>
<td>Director of Service Quality and Integrated Governance Caldicott Guardian</td>
</tr>
<tr>
<td>10.</td>
<td>RATIFYING COMMITTEE (S) &amp; DATE OF FINAL APPROVAL:</td>
<td>Executive Committee- 30th January 2013 ECCG Governing Body-13th February 2013</td>
</tr>
<tr>
<td>11.</td>
<td>VERSION:</td>
<td>2</td>
</tr>
<tr>
<td>12.</td>
<td>AVAILABLE ON:</td>
<td>Intranet</td>
</tr>
<tr>
<td></td>
<td>Code of Confidentiality</td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>-------------------------</td>
<td></td>
</tr>
<tr>
<td>14.</td>
<td><strong>DISSEMINATED TO:</strong></td>
<td>All Staff</td>
</tr>
<tr>
<td>15.</td>
<td><strong>DATE OF IMPLEMENTATION:</strong></td>
<td>April 2013</td>
</tr>
<tr>
<td>16.</td>
<td><strong>DATE OF NEXT FORMAL REVIEW:</strong></td>
<td>March 2014, or sooner if there are changes to legislation etc. that impact on this policy and procedure</td>
</tr>
</tbody>
</table>
## Document Control

<table>
<thead>
<tr>
<th>Date</th>
<th>Version</th>
<th>Action</th>
<th>Author</th>
</tr>
</thead>
<tbody>
<tr>
<td>23.01.13</td>
<td>1</td>
<td>NCL Policy amended for adoption within ECCG</td>
<td>Alison Mitchell-Hall</td>
</tr>
<tr>
<td>24.01.13</td>
<td>2</td>
<td>Policy amended following internal review</td>
<td>Alison Mitchell-Hall</td>
</tr>
<tr>
<td>30.01.2013</td>
<td>3</td>
<td>Executive Committee</td>
<td>Andy Nuckcheddee</td>
</tr>
</tbody>
</table>
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>SECTION NO.</th>
<th>TITLE</th>
<th>PAGE NO.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Introduction</td>
<td>4</td>
</tr>
<tr>
<td>2</td>
<td>ILM &amp; Records Management</td>
<td>4</td>
</tr>
<tr>
<td>3</td>
<td>Relevant Legislation</td>
<td>5</td>
</tr>
<tr>
<td>4</td>
<td>NHS Care Records Service</td>
<td>5</td>
</tr>
<tr>
<td>5</td>
<td>Policies statement</td>
<td>6</td>
</tr>
<tr>
<td>6</td>
<td>Scope of this policy</td>
<td>7</td>
</tr>
<tr>
<td>7</td>
<td>Who this policy applies to</td>
<td>7</td>
</tr>
<tr>
<td>8</td>
<td>Definitions used in this policy</td>
<td>8</td>
</tr>
<tr>
<td>9</td>
<td>Recommendations for Independent Contractors</td>
<td>9</td>
</tr>
<tr>
<td>10</td>
<td>Initiation, development and review of the policy</td>
<td>9</td>
</tr>
<tr>
<td>11</td>
<td>Risk rating of the policy</td>
<td>9</td>
</tr>
<tr>
<td>12</td>
<td>Information Security Risks and Awareness</td>
<td>9</td>
</tr>
<tr>
<td>13</td>
<td>Specific Policy Requirements</td>
<td>10</td>
</tr>
<tr>
<td>13.1</td>
<td>Roles and Responsibilities</td>
<td>10</td>
</tr>
<tr>
<td>13.2</td>
<td>Record Creation - Best Practice Principles</td>
<td>11</td>
</tr>
<tr>
<td>13.3</td>
<td>Record Creation - Best Practice Processes</td>
<td>13</td>
</tr>
<tr>
<td>13.4</td>
<td>Record Keeping</td>
<td>14</td>
</tr>
<tr>
<td>13.5</td>
<td>Record Maintenance</td>
<td>14</td>
</tr>
<tr>
<td>13.6</td>
<td>Records Retrieval</td>
<td>15</td>
</tr>
<tr>
<td>13.7</td>
<td>Records Retention</td>
<td>16</td>
</tr>
<tr>
<td>13.8</td>
<td>Records Disposal</td>
<td>17</td>
</tr>
<tr>
<td>13.9</td>
<td>Paper</td>
<td>17</td>
</tr>
<tr>
<td>13.10</td>
<td>Electronic</td>
<td>18</td>
</tr>
<tr>
<td>13.11</td>
<td>Tracking of Records</td>
<td>18</td>
</tr>
<tr>
<td>13.11.1</td>
<td>GP Practice Records</td>
<td>19</td>
</tr>
<tr>
<td>13.12</td>
<td>Appraisal of Records</td>
<td>20</td>
</tr>
<tr>
<td>13.13</td>
<td>Record Closure</td>
<td>21</td>
</tr>
<tr>
<td>13.14</td>
<td>Record Disposal</td>
<td>21</td>
</tr>
<tr>
<td>13.15</td>
<td>Process for Reviewing, Monitoring Compliance &amp; Effectiveness of this Policy</td>
<td>22</td>
</tr>
<tr>
<td>14</td>
<td>Dissemination</td>
<td>24</td>
</tr>
<tr>
<td>15</td>
<td>Implementation of this Policy</td>
<td>25</td>
</tr>
<tr>
<td>16</td>
<td>Appendix 1- Equality Impact Assessment</td>
<td>26-27</td>
</tr>
</tbody>
</table>
1. Introduction.

1.1 In order to meet its Information Governance (IG) requirements and to ensure that data and information is managed effectively, Enfield Clinical Commissioning Group (ECCG) is required to have in place a comprehensive Information Lifecycle Management (ILM) Policy. The Policy should outline the processes required for managing the risks associated with data and information held whatever the media used to hold and store such information.

1.2 ILM represents a growing set of policies, processes, practices, services and tools used by an organisation to manage its information through every phase of its existence, from creation through to destruction. Record management policies will form part of an organisation’s ILM, together with other processes, such as for example, a records inventory, secure storage, records audit, etc.

1.3 In implementing this ILM Policy, ECCG will seek to process, manage, transport, protect and archive various ECCG data and information according to the unique characteristics such as age, usage patterns, compliance and archiving policies, security and disaster protection rules, and value.

1.4 The purpose of this Policy is to:

- outline the role of ILM within ECCG and its relationship to the overall Information Governance Strategy;

- define roles and responsibilities within ECCG, including the responsibility of individuals to document their actions and decisions in the organisation’s records, and to dispose of records appropriately when they are no longer required;

- provide a framework for supporting standards, procedures and guidelines, and outline in detail key processes; and

- define the way in which compliance with the policy and its supporting standards, procedures and guidelines will be monitored and maintained.

2. ILM & Records Management

Records are a valuable resource because of the information they contain. High-quality information underpins the delivery of high-quality evidence-based healthcare, and many other key service deliverables. Information has most value when it is accurate, up-to-date and accessible when it is needed. An effective records management system ensures that information is properly managed and is available whenever and wherever there is a justifiable need for that information, and in whatever media it is required. Information may be needed to support:

- patient care and continuity of care;
• day-to-day business which underpins the delivery of care;
• evidence-based clinical practice;
• sound administrative and managerial decision-making, as part of the knowledge base for ECCG services;
• legal requirements, including requests from patients under subject access provisions of the Data Protection Act or the Freedom of Information Act;
• clinical and other types of audit;
• improvements in clinical effectiveness through research and also to support archival functions by taking account of the historical importance of material and the needs of future research; and
• patient choice and control over treatment and services designed around patients.

3. Relevant Legislation

Records Management is the process by which an organisation manages all the aspects of records whether internally or externally generated and in any format or media type, from their creation, through their lifecycle to their eventual disposal. All NHS records are Public Records under the Public Records Acts. ECCG will take actions as necessary to comply with the legal and professional obligations set out in the Records Management: NHS Code of Practice Parts 1 and 2, in particular:

• The Public Records Act 1958;
• The Data Protection Act 1998;
• The Freedom of Information Act 2000;
• The Common Law Duty of Confidentiality;
• The NHS Confidentiality Code of Practice; and
• any new legislation affecting records management as it arises.

All individuals who work for the NHS are responsible for any records which they create or use in the performance of their duties. Furthermore, any record that an individual creates is a public record.

The key statutory requirement for compliance with records management principles is the Data Protection Act 1998. This Act provides a broad framework of general standards that have to be met and considered in conjunction with other legal obligations. The Act regulates the processing of personal data, held both manually and on computer. It applies to personal information generally, not just health records. Therefore, the same principles apply to records of employees held by employers, for example in finance, human resources and occupational health departments. For further information consult the Data Protection Policy.

4. NHS Care Records Service

The impact of the Government’s health reform agenda will fundamentally affect the way the NHS approaches the management of all electronic records. The NHS Care Records Service (NHS CRS) and the establishment of Care Trusts are central to these reforms and will transform the way both health and social care information is managed.
In the mixed economy of paper and electronic records which will exist as the NHS CRS is developed, it is essential that paper and electronic records are managed consistently to ensure that a complete health record is available at the point of need. This transitional period, during which the balance of paper and electronic records will change, will generate significant challenges – for example before patient data is migrated to the national data spine, the data must be validated to ensure that duplicate registrations are not created in the future.

The Records Management: NHS Code of Practice© Part 1 and Parts 2 have been published by the Department of Health as a guide to the required standards of practice in the management of records for those who work within or under contract to NHS organisations in England. It is also based on current legal requirements and professional best practice. This Policy reflects the principal requirements of this Code of Practice.

5. Policies statement

This Policy is intended to achieve the following ILM Objectives:

- **Information and records are available when needed** - from which ECCG is able to form a reconstruction of activities or events that have taken place;
- **Information and records can be accessed** - records and the information within them can be located and displayed in a way consistent with its initial use, and that the current version is identified where multiple versions exist;
- **Information and records can be interpreted** - the context of the record can be interpreted: who created or added to the record and when, during which business process, and how the record is related to other records;
- **Information and records can be trusted** – the record reliably represents the information that was actually used in, or created by, the business process, and its integrity and authenticity can be demonstrated;
- **Information and records can be maintained through time** – the qualities of availability, accessibility, interpretation and trustworthiness can be maintained for as long as the record is needed, perhaps permanently, despite changes of format;
- **Information and records are secure** - from unauthorised or inadvertent alteration or erasure, that access and disclosure are properly controlled and audit trails will track all use and changes. To ensure that records are held in a robust format which remains readable for as long as records are required;
- **Information and records are retained and disposed of appropriately** - using consistent and documented retention and disposal procedures, which include provision for appraisal and the permanent preservation of records with archival value; and
- **Staff training** - so that all staff are made aware of their responsibilities for record-keeping and record management.
6. Scope of this policy

This Policy is applicable to all ECCG and hosted organisations IT and IS computer systems, databases, facilities and networks. It is also applicable to third-party IT and IS computer systems, databases, facilities and networks that are employed to provide services to ECCG.

This Policy applies to all ECCG information, information systems, networks, application systems and users. This Policy applies to all sites used by the organisation and applies to all those having access to information, either on site or remotely. This includes, but is not limited to: staff employed by the organisation; those engaged in duties for the organisation under a letter of authority, honorary contract or work experience programme; volunteers and any other third party such as contractors, students or visitors.

This Policy relates to all data and information regardless of the media on which it is held: Such data and information includes but is not limited to:

- patient health records (electronic or paper based, including those concerning all specialties, and GP Records);
- records of private patients seen on NHS premises;
- Accident & Emergency, birth and all other registers;
- theatre registers and minor operations (and other related) registers;
- administrative records (including for example, personnel, estates, financial and accounting records, notes associated with complaint-handling);
- X-ray and imaging reports, output and images;
- photographs, slides and other images;
- microform (i.e. microfiche/microfilm);
- audio and video tapes, cassettes, CD-ROM, etc;
- e-mails;
- computer records;
- scanned records;
- text messages (both outgoing from ECCG and incoming text messages); and
- all patient health records (for all specialties and including private patients, including x-ray and imaging reports, registers, etc.).

7. Who this policy applies to.

7.1 Staff (including temporary staff)

All staff employed by ECCG have a responsibility to ensure that:

- They work to the most up to date and relevant corporate and local Information Security policies; and
- They work to the most up to date and relevant Information Governance policies.
7.2 **Responsibilities of Employees**
All employed staff are responsible for carrying out their duties in line with the policies, to note new or amended policies and to contribute to policy making as necessary and to seek clarification if unsure.

7.3 **Managers**
All staff with a supervisory role have a responsibility to ensure that:
- All staff have been shown how to access this policy on the Intranet policy library;
- Local induction of newly employed staff includes being made aware of the relevant policies and how it impacts their own roles; and
- Policies that they are responsible for are reviewed appropriately on an ongoing basis and are disseminated and implemented within services as directed.
- Monitor staff compliance in relation to policy adherence

8. **Definitions used in this policy**

**Asset**
Any information system, computer or programme owned by the organisation

**Caldicott**
A set of principles developed in the NHS for the collection, use and confidentiality of patient-related information

**Information Governance Toolkit**
A series of requirements, produced jointly by the Department of Health and NHS Connecting for Health to assess compliance with national guidance and to support organisational development in relation to information governance

**Record**
For the purpose of this policy a record covers all health and non health information types, person identifiable information types, and records of all types including corporate information regardless of the media on which they are held. These records may consist of but are not restricted to:
- All patient health records (for all specialties and including private patients, including x-ray and imaging reports, registers, etc)
- Corporate records;
- Photographs, slides, negatives, and other images;
- Microform (i.e. microfiche/ microfilm), scanned records;
- Audio and video recordings, voicemail, cassettes, CD-ROM etc;
- Email correspondence;
- Message books;
- Staff diaries
- Computerised records
- Text messages (both outgoing from the NHS and incoming responses from the patient)
9. Recommendations for Independent Contractors

As all staff and third-parties are expected to comply with this and other policies, there are no additional recommendations.

10. Initiation, development and review of the policy

This Policy meets all relevant requirements in its initiation, development and review.

11. Risk rating of the policy

All policies are required to possess an appropriate risk rating calculated by use of the organisation’s risk-rating matrix. This Policy has been given a risk rating of LOW. This has been calculated on the basis that all requests made within the context of the Data Protection Act 1998 and the Freedom of Information Act 2000 will be managed by the Head of Governance and Risk. However, despite the controls put in place, there is the risk that records may be lost or stolen for example. If this were to occur, then there is the possibility of financial litigation not exceeding £50K and less than 3 days local media publicity. Provision of healthcare services may also be affected but not severely. Thus the Impact score is 2. Given that adequate controls are in place, the likelihood of such risks occurring is rare (1) - not expected to occur, except for in exceptional circumstances given existing controls.

12. Information Security Risks and Awareness

All staff and other users including third-parties handling ECCG. Information and Records must be aware of the following risks and issues:

- **Reputational Risk** – loss or theft of large numbers of records could have an adverse impact upon the reputation of ECCG. The confidence that ECCG currently enjoys from the NHS Executive, patients and other key stakeholders could be seriously undermined;

- **Patient Distress** – loss of PID data, in the form of records, could lead to severe stress and trauma for our patients as information on any medical conditions could be made public. Patients could take legal action against ECCG further undermining public confidence. Four principal patient risks have been identified by the Data Sharing Review, 11 July 2008, conducted at the request of the Prime Minister:

  1) **Indignity** – unnecessary exposure of facts/suspicions, for example, disclosure of a medical condition that may cause embarrassment;

  2) **Injustice** – stigmatisation resulting from wrongly disclosed information, leading to loss or denial of, for example, employment, training or credit;

  3) **Inappropriate Treatment** – unwarranted interventions by agencies into the lives of individuals or their families, for example with draconian action
being taken by mental health or child protection workers based on misinterpreted/un-contextualised data; and

4) **Ineffective Service Delivery** – because, for example, individuals do not trust agencies sufficiently to provide full and accurate information as required.

- **Legal & Regulatory Risk** – loss of any data, information or records could result in action being taken against ECCG by the Information Commissioner if it is deemed that breaches of the Data Protection Act 1998 have occurred. In addition, the Information Commissioner, as a result of changes to the Criminal Justice Act 2008, now has the power to impose fines of up to £500,000 upon organisations and individuals who are aware of information risks but have not taken reasonable care and appropriate steps to mitigate those risks. Any legal and regulatory action against ECCG would be publicised and highly damaging to public/patient confidence;

- **The NHS Care Record Guarantee** – The NHS has published a ‘Guarantee’ on how it handles patient data including the duties of keeping records confidential, secure and accurate. Unauthorised access or modification or loss of any patient data would breach such ‘guarantees’;

- **Staff Awareness** – Staff involved in the creation, keeping, maintenance, access and disclosure, closure and disposal of ECCG Information and Records must fully understand and comply with this Policy and all other relevant policies. Any breaches of this or any other policy may result in disciplinary action including dismissal. Staff must also be aware that they may be held personally liable by the Information Commissioner for any policy breaches, and could face fines of up to £500,000;

- **Third-party Awareness** – any user or third-party engaged in the creation, keeping, maintenance, access and disclosure, closure and disposal of ECCG Information and Records on behalf of the organisation must comply with this Policy and all other relevant policies. Where third-parties do not comply with this Policy or any other relevant policy, ECCG will reserve the right to terminate all current contractual agreements with immediate effect. Third-party providers and their staff must also be aware that they may be held personally liable for any non-compliance with their statutory requirements by the Information Commissioner and could face fines of up to £500,000

13. **Specific Policy Requirements**

13.1 **Roles and Responsibilities**

The Chief Officer has overall responsibility for records management at ECCG. As the accountable officer, he or she is responsible for the management of ECCG and for ensuring appropriate mechanisms are in place to support service delivery and
continuity. ILM is key to this as it will ensure appropriate, accurate information is available as and when required.

The Head of Governance and Risk will have overall responsibility for the Information Governance (IG) of all records held within ECCG.

The ECCG Caldicott Guardian has a particular responsibility for reflecting patients’ interests regarding the use of patient identifiable information. They are responsible for ensuring patient identifiable information is shared in an appropriate and secure manner.

The Head of Governance and Risk in conjunction with the NHSCB is responsible for the overall development and maintenance of health records management practices throughout ECCG. This will include drawing up guidance for good records management practice and promoting compliance with this Policy in such a way as to ensure the easy, appropriate and timely retrieval of patient information.

The responsibility for local records management is devolved to the relevant directors, directorate managers and department managers. Heads of Departments, other units and business functions within ECCG have overall responsibility for the management of records generated by their activities, and for ensuring that records controlled within their unit are managed in a way which meets the aims of this Policy.

All ECCG staff, whether clinical or administrative, who create, receive and use records have records management responsibilities. In particular, all staff must ensure that they keep appropriate records of their work and manage those records in keeping with this Policy and with any guidance subsequently produced.

It is important that ECCG ensures that staff will be trained appropriately. In the context of ILM, organisations need to ensure that their staff are fully trained in record creation, use and maintenance, including having an understanding of:

- what they are recording and how it should be recorded;
- why they are recording it;
- how to validate information with the patient or carers or against other records to ensure that staff are recording the correct data;
- how to identify and correct errors so that staff know how to correct errors and how to report them;
- the use of information so staff understand what the records are used for (and therefore why timeliness, accuracy and completeness of recording is so important); and
- how to update information and add in information from other sources
- ensure compliance with the Information Sharing and Disclosure Policy

13.2 Record Creation - Best Practice Principles

Each operational unit within ECCG will have in place a process for documenting its activities in respect of ILM. This process will take into account the legislative and regulatory environment in which the unit operates.
Records of operational activities will be complete and accurate in order to allow employees and their successors to undertake appropriate actions in the context of their responsibilities, to facilitate an audit or examination of ECCG by anyone so authorised, to protect the legal and other rights of ECCG, its patients, staff and any other people affected by its actions, and provide authentication of the records so that the evidence derived from them is shown to be credible and definitive.

Records created by ECCG will be arranged in a record-keeping system that will enable the organisation to obtain the maximum benefit from the quick and easy retrieval of information.

The following best practice guidelines will be used for creating and using health care records:

- Clearly identify the patient;
- Detail what information has been shared and with whom;
- Be kept up-to-date and be completed as soon as possible after the event has occurred or within 24 hours, i.e. contemporaneous. All important and relevant information is recorded. Professional judgement together with local standards and agreements will determine the frequency of entries;
- Be consecutive and filed in chronological order with the most recent information on top;
- All entries in records are factual, objective, consistent and accurate. Records are free from jargon, meaningless phrases, irrelevant speculation and offensive subjective statements;
- Have a clear, recognised and agreed structure, which is organised into sections;
- Be kept neat and tidy with legible entries in permanent black ink;
- Have errors crossed through with a single line and initialled;
- Involve no use of correctional fluid;
- Have each side of each page numbered;
- Have the name and either date of birth, hospital number of NHS Number recorded on each page;
- Only approved unambiguous abbreviations are used and the full meaning appears the first time of use. Abbreviations are kept to a minimum and a list of all abbreviations should be held at the front of the folder. ‘Left’ and ‘Right’ will always be written in full. Digits will be named and numbered; and
- Be created and shared with the consent of the patient or client where appropriate.

The first time a health care practitioner makes an entry in a patient’s record they will include their Name; Signature; Designation/grade and Bleep/pager number/contact number.

Each entry in the patient record will include the Date; Time; the signature of the person making the entry; be legible and be written in black ink for written patient records.
Healthcare practitioners must ensure that the frequency of their entries is appropriate to the individual’s patient requirements and any local policy.

13.3 Record Creation - Best Practice Processes

Each operational unit within ECCG will have in place a process for documenting its activities in respect of ILM. This process will take into account the legislative and regulatory environment in which the unit operates.

Records of operational activities will be complete and accurate in order to allow employees and their successors to undertake appropriate actions in the context of their responsibilities, to facilitate an audit or examination of ECCG by anyone so authorised, to protect the legal and other rights of ECCG, its patients, staff and any other people affected by its actions, and provide authentication of the records so that the evidence derived from them is shown to be credible and definitive.

In addition to the principles outlined above, the following Best Practice process will be adhered to for creating Health Records:

- Commence at the time of the initial contact with the patient;
- Set-out concisely and accurately all aspects of all contact with the patient including face-to-face contacts, telephone calls and discussions with other health professionals about the patient;
- Include the patient’s decision about treatment;
- Be multi-disciplinary with a single record for each patient or client wherever feasible; and
- Be written with the involvement of the patient wherever practicable.

Also, the clinical record will contain the following data on every page and on every chart:

- The patient’s unique NHS identification number; and
- The patient’s name in full.

Finally, the following patient’s identification data will be recorded where appropriate:

- Date of birth;
- Address and postcode;
- Telephone number;
- Name and contact details of General Practitioner;
- Name and contact details of person to notify in an emergency;
- Gender;
- Ethnic group/preferred language/religion;
- Occupation/school; and
- Hyper-sensitivities/allergies.

In order to fulfil professional and legal duties of care, clinical record keeping shall be able to demonstrate:
• Clear evidence of an assessment, the care planned, the decisions made, the care delivered and the information shared;
• Relevant information about the condition of the client, problems that have arisen, the appropriate action taken to rectify them and measures taken to respond to their needs;
• Evidence of actions agreed with the patient including consent to treatment and/or consent to share information);
• Facts presented to the patient;
• Correspondence from the patient or other parties; and
• Entries of unqualified or support staff will be encouraged and monitored by the accountable clinical practitioner for the patient. Notes that are dictated and typed in the records by a secretary should be checked, corrected, signed and dated by the professional who dictates them.

Where it is appropriate to have separate records, there will be a link to the combined case notes to ensure that all parties are aware of the other’s involvement in the care of that particular patient. Each set of records will highlight the existence of the other set/s of records including any additional identifying numbers. This will be identified prominently at the front of each record.

13.4 Record Keeping

Implementing and maintaining effective ILM depends on knowledge of what records are held, where they are stored, who manages them, in what format(s) they are made accessible, and their relationship to organisational functions (for example finance, estates, IT, healthcare). An information survey or record audit is essential to meeting this requirement. This survey will also help to enhance control over the records, and provide valuable data for developing records appraisal and disposal policies and procedures.

Paper and electronic record keeping systems will contain descriptive and technical documentation to enable the system to be operated efficiently and the records held in the system to be understood. The documentation will provide an administrative context for effective management of the records.

The record keeping system, whether paper or electronic, will include a documented set of rules for referencing, titling, indexing and, if appropriate, the protective marking of records. These must be easily understood to enable the efficient retrieval of information when it is needed and to maintain security and confidentiality.

13.5 Record Maintenance

The movement and location of records will be controlled to ensure that a record can be easily retrieved at any time, that any outstanding issues can be dealt with, and that there is an auditable trail of record transactions.

Storage accommodation for current records will be clean and tidy, should prevent damage to the records and will provide a safe working environment for staff.
For records in digital format, maintenance in terms of back-up and planned migration to new platforms will be designed and scheduled to ensure continuing access to readable information.

Equipment used to store current records on all types of media will provide storage that is safe and secure from unauthorised access and which meets health and safety and fire regulations, but which also allow maximum accessibility of the information commensurate with its frequency of use.

When paper records are no longer required for the conduct of current business, consideration will be given to their placement in a designated secondary storage area to provide a more economical and efficient way to store them. Procedures for handling records will take full account of the need to preserve important information and keep it confidential and secure. There will be archiving policies and procedures in place for both paper and electronic records.

A contingency or business continuity plan will be in place to provide protection for all types of records that are vital to the continued functioning of the organisation. Key expertise in relation to environmental hazards, assessment of risk, business continuity and other considerations rests with the CSU Information Security Officer, and their advice should be sought on these matters when required.

13.6 Records Retrieval

ECCG will comply with the range of statutory provisions that limit, prohibit or set conditions in respect of the disclosure of records to third parties, and similarly, a range of provisions that require or permit disclosure. The key statutory requirements can be found in the Department of Health publication Records Management: NHS Code of Practice. Any record disclosure and transfer will also comply with any guidance documents (for example the Information Commissioner’s Use and Disclosure of Health Information) that interpret statutory requirements, and, where appropriate, staff within organisations who have special expertise in, or can advise on, particular types of disclosure should be consulted where appropriate.

Caldicott Guardians or their support staff will be involved in any proposed disclosure of confidential patient information, informed by the Department of Health publication Confidentiality: NHS Code of Practice. In GP surgeries, the responsibility for making decisions about disclosure ultimately rests with the GP. NHSCB Data Protection Officers may be available to advise on subject access requests by members of the public, and guidance on dealing with such requests is available on the Department of Health website:

The mechanisms for transporting and transferring records from ECCG to any other organisation should also be tailored to the sensitivity of the material contained within the records and the media on which they are held. The Head of Governance and Risk will advise on appropriate safeguards.

The process for the retrieval of records that must be followed is:
• The person requesting any patient records will do so either in writing or via email outlining in full the names of the patients, their NHS numbers and the reasons for requesting such records. These details will be sent to the relevant Head of Governance and Risk for consideration;
• The Head of Governance and Risk will assess whether the request is valid and whether there are any considerations preventing the release of the records following the guidance detailed above;
• If the Head of Governance and Risk believes that it is not possible to release the patient records, the reasons for this will be recorded and given to the person who made the original request;
• If the Head of Governance and Risk believes that further consideration of the request is required, then the Head of Governance and Risk will consult with the Director of Service Quality and Integrated Governance for further details; and
• If the Head of Governance and Risk believes that the request is valid and that the records can be released, then the records will indeed be released and their release and subsequent tracking will be performed according to the requirements for the Tracking of Records defined below.

13.7 Records Retention

It is a fundamental requirement of the NHS that all records including health records are retained for a minimum period for legal, operational, research and safety reasons. The length of time for retaining records will depend on the type of record, its importance to ECCG and the detailed guidance on retention periods for a full range of NHS personal health and different types of business and corporate records is provided in the Department of Health publication Records Management: NHS Code of Practice Parts 1 & 2 (Retention Schedules).

ECCG has adopted the retention periods as set out in the DoH: Records Management NHS Code of Practice. The retention period will be calculated from the end of the calendar or accounting year following the last entry in the record (manual file, computer record) dependant on record.

Any new retention periods that are required must be proposed to the Information Governance Committee and the Quality and Safety Committee. Once agreed, they will be communicated immediately.

Records selected for permanent preservation (archive) and no longer in use by ECCG will be transferred as soon as possible to adequate storage.

Records not selected for permanent preservation and which have reached the end of their administrative life will be destroyed in a secure manner as is necessary for the type of information the record holds.

If a record for destruction is known to be the subject of a request for information, destruction must be delayed until disclosure has taken place or if ECCG has decided not to disclose the information, until any complaint and appeals provisions of the Data Protection or Freedom of Information Act have been exhausted.
13.8 Records Disposal

It is important under freedom of information legislation that the disposal of records – which is defined as the point in their lifecycle when they are either transferred to an archive or destroyed – is undertaken in accordance with clearly established policies which have been formally adopted by the organisation and which are enforced by properly trained and authorised staff.

The destruction of records is an irreversible act, whilst the cost of keeping them can be high. Most NHS records, even administrative ones, contain sensitive or confidential information. It is therefore vital that confidentiality is safeguarded at every stage and that the methods used to destroy such records is fully effective and secures their complete illegibility.

All departments and users are required to observe the Data Protection Act 1998 principles when handling information about identifiable individuals particularly patients. The seventh principle of the Data Protection Act 1998 relates specifically to destruction of confidential waste and reads as follows:

*Appropriate technical and organisational measures should be taken against unauthorised or unlawful processing of personal data, against accidental loss or destruction of or damage to personal data.*

Careless disposal of media could result in breaches of confidentiality or risk to the integrity of ECCG. Thus staff will ensure that they follow the requirements below and adhere to any disposal procedures local to their department where necessary.

The normal destruction methods to be used within ECCG are: shredding, pulping and incineration.

13.9 Paper

Confidential waste bins/bag will be provided in all work areas for staff to use. Staff will ensure that any information that has confidential/sensitive information recorded, are disposed of in the confidential waste bins/bags.

ECCG will have a contract with an external waste contractor who will take confidential waste off-site. ECCG will make arrangements to have bins emptied and bags collected on a regular basis. Staff will contact the named person for that department who will report if bins/bags are full or have not been collected.

Staff should not normally take a patient’s manual records, other staff/patient identifiable information or ECCG sensitive information outside of the normal working environment. Where this cannot be avoided, procedures should be in place to safeguard that information effectively. This includes the safe disposal of any confidential waste. In such circumstances, this information should be brought back to ECCG for secure disposal in the relevant confidential waste bins/bags.
13.10 Electronic

When deleting electronic records, special precautions will be taken to ensure that electronic storage media containing confidential material or information that may infringe upon personal privacy is electronically wiped cleaned or physically destroyed.

Deleting records in some programs does not actually remove the information. Most operating systems do not erase deleted information from hard disks, but remove the file names from the directory and eventually write over the unwanted information.

Hard disks from computers must be reformatted before the computers are disposed of (other magnetic media can also be reformatted) or re-issued. The only time when a re-issued computer is not reformatted is when a staff member is taking over a job role that requires access to the information recorded by a previous staff member to carry out their job role. This arrangement must be agreed by the Line Manager.

It is the responsibility of all staff who are leaving their employment or have a contract ending, to ensure that any non business information stored on the computer is deleted before their employment/contract terminates.

If staff are unsure on the procedure for the disposal/deletion of electronic storage or files, advice must be sought via the Head of Governance and Risk.

13.11 Tracking of Records

Record tracking is the process of recording the movement of a record to produce an audit trail (a list of the record's movements). This enables the record to be located and retrieved quickly and efficiently at any time, that any outstanding issues can be dealt with, and that there is an auditable trail of record transactions, irrespective of whether the records are electronic or paper-based or a mixture of both.

It is essential that appropriate staff are aware of the location of all records in their charge, that those records are accessible whenever required and are retained according to the ECCG. Record Retention Schedules as defined by the DoH Guidance.

To ensure that records are not misplaced or lost, each Practice and department will ensure that they use Exeter or another appropriate electronic system for tracking and tracing records, which is maintained by all staff. Tracking systems will include the following information as a minimum:

- Item reference number, NHS Number or other identifier;
- Brief description of the records;
- Name of the person who is sending the records on;
- Name of the person to whom the record is being sent, their Practice or department, location and contact number;
- Date of the transfer;
- Expected date of the return (if applicable);
• Name of the person recording the movement; and
• Any special instructions on return (e.g. forward to another department).

13.11.1 GP Practice Records

There are several electronic applications that are employed by ECCG to track the movement of records including GP2GP, GP Links and PAS. Where the record tracking functionality exists, the following process will be complied with and the information identified above will be recorded:

When a patient registers at a new practice, the full patient details will be recorded on the system and a patient file transfer request will be sent electronically to the patient’s former Practice;

On receipt of the request, the Practice will determine what records exist and how they will be transferred;

If the patients records are held in electronic form and it is possible to transfer them using GP2GP, then the records will be sent electronically and the system will be updated to record this;

On receipt of the electronic records from the former Practice, the new Practice will acknowledge receipt of such records and update the details using the electronic system;

Where there is no GP2GP service, the electronic records will be printed out by the former Practice and sent to NHSCB using the Courier Service;

The former Practice will record the sending of the printed patient notes to NHSCB;

Where there is a mixture of electronic records and paper-based records (such as ‘Lloyd George’ type notes) for a patient, the electronic records will be printed off and combined with the paper records and sent using a Courier Service to NHSCB. The electronic records will not be sent separately. This will ensure that there are no risks in failing to combine electronic and paper-based records later if separated;

Any distribution of records will be transported using the Courier Firm TNT;

If there is an immediate pressing need to transfer any records, this will be done using the Courier Firm TNT on the same day irrespective of where the Practice is located;

Where there is a need to fax any records as a consequence of an urgent medical need; the Safe Haven Policy will be consulted and complied with

When the records arrive at NHSCB, they will be managed by the NHSCB Patient Data-Service Manager;

The NHSCB Patient-Data Service Manager will check the records against the Information contained on the central spine and if all correct, will arrange for the records to be sent to the requesting Practice via Courier Service;
When the paper-based notes are given to the Courier Service, the relevant electronic system will be updated to reflect that event by the former Practice;

On receipt of the records, NHSCB will update the relevant electronic system to Record this event;

NHSCB will then arrange for the records to be sent to the correct Practice via the Courier Service;

Once sent, NHSCB will record this event using the relevant electronic system; and

The new Practice, on receipt of the paper-based records, will update the relevant electronic system to say that they have received it.

13.12 Appraisal of Records

Appraisal refers to the process of determining whether records are worthy of permanent archival preservation. This will be undertaken in consultation with the ECCG’s own archivist (where such a post exists), or The National Archives, or with an approved Place of Deposit where there is an existing relationship and in compliance with Part 2 of the Records Management NHS Code of Practice (Retention Schedules).

Procedures are required to ensure that appropriately trained staffs appraise records at the appropriate time. The retention schedules in Department of Health publication Records Management: NHS Code of Practice outline the recommended minimum retention periods for all types of NHS records. The purpose of this appraisal process is to ensure that the records are examined at the appropriate time to determine whether or not they are worthy of archival preservation, whether they need to be retained for a longer period as they are still in use, or whether they should be destroyed.

Where there are records which have been omitted from the retention schedules, or when new types of records emerge, the Department of Health and/or The National Archives will be consulted. The National Archives will provide advice about records requiring permanent preservation.

ECCG will ensure that procedures are in place for recording the disposal decisions made following appraisal. An assessment of the volume and nature of records due for appraisal, the time taken to appraise records, and the risks associated with destruction or delay in appraisal will provide information to support an organisation’s resource planning and workflow. The Head of Governance and Risk will determine the most appropriate person(s) to carry out the appraisal in accordance with the retention schedule. This will be a senior manager with appropriate training and experience who has an understanding of the operational area to which the information and record relates.
Most ECCG records, even administrative ones, contain sensitive or confidential
information. It is therefore vital that confidentiality is safeguarded at every stage of
the lifecycle of the record, including destruction, and that the method used to destroy
such records is effective and ensures their complete illegibility.

13.13 Record Closure

Records will be closed (made inactive and transferred to secondary storage) as soon
as they have ceased to be in active use other than for reference purposes. An
indication that a file of paper records or folder of electronic records has been closed,
together with the date of closure, should be shown on the record itself as well as
noted in the index or database of the files/folders. Where possible, information on the
intended disposal of electronic records should be included when the record is
created.

The storage of closed records will follow accepted standards relating to environment,
security and physical organisation of the files.

13.14 Record Disposal

ECCG will manage record retention and disposal based on the retention schedules
contained in Department of Health publication Records Management: NHS Code of
Practice Parts 1 & 2 (Retention Schedules).

Information and records selected for archival preservation and no longer in regular
use by ECCG will be transferred as soon as possible to an archival institution (for
example a Place of Deposit) that has adequate storage and public access facilities.

Non-active records will be transferred no later than 30 years from creation of the
record, as required by the Public Records Act.

Information and records (including copies) not selected for archival preservation and
which have reached the end of their administrative life will be destroyed in as secure
a manner as is appropriate to the level of confidentiality or protective markings they
bear. This can be undertaken on site or via an approved contractor.

When destroying ECCG information and records, it is necessary to ensure that the
methods used throughout the destruction process provide adequate safeguards
against the accidental loss or disclosure of the contents of the records. Contractors,
if used, should be required to sign confidentiality undertakings and to produce written
certification as proof of destruction.

A record of the destruction of records, showing their reference, description and date
of destruction will be maintained and preserved by the Head of Governance and
Risk, so that the organisation is aware of those records that have been destroyed
and are therefore no longer available. Disposal schedules will constitute the basis of
such a record.

If a record due for destruction is known to be the subject of a request for information,
or potential legal action, destruction should be delayed until disclosure has taken
place or, if ECCG has decided not to disclose the information, until the complaint and appeal provisions of the Freedom of Information Act have been exhausted or the legal process completed.

13.15 Process for Reviewing, Monitoring Compliance & Effectiveness of this Policy

ECCG will regularly audit its records management practices for compliance with this framework. The audit will examine as a minimum:

- areas of operation that are covered by ECCG policies and identify which procedures and/or guidance should comply to the Policy;
- mechanisms for adapting the Policy to cover missing areas if these are critical to the creation and use of records, and use a subsidiary development plan if there are major changes to be made;
- the process of setting and maintaining standards by implementing new procedures, including obtaining feedback where the procedures do not match the desired levels of performance; and
- any areas where non-conformance to the procedures is occurring and suggest a tightening of controls and adjustment to related procedures.

The results of audits will be reported to the Head of Performance and Informatics and the Audit Committee.

In addition to internal audits, monitoring of ECCG information and record management systems will be conducted externally as follows:

- **Healthcare Commission** – Assessing Records Management performance as part of the Annual Health Check;
- **Audit Commission** – Conducting audits and studies into Records Management and information issues;
- **Department of Health** – Collecting performance details as part of the Trusts Annual IG Toolkit submission;
- **NHS Litigation Authority** – Undertaking risk assessment surveys as part of the Clinical Negligence Scheme for Trusts;
- **Health Service Ombudsman** – Investigating complaints about poor service; and

14. Dissemination

This Policy will be available via the ECCG Intranet.
An approach to dissemination of this Policy has been agreed whereby all staff will be notified, by email, of the location and nature of this Policy.

15. Implementation of this Policy.

The Records Management: NHS Code of Practice© Part 1 and Parts 2 have been published by the Department of Health as a guide to the required standards of practice in the management of records for those who work within or under contract to NHS organisations in England. All users of this Policy will ensure that they understand and comply with these guidelines.

This Policy is, and will continue to be, supported by a framework of additional policies, technical standards, operational procedures and guidance, released by the Department of Health, to ensure that records management requirements are understood and met throughout the organisation.
Appendix 1 – Equality Impact Assessment Tool

Enfield Clinical Commissioning Group Equality Impact Analysis (EQIA) screening

Proposal Title: Information Lifecycle Management (Records Management) Policy

<table>
<thead>
<tr>
<th>Author/editor/assessors</th>
<th>At least one of the people carrying out an EQIA must be the person responsible for the policy/function/service</th>
<th>Andy Nuckcheddee, Interim Head of Governance &amp; Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Partners/decision-makers/implementers</td>
<td>Identify who else will need to be involved. This can be decision-makers, frontline staff implementing the policy, partner/parent organisations, etc</td>
<td>Reviewed by Executive Committee</td>
</tr>
<tr>
<td>Start Date</td>
<td>The EQIA should be started prior to policy/service development or at the design stages of the review and continue throughout the policy development/review. For an existing policy/service, any changes identified have to be implemented.</td>
<td>February 2013</td>
</tr>
<tr>
<td>End date</td>
<td>The EQIA will need to inform decision-making so the date should take this into account</td>
<td>March 2014</td>
</tr>
<tr>
<td>Due regard, proportionality and relevance in relation to the following characteristics</td>
<td>Has due regard been given to equality (i.e. promote equality of opportunity between communities, eliminate discrimination that is unlawful, promote positive attitudes towards communities) for this proposal/policy/function? Due regard has two linked elements: proportionality and relevance. The weight given to equality should therefore be proportionate to its relevance to a particular function. The greater the relevance of a function/policy/proposal to equality, the greater regard that should be paid. Where it is</td>
<td>Please refer to completed EQIA assessment tool</td>
</tr>
<tr>
<td>• Gender including gender reassignment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Proposal/ policy/function/service aims</td>
<td>Consider:</td>
<td></td>
</tr>
<tr>
<td>--------------------------------------</td>
<td>-----------</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Why is the proposal/policy/function/service needed?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• What does ECCG hope to achieve by it?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• How will ECCG ensure that it works as intended?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Who benefits?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Who doesn’t benefit and why not?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Who should be expected to benefit and why don’t they?</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Evidence gaps</th>
<th>Identify what evidence is available and set it out here. This includes evidence from involvement and consultation. Identify where there are gaps in the evidence and set out how these will be filled</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>None currently Identified</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Involvement &amp; consultation</th>
<th>What involvement and consultation has been done in relation to this (or a similar) policy or function, and what are the results? What involvement and consultation will be needed and how will it be undertaken? Report any results.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>CCG Executive Committee</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Addressing the impact</th>
<th><strong>Outcome 1: No major change:</strong> the EQIA demonstrates the policy/change is robust and there is no potential for discrimination or adverse impact</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Outcome 2: Adjust the policy:</strong> the EQIA identifies potential problems or missed opportunities. Adjust the policy to remove barriers or better promote equality.</td>
</tr>
<tr>
<td></td>
<td><strong>Outcome 3: Continue the policy:</strong> the EQIA identifies the potential for adverse impact or missed opportunities to promote equality. Clearly set out the justifications for continuing with it. The justification must be in line with the duty to have due regard. For the most relevant policies, compelling reasons will be needed.</td>
</tr>
<tr>
<td></td>
<td><strong>Outcome 4: Stop and remove the policy:</strong> the policy shows actual or potential unlawful discrimination.</td>
</tr>
<tr>
<td></td>
<td>Outcome 1</td>
</tr>
</tbody>
</table>
BEFORE USING THIS POLICY ALWAYS CHECK THAT YOU ARE USING THE MOST RECENT VERSION

INTERNET SERVICE POLICY

1. **SUMMARY**
   This Policy defines the Information Governance requirements for Internet use within Enfield Clinical Commissioning Group (including local presences) and hosted organisations.

2. **RESPONSIBLE PERSON:**
   Head of Governance and Risk

3. **ACCOUNTABLE DIRECTOR**
   Aimee Fairbairns – Director of Service Quality and Integrated Governance

4. **APPLIES TO:**
   All staff

7. **EQUALITY IMPACT ANALYSIS COMPLETED:**
   Policy Screened | Template completed

8. **GROUPS/INDIVIDUALS WHO HAVE OVERSEEN THE DEVELOPMENT OF THIS POLICY:**
   Director of Service Quality and Integrated Governance
   Caldicott Guardian

10. **RATIFYING COMMITTEE (S) & DATE OF FINAL APPROVAL:**
   Executive Committee- 30th January 2013
   ECCG Governing Body- 13th January 2013

11. **VERSION:**
   2

12. **AVAILABLE ON:**
   Intranet X Website

13. **RELATED DOCUMENTS:**

14. **DISSEMINATED TO:**
   All Staff

15. **DATE OF IMPLEMENTATION:**
   April 2013

16. **DATE OF NEXT FORMAL REVIEW:**
   March 2014, or sooner if there are changes to legislation etc. that impact on this policy and
## Document Control

<table>
<thead>
<tr>
<th>Date</th>
<th>Version</th>
<th>Action</th>
<th>Author</th>
</tr>
</thead>
<tbody>
<tr>
<td>22/01/13</td>
<td>1</td>
<td>NCL Policy amended for adoption within ECCG</td>
<td>Alison Mitchell-Hall</td>
</tr>
<tr>
<td>24/01/13</td>
<td>2</td>
<td>Updated following internal review</td>
<td>Alison Mitchell-Hall</td>
</tr>
<tr>
<td>30/01/2013</td>
<td>3</td>
<td>Executive Committee</td>
<td>Andy Nuckcheddee</td>
</tr>
<tr>
<td>SECTION NO.</td>
<td>TITLE</td>
<td>PAGE NO.</td>
<td></td>
</tr>
<tr>
<td>------------</td>
<td>--------------------------------------------</td>
<td>----------</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Introduction</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Policy Statement</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Scope of this Policy</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Who this policy applies to</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Definitions used in this policy</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Recommendations for Independent Contractors</td>
<td>7</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Initiation, development and review of the policy</td>
<td>7</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Risk rating of the policy</td>
<td>7</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Internet Security Risks and Awareness</td>
<td>7</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>Specific Policy Requirements</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>Dissemination</td>
<td>15</td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>Implementation of this Policy</td>
<td>15</td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>Appendix 1- Equality Impact Assessment</td>
<td>18-21</td>
<td></td>
</tr>
</tbody>
</table>
1. Introduction

1.1 Enfield Clinical Commissioning Group (ECCG) provides users with access to the Internet and ECCG’s Intranet (Internet Service). In using the Internet Service, all users must be aware of the requirements that must be complied with to ensure access to this Service is safe, secure and lawful. Users must also recognise there is both acceptable and unacceptable use of the Internet Service, and must be aware of their obligations for not conducting any unacceptable use of the Service.

1.2 ECCG provides an Internet Service to empower staff in one or more of the following areas:

- Their work duties;
- Work-related educational purposes; and
- Work related research purposes.

1.3 The purpose of this Policy is to establish ECCG’s definition of acceptable and unacceptable use by users accessing the Internet, as granted by ECCG. If any user disregards the rules set out in this Policy, the user may be liable and may be subject to disciplinary action.

1.4 The Internet is an important source of information, and an educational and research system. Users are obliged to use this system in a responsible, effective and lawful manner. It is important users are aware of the legal risks of accessing Internet content.

1.5 This Policy prohibits certain activities in the use of the Internet. Such use is deemed unacceptable and users are required to carefully study and understand the implications of unacceptable use of the Internet Service.

1.6 This Policy complements the Information Security Policy and is compliant with ISO 27001 particularly Sections three, four, seven and eight. The Policy also meets current legal requirements and current NHS standards.

1.7 All staff and third-parties will be expected to comply with this Policy in full.
2. Policy statement
2.1 The Policy is intended to achieve the following Information Security Objectives:

- **Confidentiality** – Access to data and information must be confined to only those users with a specific authority to view the data. ECCG must ensure use of the Internet Service will not lead to any confidentiality compromises of ECCG data, for example, by sending PID data via email to another user. In using the Internet, all users will be aware of the additional requirements to understand and comply with the requirements of the Caldicott Guidelines and the Data Protection Act 1998.

- **Integrity** – ECCG data and information must be complete and accurate, and protected from unauthorised modification. All systems, assets and networks must be operated in a manner to ensure there is no unauthorised or accidental modification of data and systems as a result of Internet misuse.

- **Availability** – information must be available and delivered to the right person at the right time. The Internet Service must be employed and used in a manner that will not lead to any service denial of access to key ECCG data and systems. Also, staff may access the Internet for personal use, but only during their official break times agreed with their Line manager.

- **Accountability** – users will be held responsible for their use of the Internet Service. ECCG will ensure, where appropriate, there is logging of relevant Internet usage, and such logging be analysed regularly to provide assurance against Internet misuse. Users who object to monitoring of their Internet usage will not be able to use the Internet Service further.

3. Scope

3.1 This Policy is applicable to ECCG (including local presences) and hosted organisations Internet Service including all Internet email communications and Internet web use.

3.2 This Policy applies to all sites used by the organisation and applies to all those having access to information, either on site or remotely. This includes, but is not limited to; staff employed by the organisation; those engaged in duties for the organisation under a letter of authority, honorary contract or work experience programme; volunteers and any other third party such as contractors, students or visitors.
4. **Who does this policy applies to?**

4.1 **Staff (including temporary staff)**
   All staff employed by ECCG have a responsibility to ensure:
   - They work to the most up to date and relevant corporate and local Information Security policies; and
   - They work to the most up to date and relevant Information Governance policies.

4.2 **Responsibilities of Employees**
   All employed staff are responsible for carrying out their duties in line with this Policy, to note any new or amended version of this Policy and to contribute to policy making as necessary.

4.3 **Managers**
   All staff with a supervisory role have a responsibility to ensure:
   - All staff have been shown how to access this Policy on the Intranet policy library;
   - Local induction of newly employed staff includes being made aware of the relevant policies and how it impacts their own roles; and
   - Policies they are responsible for are reviewed appropriately on an ongoing basis and are disseminated and implemented within services as directed.

5. **Definitions used in this policy**

   **Asset**
   Any information system, computer or programme owned by the organisation

   **Authorisation**
   The granting or denying of access rights to network resources, programmes or processes.

   **Caldicott**
   A set of standards developed in the NHS for the collection, use and confidentiality of patient-related information.

   **Internet**
   A global system connecting computers and computers networks. The computers are owned separately by a range of organisations, government agencies, companies and educational institutes.

   **Information Governance Toolkit**
   A series of requirements, produced jointly by the Department of Health and NHS Connecting for Health.
**ISMS – Information Management System**
An information security management system (ISMS) standard to help establish and maintain an effective information management system, using a continual improvement approach.

**Network**
A system of interconnected computers which allows the exchange of information network connection. An individual's access to the network usually involves password checks and similar security measures.

**PID – Person Identifiable Information**
Data that contains sufficient information to relate the data to a specific patient.

**Software**
Computer programmes sometimes also called applications.

**Virus**
An unauthorised piece of computer code attached to a computer programme which secretly copies itself using shared discs or network connections. Viruses can destroy information or make a computer inoperable.

6. **Recommendations for Independent Contractors**

As all staff and third-parties are expected to comply with this and other policies, there are no additional recommendations.

7. **Initiation, development and review of the policy**

This policy meets all relevant requirements in its initiation, development and review.

8. **Risk rating of the policy**

All policies are required to possess an appropriate risk rating calculated by use of the organisation’s risk-rating matrix. This Policy has been given a risk rating of HIGH due to the risk of adverse national publicity as it is possible that breaches of this policy are still possible given the nature of the controls and the potential for misuse by staff.

9. **Internet Security Risks and Awareness**

9.1 All staff and other users including third-parties utilising the Internet Service must be aware of the following risks and issues:

- **Reputational Risk** – loss of any data could have an adverse impact upon the reputation of ECCG. In addition, any misuse of the Internet, for example the downloading of offensive material by staff will have a detrimental impact upon ECCG’s standing. The confidence ECCG currently enjoys from the NHS Executive, patients and other key stakeholders could be seriously undermined by misuse of the Internet Service;
• **Patient Distress** – disclosure of PID data or other patient details via the Internet could lead to severe stress and trauma for our patients as information on any medical conditions could be made public. Patients could take legal action against ECCG further undermining public confidence. Some four principal patient risks have been identified by the Data Sharing Review, 11 July 2008, conducted at the request of the Prime Minister:

1) **Indignity** – unnecessary exposure of facts/suspicions, for example, disclosure of a medical condition that may cause embarrassment;

2) **Injustice**– stigmatisation resulting from wrongly disclosed information, leading to loss or denial of, for example, employment, training or credit;

3) **Inappropriate Treatment** – unwarranted interventions by agencies into the lives of individuals or their families, for example with draconian action being taken by mental health or child protection workers based on misinterpreted/un-contextualised data; and

4) **Ineffective Service Delivery** – because, for example, individuals do not trust agencies sufficiently to provide full and accurate information as required.

• **Repudiation Risk** – To repudiate is to deny. Users must be aware of the commercial, contractual and legal risks of using the Internet Service for the conduct of any business transactions. Email should never be relied upon from any legal perspective due to the fact a user or organisation could deny ever sending any email. Non-repudiation is the assurance someone cannot deny something. For the Internet Service, non-repudiation refers to the ability to ensure a party to a contract or communication cannot deny the authenticity of their signature on a document or the sending of a message they originated. Until proven non-repudiation mechanisms exist, users must exercise awareness and caution in this matter.

• **Legal & Regulatory Risk** – loss of any patient data via the Internet, particularly PID data, could result in action being taken against ECCG by the Information Commissioner if it is deemed breaches of the Data Protection Act 1998 have occurred. In addition, the Information Commissioner, as a result of changes to the Criminal Justice Act 2008, now has the power to impose fines of up to £500,000 upon organisations and individuals who are aware of information risks but have not taken reasonable care and appropriate steps to mitigate those risks. Any legal and regulatory action against the Cluster would be publicised and highly damaging to confidence;

• **The NHS Care Record Guarantee** – The NHS has published a ‘Guarantee’ on how it handles patient data including the duties of keeping records confidential, secure and accurate. Unauthorised access or modification of any patient data would breach such ‘guarantees’;

• **Human Rights Breaches** – In a Landmark Judgement, the European Court of Human Rights found that in the case of *I v Finland*, a patients’ Right to Family Life was breached after a hospital was found not to have maintained
sufficient confidentiality of I’s medical records. Failures in maintaining the confidentiality of patient data could be interpreted by a Court of Law as a breach of a patients’ Human Rights by the Cluster;

- **Staff Awareness** – Staff utilising ECCG’s Internet Service must fully understand and comply with this Policy and all other relevant policies. Staff must understand they must use their best endeavours to ensure there is no sending or loss of any data or other sensitive data due to misuse of the Internet Service. Staff must understand they may be liable for any such loss, and any breaches of this or any other policy may result in disciplinary action including dismissal. Staff must also be aware they may be held personally liable by the Information Commissioner, and could face fines of up to £500,000;

- **Third-party Awareness** – any user or third-party utilising ECCG’s Internet Service must comply with this Policy and all other relevant policies. Where third-parties do not comply with this Policy or any other relevant policy, ECGG will reserve the right to terminate all current contractual agreements with immediate effect. Third-party providers and their staff must also be aware they may be held personally liable for any non-compliance with their statutory requirements by the Information Commissioner and could face fines of up to £500,000

### 10. Specific Policy Requirements

#### Authorised Users

10.1 Any member of staff who wishes to use the Internet Service must apply to become an authorised user.

10.2 A staff member will be required to request an Internet Service account from their Line Manager.

10.3 The Line Manager will be required to complete an appropriate request form and send it to the CSU IT Services Department for review and authorisation.

10.4 All Internet Service Users must review this Policy and sign an appropriate declaration that they understand the Policy and agree to comply with it.

10.5 The Internet Policy declaration staff must read and agree to is as follows:

“I have seen and read a copy of the ECGG’s Internet Services Policy. I understand the terms of the Policy and agree to abide by them. I understand that Policy Enforcement and Monitoring Software may record the use I make of any applications and the Internet, which may include logging the content of e-mails and attachments and the addresses of any web sites and noting what file transfers or downloads I make. I have no objection to any monitoring of the use I make of any application or NHS establishment equipment. I understand that any violation of this Policy could result in disciplinary action, and possibly dismissal or criminal prosecution.”
Email

10.6 Emails should not have any content that is deemed libellous, pornographic, sexually or racially offensive, or otherwise illegal.

10.7 All users must be aware the Internet Service is primarily for business use and can be withdrawn at any time if ECCG deems this is necessary.

10.8 Users must also be aware ECCG has the right to monitor the content of all emails sent and received via the Internet Service.

10.9 Users will acknowledge they do not have the right to privacy with respect to the sending and receiving of any Internet emails.

10.10 Users will not send emails to large number of people (greater than 10 recipients) unless they are convinced there is a business requirement for each recipient to receive such email.

10.11 Users will not be permitted to send one or more emails to large numbers, when it is questionable whether the recipients are required to receive such emails. Users will recognise that it is not permitted to send unsolicited email to large numbers of users – a process commonly known as ‘spamming’.

10.12 When receiving email attachments from an unknown originator, users must exercise caution in opening such attachments due to the risks of viruses and other harmful code.

10.13 When receiving so-called spam emails, users should not select the ‘Unsubscribe’ feature of the spam emails, as confirming the email address is real will encourage additional spam emails.

10.14 Users should exercise caution when receiving emails from what may appear to be a reputable organisation requesting any personal or financial details. Where users receive such apparent genuine requests, strong consideration should be given to validating the authenticity of the request by other means, for example by telephone, before providing any such sensitive information.

Person Identifiable Data and Commercial/Sensitive Data

10.15 The transmission of PID data and other commercial and sensitive data by email via the Internet is strictly prohibited.

10.16 The transmission of PID data and other commercial and sensitive data by file transfer protocol (FTP) by users other than IT Services is strictly prohibited. However, where there is a justifiable business need for file transfer by FTP, users should contact their Service Manager to obtain this service via CSU IT Services.

10.17 Any users who wish to use the Internet for the transmission of data via email will be required to apply for a policy waiver dispensation.
Virus Protection

10.18 All users must ensure any incoming file attachments sent by Internet email are checked for viruses and other forms of malicious code.

10.19 When sending attachments of any sort, users must ensure no viruses or other malicious code is contained in such attachments.

Software Downloads

10.20 Users will not be permitted to download any software of any sort from the Internet.

10.21 Users will not be permitted to use the Internet to distribute software of any sort.

10.22 Users wishing to download any software of any form from the Internet must contact their relevant Services Manager for further information.

Web-browser Settings

10.23 Users will not be permitted to change, or interfere with in any way, their web browser settings.

10.24 Users will not be permitted to use the web-browser function for storing or retaining user name and password details.

Financial Transactions

10.25 Users using ECCG Internet Service to conduct any personal financial transaction do so at their own risk.

10.26 ECCG is not liable for any personal financial transactions that are undertaken by staff whilst using ECCG’s Internet Service.

10.27 Users should exercise caution when disclosing any personal, financial or payment card details over the Internet.

Newsgroups and Chat Rooms

10.28 Only newsgroups and chat rooms directly related to work are authorised.

10.29 Staff using the Internet facilities of ECCG shall identify himself or herself honestly, accurately and completely (including ECCG affiliation and function where requested) when participating in chat rooms or newsgroups, or when setting up accounts on outside computer systems.

10.30 Only those employees or officials who are duly authorised to speak to the media, to analysts or in public gatherings on behalf of ECCG may speak/write in the name of ECCG to any newsgroups or chat room.
10.31 Other staff may participate in newsgroups or chat room strictly in the course of business when relevant to their duties, but they do so as individuals speaking only for themselves. Where an individual participant is identified as an employee or agent of ECCG, the employee must refrain from any unauthorised political advocacy and must refrain from the unauthorised endorsement or appearance of endorsement by ECCG of any commercial product or services not sold or serviced by ECCG, its subsidiaries or its affiliates.

10.32 ECCG retains the copyright to any material posted to any forum, newsgroup, chat-room or web page by staff in the course of their duties.

10.33 Staff must be aware they are not permitted to disclose any ECCG information on any newsgroups, etc and must not discuss any ECCG related matters such as current projects, etc.

10.34 Staff are not permitted to disclose any patient details or patient information of any sort.

**Legal Transactions and Non-Repudiation**

10.35 All Users using the Internet Service for the initiation and management of commercial, legal or contractual issues will be fully aware of the risks of repudiation.

10.36 Where the Internet Service will be used for the transmission of any commercial, legal or contractual agreements from third-parties to ECCG, users will ensure paper copies of such documentation will also be sent.

10.37 The transmission and receipt of any commercial, legal or contractual documents of any sort will not constitute in any way any agreement between ECCG and one or more third-parties. Where agreement of any kind is sought, this will be achieved through the usual review and signing of ‘hard’ paper copies of any proposed agreements.

10.38 Users will be aware that the sending of any documents and the receipt of any documents is not guaranteed in any way by the wider Internet and by ECCG’s Internet Service.

10.39 Emails must not be relied upon from any legal perspective as they cannot be authenticated in any way (as they lack a signature) whilst the original sender can deny ever sending the email.

10.40 Any proposals for the use of ‘digital signatures’ must be reviewed by the ECCG’s Data Manager prior to implementation and use.

**Denial of Service**

10.41 Internet users will not engage in any attempts to create any denial of service attempts uponECCG, Internet or any other systems and applications.
10.42 Internet users will not download, distribute or use in any way any Internet security tools or penetration testing tools of any type.

10.43 Internet users will not download, distribute or use in any way any software or application or facility that causes or is likely to cause either the slowing down or crashing of ECCG’s systems and applications, any Internet system and application or any other system or application of any sort.

**Acceptable Internet Use**

10.44 Access to the Internet is given for ECCG business and healthcare related use; ECCG will, however, allow the use of the Internet for personal use, but only where this does not interfere with the normal work duties of the individual user or the work of other users.

10.45 It must be noted there is no absolute right for staff to have access to the Internet Service for private use, and ECCG retains the right to withdraw such personal use at any time.

10.46 It is expected that such use will be made out-of-hours times and in designated breaks such as lunchtime. Personal Internet use must adhere to this Policy whenever it is performed via the Internet Service.

10.47 ECCG will not be held liable for any financial or material loss to an individual user in accessing the Internet for personal use.

10.48 Acceptable Internet Usage will be based upon reasonable access to:

- Research material and other relevant information to your work; and
- Websites and web-mail accounts for personal use but only during official break times agreed with their Line Manager.

**Unacceptable Internet Use**

10.49 Staff must not engage in any activity that may be deemed ‘unacceptable’, ‘offensive’ and/or ‘unlawful’. Unacceptable Internet use may be defined as one or more of the following:

- Creating, downloading and storing or displaying (other than authorised and lawful health care work or research) any obscene or indecent images, data or material or any data capable of being resolved into obscene or indecent images or materials;
- Creating, downloading or storing or displaying (other than authorised and lawful health care work or research) any defamatory, sexist, racist, offensive or otherwise unlawful images, data or other material;
- Creating, downloading, transmitting or displaying material which is designed or intended to annoy, harass, bully, inconvenience or cause needless anxiety to others;
• Downloading, installing and using unauthorised and unlicensed software or routines for purposes such as, but not limited to: streamlining video, audio or gaming;

• Creating or transmitting ‘junk mail’ or ‘spam’. This includes unsolicited commercial webmail, chain letters or advertisements;

• Using the Internet Service to conduct private or freelance business for the purpose of commercial gain; and

• Creating, downloading or transmitting data or material that is created for the purpose of corrupting or destroying other users data, computer installation or network.

10.50 Where there is disagreement upon any activity being investigated for being unacceptable, the final arbiter on what is or is not offensive material, or what is or is not permissible access to the Internet will be decided by ECCG’s Governing Body.

Unintentional Access to Obscene/Ilegal/Offensive Material

10.51 Any User accessing any site considered to be obscene or illegal or offensive in any way must logout of the site immediately. The user must then inform their Line Manager that they have accessed the site and detail how such access occurred.

Monitoring

10.52 All Internet users will be aware that all use of the Internet Service is subject to intense monitoring for compliance with this and other relevant ECCG policies and with ECCG’s regulatory obligations.

10.53 Any staff member deemed to have violated this Policy in any way will be subject to appropriate disciplinary proceedings, including where appropriate, suspension and instant dismissal.

10.54 Staff will be aware that any non-compliance with this Policy could result in a criminal act and would require ECCG to report the staff member to the Police.

Accounting and Audit

10.55 ECCG will monitor and record, as a minimum, the following events for use of the Internet Service for each individual user:

• User logon (user, time date);

• User logoff (user, time date);

• Duration times;
• Sites visited (recorded by URL or IP Address); and
• Date and time of such visits; and
• All download requests including file transfers.

10.56 All logging, accounting and audit information will be backed-up as appropriate and will be securely archived for a minimum of six months.

11. Dissemination

11.1 This Policy will be available via ECCG’s Intranet.

11.2 An approach to dissemination of this Policy has been agreed whereby all staff will be notified, by email, of the location and nature of this Policy.

12. Implementation of this Policy.

12.1 This Policy will be disseminated to all staff.

12.2 The Internet Policy declaration statement outlined in Section 10.5 will be added to the ‘New Starter Kit.’

12.3 The Policy is, and will continue to be supported by a framework of additional policies, technical standards, operational procedures and guidance, to ensure information security requirements are understood and met throughout the organisation. As stated previously, these will be updated, where necessary, following additional risk and gap analysis studies.

12.4 Training will from part of staff local induction so that the ECCG’s policy on the appropriate use of internet facilities and data confidentiality is reinforced with staff.
**Appendix 1 – Equality Impact Assessment Tool**

**Enfield Clinical Commissioning Group Equality Impact Analysis (EQIA) screening**

**Proposal Title: Internet Service Policy**

<table>
<thead>
<tr>
<th>Author /editor/assessors</th>
<th>At least one of the people carrying out an EQIA must be the person responsible for the policy/function/service</th>
<th>Andy Nuckcheddee, Interim Head of Governance &amp; Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Partners/decision-makers/implementers</td>
<td>Identify who else will need to be involved. This can be decision-makers, frontline staff implementing the policy, partner/parent organisations, etc</td>
<td>Reviewed by Executive Committee</td>
</tr>
<tr>
<td>Start Date</td>
<td>The EQIA should be started prior to policy/service development or at the design stages of the review and continue throughout the policy development/review. For an existing policy/service, any changes identified have to be implemented.</td>
<td>February 2013</td>
</tr>
<tr>
<td>End date</td>
<td>The EQIA will need to inform decision-making so the date should take this into account</td>
<td>March 2014</td>
</tr>
<tr>
<td>Due regard, proportionality and relevance in relation to the following characteristics</td>
<td>Has due regard been given to equality (i.e. promote equality of opportunity between communities, eliminate discrimination that is unlawful, promote positive attitudes towards communities) for this proposal/policy/function?</td>
<td>Please refer to completed EQIA assessment tool</td>
</tr>
<tr>
<td>• Gender including gender reassignment</td>
<td>Due regard has two linked elements: proportionality and relevance. The weight given to equality should therefore be proportionate to its relevance to a</td>
<td></td>
</tr>
<tr>
<td>• Race/ethnicity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Disability</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Age</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Religion or belief</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Please refer to completed EQIA assessment tool

Worksheet in K ECCG AUTHORISATION

![Worksheet in K ECCG AUTHORISATION](image-url)
<table>
<thead>
<tr>
<th>Topic</th>
<th>Description</th>
<th>Relevant Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pregnancy and maternity</td>
<td>particular function. The greater the relevance of a function/policy/proposal to equality, the greater regard that should be paid. Where it is concluded that the policy is not relevant for an EQIA, this should be recorded here with the reasons and evidence.</td>
<td></td>
</tr>
<tr>
<td>Sexual orientation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Deprivation</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Proposal/policy/function/service aims**

Consider:
- Why is the proposal/policy/function/service needed?
- What does ECCG hope to achieve by it?
- How will ECCG ensure that it works as intended?
- Who benefits?
- Who doesn’t benefit and why not?
- Who should be expected to benefit and why don’t they?

It is important that the CCG has an overarching policy that provides the framework for staff using internet services in the workplace.

**Evidence gaps**

Identify what evidence is available and set it out here. This includes evidence from involvement and consultation. Identify where there are gaps in the evidence and set out how these will be filled.

None currently identified

**Involvement & consultation**

What involvement and consultation has been done in relation to this (or a similar) policy or function, and what are the results?

What involvement and consultation will be needed and how will it be undertaken? Report any results.

CCG Executive Committee

**Addressing the impact**

**Outcome 1: No major change**: the EQIA demonstrates the policy/change is robust and there is no potential for discrimination or adverse impact

**Outcome 2: Adjust the policy**: the EQIA identifies potential problems or missed opportunities. Adjust the policy to remove barriers or better promote equality.

**Outcome 3: Continue the policy**: the EQIA identifies...
the potential for adverse impact or missed opportunities to promote equality. Clearly set out the justifications for continuing with it. The justification must be in line with the duty to have due regard. For the most relevant policies, compelling reasons will be needed.

**Outcome 4: Stop and remove the policy**: the policy shows actual or potential unlawful discrimination.
INFORMATION SHARING AND DISCLOSURE POLICY

<table>
<thead>
<tr>
<th>1. SUMMARY</th>
<th>This Policy defines the requirements for information sharing and disclosure with patients and third-parties for Enfield Clinical Commissioning Group and hosted organisations.</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. RESPONSIBLE PERSON:</td>
<td>Head of Governance</td>
</tr>
<tr>
<td>3. ACCOUNTABLE DIRECTOR</td>
<td>Aimee Fairbairns – Director of Service Quality and Integrated Governance</td>
</tr>
<tr>
<td>4. APPLIES TO:</td>
<td>All staff</td>
</tr>
<tr>
<td>7. EQUALITY IMPACT ANALYSIS COMPLETED:</td>
<td>Policy Screened</td>
</tr>
</tbody>
</table>
| 8. GROUPS/INDIVIDUALS WHO HAVE OVERSEEN THE DEVELOPMENT OF THIS POLICY: | Director of Service Quality and Integrated Governance  
Head of Governance and Risk  
Caldicott Guardian |
| 10. RATIFYING COMMITTEE (S) & DATE OF FINAL APPROVAL: | Executive Committee -30th January 2013  
ECCG Governing Body-13th February 2013 |
<p>| 11. VERSION: | 2 |
| 12. AVAILABLE ON: | Intranet | Website |
| 14. DISSEMINATED TO: | All Staff |
| 15. DATE OF IMPLEMENTATION: | April 2013 |
| 16. DATE OF NEXT FORMAL | March 2014, or sooner if there are changes to |
| REVIEW: | legislation etc. that impact on this policy and procedure |</p>
<table>
<thead>
<tr>
<th>Date</th>
<th>Version</th>
<th>Action</th>
<th>Author</th>
</tr>
</thead>
<tbody>
<tr>
<td>23.01.13</td>
<td>1</td>
<td>NCL Policy amended for adoption within ECCG</td>
<td>Alison Mitchell-Hall</td>
</tr>
<tr>
<td>28.01.13</td>
<td>2</td>
<td>Updated following internal review</td>
<td>Alison Mitchell-Hall</td>
</tr>
<tr>
<td>30/01/2013</td>
<td>3</td>
<td>Executive Committee</td>
<td>Andy Nuckcheddee</td>
</tr>
</tbody>
</table>
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>SECTION NO.</th>
<th>TITLE</th>
<th>PAGE NO.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Introduction</td>
<td>4</td>
</tr>
<tr>
<td>2</td>
<td>Policies Statement</td>
<td>4</td>
</tr>
<tr>
<td>3</td>
<td>Scope of this Policy</td>
<td>5</td>
</tr>
<tr>
<td>4</td>
<td>Policy Application</td>
<td>5</td>
</tr>
<tr>
<td>5</td>
<td>Definitions used in this Policy</td>
<td>6</td>
</tr>
<tr>
<td>6</td>
<td>Recommendations for Independent Contractors</td>
<td>7</td>
</tr>
<tr>
<td>7</td>
<td>Initiation, development and review of the policy</td>
<td>7</td>
</tr>
<tr>
<td>8</td>
<td>Risk rating of the policy</td>
<td>7</td>
</tr>
<tr>
<td>9</td>
<td>Data Protection Act Risks and Awareness</td>
<td>8</td>
</tr>
<tr>
<td>10</td>
<td>Specific Policy Requirements</td>
<td>9</td>
</tr>
<tr>
<td>10.1</td>
<td>General Responsibilities</td>
<td>9</td>
</tr>
<tr>
<td>10.2</td>
<td>Confidentiality</td>
<td>9</td>
</tr>
<tr>
<td>10.3</td>
<td>Sharing of PID Information</td>
<td>10</td>
</tr>
<tr>
<td>10.4</td>
<td>Sharing PID Information by Phone</td>
<td>10</td>
</tr>
<tr>
<td>10.5</td>
<td>Sharing PID Information by Post</td>
<td>11</td>
</tr>
<tr>
<td>10.6</td>
<td>Transporting PID Information</td>
<td>11</td>
</tr>
<tr>
<td>10.7</td>
<td>Sharing PID Information by Fax</td>
<td>11</td>
</tr>
<tr>
<td>10.8</td>
<td>Sharing PID Information by Email</td>
<td></td>
</tr>
<tr>
<td>10.9</td>
<td>Sharing the minimum amount of Information</td>
<td>11</td>
</tr>
<tr>
<td>10.10</td>
<td>Informing Patients</td>
<td>13</td>
</tr>
<tr>
<td>10.11</td>
<td>Consent – Explicit Consent</td>
<td>13</td>
</tr>
<tr>
<td>10.12</td>
<td>Consent – Young People</td>
<td>14</td>
</tr>
<tr>
<td>10.13</td>
<td>Consent – Patient unable to give Consent</td>
<td>14</td>
</tr>
<tr>
<td>10.14</td>
<td>Disclosure of Information</td>
<td>15</td>
</tr>
<tr>
<td>10.15</td>
<td>In the Public Interest and to protect the Public</td>
<td>15</td>
</tr>
<tr>
<td>10.16</td>
<td>Respect Patients' decisions to restrict the disclosure and/or use of information</td>
<td>16</td>
</tr>
<tr>
<td>10.17</td>
<td>The Implications of Disclosing and Not Disclosing</td>
<td>16</td>
</tr>
<tr>
<td>10.18</td>
<td>Use of PID Information by non-NHS Organisations</td>
<td>16</td>
</tr>
<tr>
<td>11</td>
<td>Dissemination</td>
<td>18</td>
</tr>
<tr>
<td>12</td>
<td>Implementation of this Policy</td>
<td>19</td>
</tr>
<tr>
<td>13</td>
<td>Appendix 1- Equality Impact Assessment</td>
<td>20-22</td>
</tr>
</tbody>
</table>
1. Introduction.

1.1 This Policy outlines, in broad terms, Enfield Clinical Commissioning Group (ECCG) requirements for communication and information sharing with patients and third-party organisations. The Policy outlines the need for effective and lawful communication with patients and third-parties within the context of ECCG legal and healthcare obligations.

1.2 This Policy outlines the ways in which ECCG communicates with its patients, and outlines how such communication should be undertaken. Types of communication include email, telephone, post and fax. In addition, this Policy outlines the requirements for developing and providing information to patients in the form of, for example, leaflets.

1.3 Obtaining consent from patients is a key activity of ECCG. This Policy outlines the considerations which must be undertaken when seeking to obtain consent, particularly when such consent is required from young people or where patients have difficulty in giving consent or worse, are unable to give consent.

1.4 Finally, this Policy outlines the requirements for the secure lawful handling of patient data by non-NHS organisations. Such instances will occur where ECCG has entered into an agreement with a third-party to undertake such storage or processing of patient data on behalf of ECCG.

1.5 Access to information that is deemed to be ‘personal’ is subject to the Data Protection Act 1998, the requirements for which are set out in the Data Protection Policy. The Data Protection Policy should therefore be consulted in handling any data requests for personal or Patient Identifiable Information (PID).

1.6 Access to information that is not deemed to be ‘personal’ may be subject to the Freedom of Information Act 2000, the requirements for which are set out in the Freedom of Information Policy. The Freedom of Information Policy should therefore be consulted in handling any requests for information that are not related to PID or personal data.

1.7 All staff and third-parties will be expected to comply with this Policy in full.

2. Policy statement

2.1 The Policy is intended to achieve the following Information Governance objectives:

Confidentiality – access to data and information must be confined to those users with a specific authority to view the data. The sharing and disclosure of any data and information must be appropriate and lawful;

Integrity – ECCG data and information must be complete and accurate, and protected from unauthorised modification. All systems, assets and networks must be operated in a manner to ensure that there is no unauthorised or
accidental modification of data and systems as a result of any deliberate or accidental misuse;

**Availability** – information must be available and delivered to the right person at the right time it is needed. ECCG must also ensure that it is able to respond to appropriate requests from patients; and

**Accountability** – users will be held responsible for their collection, use and processing of data and information. ECCG will ensure that, where appropriate, there is sufficient accountability for use and processing of data and information.

### 3. Scope of this policy

3.1 This Policy is applicable to all ECCG and hosted organisations IT and IS computer systems, databases, facilities and networks. It is also applicable to third-party IT and IS computer systems, databases, facilities and networks that are employed to provide services to ECCG.

3.2 This policy applies to all ECCG information and data, stored in relevant IT and IS systems and paper-based record systems that are comparable in structure to a computer system. This Policy applies to all sites used by the organisation and applies to all those having access to information, either on site or remotely. This includes, but is not limited to; staff employed by the organisation; those engaged in duties for the organisation under a letter of authority, honorary contract or work experience programme; volunteers and any other third party such as contractors, students or visitors.

### 4. Policy Application:

4.1 **Staff (including temporary staff)**

All staff employed by ECCG have a responsibility to ensure that:

- They work to the most up to date and relevant corporate and local Information Security policies; and
- They work to the most up to date and relevant Information Governance policies.

4.2 **Responsibilities of Employees**

All employed staff are responsible for carrying out their duties in line with the policies, to note new or amended policies and to contribute to policy making as necessary.

4.3 **Managers**

All staff with a supervisory role have a responsibility to ensure that:

- All staff have been shown how to access this Policy on the Intranet policy library;
- Local induction of newly employed staff includes being made aware of the relevant policies and how it impacts their own roles; and
Policies that they are responsible for are reviewed appropriately on an ongoing basis and are disseminated and implemented within services as directed.

5. **Definitions used in this policy**

**Asset**
Any information system, computer or programme owned by the organisation.

**Authorisation**
The granting or denying of access rights to network resources, programmes or processes.

**Caldicott**
A set of standards developed in the NHS for the collection, use and confidentiality of patient-related information.

**Data Controller**
A person who determines the purposes for which, and the manner in which, personal information is to be processed. This may be an individual or an organisation and the processing may be carried out jointly or in common with other persons.

**Data processor**
A person who processes personal information on a data controller’s behalf. Anyone responsible for the disposal of confidential waste is also included under this definition.

**Data subject**
This is the individual who is the subject of the personal information (data). A set of standards developed in the NHS for the collection, use and confidentiality of patient-related information.

**Internet**
A global system connecting computers and computers networks. The computers are owned separately by a range of organisations, government agencies, companies and educational institutes.

**Information Governance Toolkit**
A series of requirements, produced jointly by the Department of Health and NHS Connecting for Health.

**Network**
A system of interconnected computers which allows the exchange of information network connection. An individual's access to the network usually involves password checks and similar security measures.
Notifications
Notification is the process by which a data controller’s processing details are added to a register. Under the Data Protection Act, every data controller who is processing personal information needs to notify unless they are exempt. Failure to notify is a criminal offence. Even if a data controller is exempt from notification, they must still comply with the data protection principles.

Personal data
Personal data means information about a living individual who can be identified from that information and other information which is in, or likely to come into, the data controller’s possession.

Person Identifiable Data (PID)
PID may be defined as data that contains sufficient information to relate the data to a specific patient.

Processing
Processing, within the context of this Policy means obtaining, recording or holding the data or carrying out any operation or set of operations on data.

Software
Computer programmes sometimes also called applications.

Subject access request
Under the Data Protection Act, individuals can ask to see the information about themselves that is held on computer and in some paper records. If an individual wants to exercise this subject access request right, they need to write to ECCG.

6. Recommendations for Independent Contractors
As all staff and third-parties are expected to comply with this and other policies, there are no additional recommendations.

7. Initiation, development and review of the policy
This Policy meets all relevant requirements in its initiation, development and review.

8. Risk rating of the policy
All policies are required to possess an appropriate risk rating calculated by use of the organisation’s risk-rating matrix. This Policy has been given a risk rating of MODERATE. If PID or personal data were released to the wrong individual following a request under the Act, there would be a risk of adverse national publicity. Thus the risk impact score is Major (4). However, as the Information Manager will manage all Data Protection Act requests, this risk is not expected to occur given existing controls (2). Dissemination of this Policy to all staff...
involved in sharing and disclosing data and information also serves to significantly reduce the likelihood of this risk occurring.

9. **Data Protection Act Risks and Awareness**

9.1 All staff and other users including third-parties sharing and disclosing information and data, must be aware of the following risks and issues:

**Reputational Risk** – any errors in the sharing and disclosure of information could have an adverse impact upon the reputation of ECCG. The confidence that ECCG currently enjoys from the NHS Executive, patients and other key stakeholders could be seriously undermined by any misuse of personal data;

**Patient Distress** – incorrect sharing and disclosure of information could lead to severe stress and trauma for our patients as information on, for example, any medical conditions could be sent to the wrong users. Patients could take legal action against ECCG further undermining public confidence. Some four principal patient risks have been identified by the Data Sharing Review, 11 July 2008, conducted at the request of the Prime Minister:

1) **Indignity** – unnecessary exposure of facts/suspicions, for example, disclosure of a medical condition that may cause embarrassment;

2) **Injustice** – stigmatisation resulting from wrongly disclosed information, leading to loss or denial of, for example, employment, training or credit;

3) **Inappropriate Treatment** – unwarranted interventions by agencies into the lives of individuals or their families, for example with draconian action being taken by mental health or child protection workers based on misinterpreted/un-contextualised data; and

4) **Ineffective Service Delivery** – because, for example, individuals do not trust agencies sufficiently to provide full and accurate information as required.

**Legal & Regulatory Risk** – any errors in the sharing and disclosure of data and information could result in action being taken against ECCG by the Information Commissioner if it is deemed that breaches of the Act have occurred. In addition, the Information Commissioner, as a result of changes to the Criminal Justice Act 2008, now has the power to impose fines of up to £500,00.00 upon organisations and individuals who are aware of information risks but have not taken reasonable care and appropriate steps to mitigate those risks. Any legal and regulatory action against ECCG would be publicised and may be highly damaging to its reputation;

**The NHS Care Record Guarantee** – the NHS has published a ‘Guarantee’ on how it handles patient data including the duties of keeping records confidential, secure and accurate. Unauthorised access or modification of any patient data would breach such ‘guarantees’;
Human Rights Breaches – in a Landmark Judgement, the European Court of Human Rights found that in the case of *I v Finland*, a patients’ Right to Family Life under Article 8, was breached after a hospital was found not to have acted in accordance with the law in maintaining the claimant’s confidentiality pertaining to his medical records. Sufficient confidentiality of the claimant’s medical records. Failures in maintaining the confidentiality of patient data or records could give rise to a breach of privacy and confidentiality and therefore, interpreted by a Court of Law as a breach of a patient’s human rights by ECCG under the ECHR and the Human Rights Act 1998;

Staff Awareness – staff involved in any stage of sharing and disclosing data and information must fully understand and comply with this Policy and all other relevant policies. Staff must understand that they may be liable for any such loss, and that any breaches of this or any other policy may result in disciplinary action including dismissal. Staff must also be aware that they may be held personally liable by the Information Commissioner, and could face fines of up to £500,000;

Third-party Awareness – any user or third-party sharing and disclosing data and information on behalf of ECCG must comply with this Policy and all other relevant policies. Where third-parties do not comply with this Policy or any other relevant policy, ECCG will reserve the right to terminate all current contractual agreements with immediate effect. Third-party providers and their staff must also be aware that they may be held personally liable for any non-compliance with their statutory requirements by the Information Commissioner and could face fines of up to £500,000.

10. **Specific Policy Requirements**

10.1 **General Responsibilities**

The Chief Officer has overall responsibility for meeting the requirements of this Policy.

The Head of Governance and Risk, within the context of this Policy, will be responsible for promoting awareness of this Policy.

10.2 **Confidentiality**

The duty of confidentiality arises out of the common law of confidentiality, professional obligations and also staff employment contracts, including those for contractors. Breach of confidence, inappropriate use of health records or abuse of computer systems may lead to disciplinary measures, bring into question professional registration and possibly result in legal proceedings. Staff should ensure that they are aware of the requirements and standards of behaviour that apply.

Voluntary staff who are not employees and students are also under obligations of confidentiality and must sign the relevant confidentiality agreements.
Maintaining proper records is vital to patient care. If records are inaccurate, future decisions may be wrong and harm the patient. If information is recorded inconsistently, then records are harder to interpret, resulting in delays and possible errors. The information may be needed not only for the immediate treatment of the patient and the audit of care, but also to support research that can lead to better treatments in the future. The practical value of privacy enhancing measures and anonymisation techniques will be undermined if the information they are designed to safeguard is unreliable. The Information Lifecycle Management Policy provides further details on record management.

Staff should not leave portable computers, medical notes or files in unattended cars or in easily accessible areas. All files and portable equipment should be under lock and key when not actually being used.

Staff will not take patient records home, and where this cannot be avoided, procedures for safeguarding the information effectively should be agreed by the line manager. In handling such data, staff will comply with the Data Encryption Policy.

10.3 Sharing of Person Identifiable Data (PID) or Information

Where ECCG shares information with other organisations, an information sharing agreement will be implemented. The purpose of the agreement will be to facilitate the lawful exchange of personal and sensitive data, in any form, within and between organisations for notified and defined purposes, respecting the rights of individuals set out in the relevant legal acts and common law. It will cover the sharing of information that in any way, personally identifies living individuals. The principles may be used as a basis for any policy area that requires information to be shared such as protection of vulnerable people and children.

Staff will comply with the Email Policy, Internet Service Policy, Data Encryption Policy and the Safe Haven Policy when sharing information via email, faxes and internal and external post. Particular care is required when transferring confidential clinical information.

10.4 Sharing PID Information by Phone

When sharing PID information by phone, the staff member must:

- Confirm the name, job title, department and organisation of the person requesting the information;

- Confirm the reason for information request if appropriate;

- Take a contact telephone number, for example, the main switchboard number;

- Check whether the information can be provided. If in doubt, tell the enquirer you will call them back;
• Provide the information only to the person who has requested it. Do not for example leave such information in the form of a message; and

• Ensure that you record your name, date and the time of disclosure, the reason for it and who authorised it. Also record the recipient’s name, job title, organisation and telephone number.

10.5 Sharing PID Information by Post

When sharing information by post, the staff member must:

• Confirm the name, department and address of the recipient;
• Seal the information in a robust envelope;
• Mark the envelope ‘Private & Confidential – to be opened by Addressee only’;
• When appropriate, send the information by Recorded Delivery; and
• When necessary, ask the recipient to confirm receipt.

10.6 Transporting PID Information

When transporting personal information, staff must comply with all relevant policies including the Information Security Policy, the Safe Haven Policy, the Email Policy, the Internet Service Policy and the Data Encryption Policy.

10.7 Sharing PID Information by Fax

When sharing information by fax, staff will:

• Telephone the recipient of the fax to let them know they are going to send confidential information;
• Ask them to acknowledge receipt of the fax;
• double check the fax number;
• Us pre-programmed numbers whenever possible;
• make sure the fax cover sheet states who the information is for, and mark it ‘Private & Confidential’; and
• if appropriate, request a report sheet to confirm that transmission was received.
(Alison, how about sharing PID /information electronically) and the significance of using NHS net mail as it is encrypted and safe.

10.8 Sharing PID Information by Email

When sharing information by email, staff will:

- Comply with ECCG Email Policy

- The NHSmail Service is a secure service. All information that is sent within the service (i.e. from an @nhs.net to an @nhs.net address) is encrypted while in transit. This means NHSmail is authorised for sending sensitive information such as clinical data between NHSmail addresses.

- For the avoidance of doubt, NHSmail must not be used to send sensitive information from a @nhs.net account to a non-NHS account.

- Once a file has been sent, staff should consider whether it is necessary to delete the file from the email system.

- Staff should always request a delivery and read receipt so the User can be sure the information has been received safely. This requirement is especially important for time-sensitive information such as referrals;

10.9 Sharing the minimum amount of Information

It is important to minimise the amount of information to only that which is absolutely required. It is important to consider how much information is needed before disclosing it. Simply providing an entire medical file may not be appropriate and could lead to a potential breach of confidence. When seeking to share the minimum amount of information, it is important to:

- Justify the purpose (to be undertaken by ECCG staff irrespective of whether it is due to a request to provide information or to receive information from another source);

- Do not use patient identifiable information unless it is absolutely necessary;

- Use the minimum necessary patient identifiable information;

- Ensure that access to patient identifiable data and information occurs on a strict ‘need to know’ basis;

- Be aware of all relevant policies;

- and ensure appropriate sign-off from the Line Manager and Caldicott Guardian and full compliance with the Safe Haven Policy before releasing such data.
10.10 Informing Patients

The Data Protection Act 1998 requires that patients be informed, in general terms, how their information may be used, who will have access to it and the organisations that it may be disclosed to. The requirement falls upon both those who provide information and those who can receive it.

Where patients are to be offered choice about how information that relates to them might be used, they must also be made aware of their right to impose restrictions, even though this right will be provided in most circumstances by the common law of confidentiality rather than the Data Protection Act.

In handling any requests for personal data, staff will comply fully with the Data Protection Policy.

10.11 Consent – Explicit Consent

When seeking explicit consent from patients, the approach must be to provide:

- Honest, clear, objective information about information uses and their choices. This information may allow patients to seek as much detail as they require;
- An opportunity for patients to talk to someone they can trust and of whom they can ask questions;
- Reasonable time and privacy to reach decisions;
- Support and explanations about any form that they may be required to sign;
- A choice as to whether to be contacted in the future about further uses, and how such contacts should be made; and
- Evidence that consent has been given, either by noting this within a patient’s health record or by including a consent form signed by the patient.

The staff member must cover:

- A basic explanation of what information is recorded and why and what further uses may be made of it;
- A description of the benefits that may result from the proposed use or disclosure of the information;
- How the information and its future uses will be protected and assured, including how long the information is likely to be retained and under what circumstances it will be destroyed;
• Any outcomes, implications or risks if consent is withheld. This must be honest, clear and objective. It must not be or appear coercive in any way; and

• An explanation that any consent can be withdrawn in the future, including any difficulties in withdrawing information that has already been shared.

• The information provided must allow for disabilities, illiteracy, diverse cultural conditions and language differences.

10.12 Consent – Young People

Young people aged 16 or 17 years are presumed to be competent for the purposes of consent to treatment and are therefore entitled to the same duty of confidentiality as adults.

Children under the age of 16 years who have the capacity and understanding to take decisions about their own treatment are also entitled to make decisions about the use and disclosure of information they have provided in confidence.

When assessing these issues, staff will give consideration to the Fraser Assessment: ‘where a child is under 16, but has sufficient understanding in relation to the proposed treatment, to give (or withhold) his or her consent (or refusal) should be respected’. However the child should be encouraged to involve parents or other legal guardians.

Where a young competent person or child is refusing treatment for a life threatening condition, the duty of care would require confidentiality to be breached to the extent of informing those with parental responsibility for the child who might be able to provide the necessary consent to the treatment.

It is important to check that persons have proper authority, as parents or guardians. Ideally, there should be notes within the child’s case notes as to any unusual arrangements.

10.13 Consent – Patient unable to give Consent

If a patient is unconscious or unable, due to a mental or physical condition, to give consent or to communicate a decision, the health professionals concerned must take decisions about the use of information. This needs to take into account the patient’s ‘best interests’ and any previously expressed wishes, informed by the views of relatives or carers as to the likely wishes of the patient. If a patient has made his or her preference about information disclosures known in advanced, this should be respected.

Sometimes it may not be practical to locate or contact an individual to gain consent. If this is well evidenced and documented and anonymised data is not suitable, the threshold for disclosure in the public interest may be lessened where the likelihood of detriment to the individual concerned is minimal. Where explicit consent cannot be gained and the public interest does not justify breaching confidentiality, then support would be needed under Section 251 of the NHS Act 2006.
Where the patient is incapacitated and unable to consent, information should only be disclosed in the patient’s best interests and only as much information as is needed to support their care. This might, however, cause unnecessary suffering to the patient’s relatives and could in turn cause distress to the patient. Each situation must be judged on its own merits. Great care should be taken to avoid breaching confidentiality or creating difficulties for the patient. Decisions to disclose and the reasons for disclosing should be noted in the patient’s records.

Patients are often asked to indicate the person they would like to be involved in decisions about their care should they become incapacitated. This will normally, but not always, be the next of kin. It should be made clear that limited information will be shared with that person provided the patient does not object. This gives patients the opportunity to agree to disclosure or to choose to limit disclosure of information.

10.14 Disclosure of Information

The key principle of the duty of confidence is that information confided should not be used for disclosure further in an identifiable form, except where the confider has given his/her permission.

There are exceptions to the duty of confidence that may make use or disclosure of confidential information appropriate. Statute law requires or permits the disclosure of confidential patient and/or staff information in certain circumstances, and the Courts may also order disclosure.

10.15 In the Public Interest and to protect the Public

Under common law, staff are permitted to disclose personal information in order to prevent and support detection, investigation and punishment of serious crime and/or to prevent abuse or serious harm to other where they judge, on a case by case basis, that the public good that would be achieved by the disclosure outweighs both the obligation of confidentiality to the individual patients concerned and the broader public interest in the provision of a confidential service.

Whoever authorises disclosure must make a record of any such circumstances, so that there is clear evidence of the reasoning used and the circumstances prevailing. Disclosures in the public interest should also be proportionate and limited to relevant details. It may be necessary to justify such disclosures to the courts or to regulatory bodies and a clear record of the decision making process and the advice sought is in the interests of both the staff and ECCG.

Wherever possible, the issue of disclosure should be discussed with the individual concerned, and consent sought. Where this is not forthcoming, the individual should be told of any decisions to disclose against his or her wishes. This will not be possible in certain circumstances, for example, where the likelihood of a violent response is significant or where informing a potential suspect in a criminal investigation might allow them to evade custody, destroy evidence or disrupt an investigation.
Each case must be considered on its merits. Decisions will sometimes be finally balanced and staff may find it difficult to make a judgement. It may be necessary to seek advice from either ECCG Legal Services and/or the Head of Governance and Risk.

10.16 Respect Patients’ decisions to restrict the disclosure and/or use of information

Through the advent of electronic records and the Integrated healthcare Records System, NHS systems provide sufficient flexibility to meet all reasonable requests.

In some cases, it may not be possible to restrict information disclosure without compromising care. This would require careful discussion with the patient, but ultimately the patient’s choice must be respected.

In the short-term, it may not be possible to meet some patients’ requests directly though a compromise arrangement should be sought. This may require discussion about where the patients concerns really lie as it may be possible to allay concerns without significant change to the information disclosure arrangements in place or discussing options in the care process.

It is essential that complete records are kept of all care provided and of any restrictions places on disclosing by patients. When patients impose constraints it is important to demonstrate that neither patient safety nor clinical responsibility for healthcare provision has been neglected.

10.17 The Implications of Disclosing and Not Disclosing

In order to make valid choices patients must not only know what their options are, but also what are the consequences of making those choices. Explanations must be proportionate to the risks involved and reflect, where possible, the patient’s particular circumstances.

Where patients insist on restricting how information may be used or shared in ways that compromise ECCG ability to provide them with high quality care, this should be documented within the patient’s record. It should be made clear to the patient that they will be able to change their mind at a later point.

ECCG Information Security Policy outlines the ECCG technical and organisational measures that are to be taken against unauthorised or unlawful processing of personal data and against accidental loss or destruction of, or damage to, personal data.

10.18 Use of PID Information by non-NHS Organisations

When considering any proposals or initiatives to provide PID or personal data to a non-NHS entity, the Head of Governance and Risk and the Caldicott Guardian must be consulted in the first instance.
Where a non-NHS entity or individual is contracted to carry out or support a NHS function, the agreement between the parties must contain sufficient agreement on information sharing, confidentiality and integrity requirements and security requirements. This is highlighted further in the Safe Haven Policy.

11. Dissemination

This Policy will be available via the ECCG Intranet.

An approach to dissemination of this Policy has been agreed whereby all relevant staff will be notified, by email, of the location and nature of this Policy.

12. Implementation of this Policy.

This Policy is, and will continue to be, supported by a framework of additional policies, technical standards, operational procedures and guidance, to ensure that information governance requirements are understood and met throughout the organisation. As stated previously, these will be updated, where necessary following additional risk and gap analysis studies.
## Proposal Title: Information Sharing and Disclosure Policy

<table>
<thead>
<tr>
<th>Author /editor/assessors</th>
<th>At least one of the people carrying out an EQIA must be the person responsible for the policy/function/service</th>
<th>Andy Nuckcheddee, Interim Head of Governance &amp; Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Partners/decision-makers/implementers</td>
<td>Identify who else will need to be involved. This can be decision-makers, frontline staff implementing the policy, partner/parent organisations, etc…</td>
<td>Reviewed by Executive Committee</td>
</tr>
<tr>
<td><strong>Start Date</strong></td>
<td>The EQIA should be started prior to policy/service development or at the design stages of the review and continue throughout the policy development/review. For an existing policy/service, any changes identified have to be implemented.</td>
<td>February 2013</td>
</tr>
<tr>
<td><strong>End date</strong></td>
<td>The EQIA will need to inform decision-making so the date should take this into account</td>
<td>March 2014</td>
</tr>
<tr>
<td>Due regard, proportionality and relevance in relation to the following characteristics</td>
<td>Has due regard been given to equality (i.e. promote equality of opportunity between communities, eliminate discrimination that is unlawful, promote positive attitudes towards communities) for this proposal/policy/function?</td>
<td>Please refer to completed EQIA assessment tool</td>
</tr>
<tr>
<td>- Gender including gender reassignment</td>
<td>Due regard has two linked elements: <strong>proportionality and relevance</strong>. The weight given to equality should therefore be proportionate to its relevance to a particular function. The greater the relevance of a function/policy/proposal to equality, the greater regard that should be paid. Where it is concluded that the policy is not relevant for an EQIA, this should be recorded here with the reasons and evidence.</td>
<td></td>
</tr>
<tr>
<td>- Race/ethnicity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Disability</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Age</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Religion or belief</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Pregnancy and maternity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Proposal/ policy/function/service aims</td>
<td>Consider:</td>
<td></td>
</tr>
<tr>
<td>--------------------------------------</td>
<td>----------</td>
<td></td>
</tr>
<tr>
<td>Why is the proposal/policy/function/service needed?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>What does ECCG hope to achieve by it?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>How will ECCG ensure that it works as intended?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Who benefits?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Who doesn't benefit and why not?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>It is important that the CCG has a policy that provides the framework for information sharing in line with its Confidentiality policy.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Evidence gaps</th>
<th>Identify what evidence is available and set it out here. This includes evidence from involvement and consultation. Identify where there are gaps in the evidence and set out how these will be filled.</th>
</tr>
</thead>
<tbody>
<tr>
<td>None currently Identified</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Involvement &amp; consultation</th>
<th>What involvement and consultation has been done in relation to this (or a similar) policy or function, and what are the results? What involvement and consultation will be needed and how will it be undertaken? Report any results.</th>
</tr>
</thead>
<tbody>
<tr>
<td>CCG Executive Committee</td>
<td></td>
</tr>
</tbody>
</table>

| Addressing the impact | **Outcome 1: No major change:** the EQIA demonstrates the policy /change is robust and there is no potential for discrimination or adverse impact  
**Outcome 2: Adjust the policy:** the EQIA identifies potential problems or missed opportunities. Adjust the policy to remove barriers or better promote equality.  
**Outcome 3: Continue the policy:** the EQIA identifies the potential for adverse impact or missed opportunities to promote equality. Clearly set out the justifications for continuing with it. The justification must be in line with the |
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Outcome1</td>
<td></td>
</tr>
</tbody>
</table>

| | |
duty to have due regard. For the most relevant policies, compelling reasons will be needed.

**Outcome 4: Stop and remove the policy:** the policy shows actual or potential unlawful discrimination.
MEETING: Enfield Clinical Commissioning Group Governing Body
DATE: Wednesday 13th February 2013, 3.00-4.30 pm
TITLE: Enfield Clinical Commissioning Group Quality Report
LEAD DIRECTOR/MANAGER: Aimee Fairbairns Director of Quality Services and Integrated Governance (Designate)
AUTHOR: Aimee Fairbairns Director of Quality Services and Integrated Governance (Designate)
CONTACT DETAILS: Aimee.Fairbairns@nclondon.nhs.uk
Andy.Nuckcheddee@nclondon.nhs.uk
APPROVED BY: Enfield Quality and Safety Committee 6th February 2013
REVIEW DATE: N/A

SUMMARY:

This Quality Report will be a regular Governing Body paper and will reflect the work plan and priorities of the Enfield CCG Quality Directorate. This current report provides an update on quality since the January 2013 meeting to the Governing Body.

This Report has also been presented and discussed at Enfield CCG’s Quality and Safety Committee on 6th February 2013.

SUPPORTING PAPERS:

Minutes of January’s Q&S Committee

RECOMMENDED ACTION:

The Governing Body members are asked to note the contents of this report.

Plans supported by this paper: This paper supports the Enfield Clinical Commissioning Group’s (CCG) strategic plan to achieve a robust governance framework and to ensure service quality.

Audit Trail: This paper has been reviewed at the Enfield CCG Quality and Safety Committee on the 6th of February 2013

Patient & Public Involvement (PPI): Enfield CCG’s Quality and Safety Committee wishes to involve patients and the public at all levels within the CCG and will be working with its patients and public engagement committee to determine the most effective way to achieve this.
Equality Impact Assessment: N/A

Risks: Capacity, development, duplication and transition are all risks to quality and safety and are reflected in the corporate risk register

Resource Implications: Duplication of effort and resources during transition.

Report

1. Governance and Capacity Management Arrangements

Working with the Commissioning Support Unit (CSU) Enfield CCG will lead on the Clinical Quality Review Groups (CQR) of two contracts (BEHMHT and Barnet Chase Farm). The CSU Contract and Quality leads for these contracts will deliver the coordination, reporting and administration of the CQR meetings with leadership chairing and oversight from the CCG. This includes an annual work plan and reporting schedule for all quality and safety elements of contract reporting requirements for example complaints, safeguarding, incidents.

These arrangements are replicated across North Central London contracts. Enfield CCG has clear arrangements in place with NCL CCGs and the CSU to ensure reporting and assurance on quality monitoring across contracts. Enfield CCG Quality Team members will be in attendance at other key contract meetings, for example, North Middlesex University Hospital. The Quality and Safety Committee will receive CQR reports from all providers and will report these regularly (bi-monthly) to the Governing Body.

There are three key posts for the Governance team in Enfield CCG. The Head of Governance and Risk is due to start mid-March 2013. The Governance Manager and Risk Manager posts will be recruited to shortly and interim arrangements are in place to ensure capacity through transition.

2. Governing Body Nurse Leadership

ECCG has successfully appointed the Registered Nurse Member to the Governing Body. The post holder started on 1 February 2013. The role of the Governing Body Nurse is to ensure that the CCG has a strong strategic focus on high quality care and patient safety, promoting excellence in professional practice and leading quality improvements across care pathways and organisational boundaries. The post holder will lead on quality assurance and the quality framework for monitoring the clinical outcomes of all commissioned services.

3. Care Quality Commission’s (CQC) Registration & Deregistration

The CCG’s Quality & Safety Team has sought advice from the Care Quality Commission’s Compliance Inspector and its Registration Department in relation to the Enfield PCT’s current registration. The CCG has been formally advised by the CQC, that it should submit a cancellation form to deregister Enfield PCT as it is no longer providing any Regulated
Activity. The CCG has been advised that it does not require registration with the CQC as services do not fall within the scope of registration for Regulation Activities.

4. Risk Management

ECCG’s Quality & Safety Committee will have responsibility for reviewing the Quality and Safety Directorate’s Risk Register to ensure that risks relating to safety and quality are being managed and mitigated in accordance with the CCG’s Risk Management Strategy. It will also ensure that risks are escalated appropriately onto the Board Assurance Framework.

5. Policy Development, Review and Adoption

As part of the CCG Authorisation process and to deliver its statutory requirements from April 2013 a range of policies have been amended from existing North Central London policies. These have been reviewed through sub committees of the Governing Body and the Executive Group endorsed for adoption by the Governing Body. The latest batch recommended for adoption at the February’s Governing Body are all required for the registration with the information commissioner and as part of the CCG’s requirements for information governance.

If or when minor changes are required and in keeping with the Policy for the Development of Policies and Procedural Documents requirements these policies can be reviewed and amended by the relevant sub-committees.

Any significant changes within local, regional and or national policy that impact on any policy approved by the Governing Body will be effected accordingly and for the Governing Body’s approval.

6. Complaints

As part its commitment to drive quality improvement and ensuring that people who use NHS services have a positive experience of the care that they receive, the CCG is embedding complaints monitoring into its quality assurance framework. Complaints will be reviewed and discussed at CQR meetings where actions in relation to complaints can be monitored and utilised to inform future commissioning plans. The CCG will communicate concerns and complaints, along with resulting action taken to patients and the public via its website and through reports to the Quality and Safety Committee.

7. Quality Alerts

Enfield CCG has a system in place for receiving quality alerts from primary care practitioners. These alerts enable the proactive management of intelligence from primary care and are raised with the relevant services for action. It is planned to review and refresh the quality alert system in April 2013 to maximise the benefit this can bring.

8. Clinical Quality Reports (CQRs) from NHS Providers

The Quality Report to the Governing Body in March 2013 will include updates from the Clinical Quality Review Group reports from the meetings scheduled with providers in February 2013.
9. Quality Premium

The ‘Quality Premium’ has been outlined as part of the Operating Framework for the NHS Everyone Counts Planning for Patients 2013/14. It is intended to reward Clinical Commissioning Groups (CCGs) for improvements in the quality of the services that they commission and for associated improvements in health outcomes and reducing health inequalities. For example determining which aspects of premature mortality rates are of greatest relevance in their local population or communities. CCGs will be measured on three locally determined measures and on four set national quality measures.

- Potential years of life lost from causes considered amenable to healthcare: adults, children and young people
- Avoidable emergency admissions (a composite of four NHS Outcomes indicators)
- The Friends and Family test
- Incidence of healthcare associated infections (MRSA and Clostridium difficile)

The measures form part of the 2013/14 Operating Plan. This has been developed in partnership with key stakeholders including the Health and Well-being Board. The Quality and Safety Committee will further review and inform the local determined quality outcomes and make recommendation to the Governing Body for 2013/14.

Next Steps:

- To implement the CCG quality framework and schedule of work for the year;
- To collaborate effectively with other quality leads and CSU to mitigate the risk of transition and maximise efficiency;
- To enable and assure the clinical and integrated governance for Enfield CCG’s authorisation process;
- To continue to recruit to vacancies in the Quality Services Directorate;
- To monitor and highlight any risks regarding North Central London’s transition plan; and
- To review Francis Report released 6th February 2013 through the Q&S Committee and report back to the March 2013 Governing Body on requirements and actions.

End of Report
SUMMARY:

This report updates the Board on current finance issues in relation to the local Enfield NHS.

SUPPORTING PAPERS:

No additional supporting papers.

RECOMMENDED ACTION:

The Board is asked to note the report.

Objective(s) / Plans supported by this paper: The NHS North Central London Commissioning Strategy 2012-15 and Operating Plan for 2012-13.

Patient & Public Involvement (PPI): N/A

Equality Impact Analysis: N/A.

Risks: The risks of the work detailed in this paper are recorded on the Enfield Risk Register and Board Assurance Framework, or available as part of individual programmes of work.

Resource Implications: Resource implications are detailed in the paper where they are relevant to members.

Audit Trail: The Finance Report provides an audit trail of progress against statutory financial requirements.

Next Steps: This report will be produced for every meeting of the Board.
Summary

The purpose of this report is to provide Enfield Shadow Clinical Commissioning Group (CCG) Board with information on the financial position of NHS Enfield and the prospective position for the CCG.

This report covers the financial position for Month 9 2012/13 including the QIPP position.

Financial Position – Month 9 2012/13

Summary

The month 9 cumulative results show a deficit of £557k against a zero budget. The shortfall is primarily made up of overspends on National Commissioning Board budgets (Specialist Commissioning) and unidentified QIPP. The forecast to the end of the year shows a deficit of £3,466K with Specialist Commissioning £1,180k and an unallocated QIPP deficit of £6,107k the key items. These are partially offset by underspends on Prescribing £800k, Non Acute Commissioning Budgets of £325k, Operating Costs £569k plus the Contingency Reserve of £2.4m.

Results

The results are shown below together with comments as follows:

<table>
<thead>
<tr>
<th>EXPENDITURE</th>
<th>YTD Budget</th>
<th>YTD Actual</th>
<th>YTD Variance</th>
<th>Variance %</th>
<th>Full Year Budget</th>
<th>Full Year Actual</th>
<th>Full Year Variance</th>
<th>Variance %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prescribing</td>
<td>28,517</td>
<td>27,424</td>
<td>1,093</td>
<td>3.8%</td>
<td>38,022</td>
<td>37,222</td>
<td>800</td>
<td>2.1%</td>
</tr>
<tr>
<td>Acute &amp; Integrated Care Total</td>
<td>203,922</td>
<td>203,701</td>
<td>221</td>
<td>0.1%</td>
<td>272,383</td>
<td>272,292</td>
<td>91</td>
<td>0.0%</td>
</tr>
<tr>
<td>Non Acute</td>
<td>68,794</td>
<td>68,536</td>
<td>257</td>
<td>0.4%</td>
<td>93,071</td>
<td>92,746</td>
<td>325</td>
<td>0.3%</td>
</tr>
<tr>
<td>CCG Total Budgets</td>
<td>301,232</td>
<td>299,662</td>
<td>1,571</td>
<td>0.5%</td>
<td>403,476</td>
<td>402,260</td>
<td>1,216</td>
<td>0.3%</td>
</tr>
<tr>
<td>NCB shadow budgets Total</td>
<td>65,244</td>
<td>66,396</td>
<td>(1,151)</td>
<td>(1.8)%</td>
<td>87,000</td>
<td>88,532</td>
<td>(1,532)</td>
<td>(1.8)%</td>
</tr>
<tr>
<td>Public Health Total</td>
<td>2,894</td>
<td>2,691</td>
<td>202</td>
<td>7.0%</td>
<td>3,858</td>
<td>3,858</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>Operating Costs Total</td>
<td>12,928</td>
<td>11,306</td>
<td>1,622</td>
<td>12.5%</td>
<td>17,199</td>
<td>16,630</td>
<td>569</td>
<td>3.3%</td>
</tr>
<tr>
<td>Reserves and Contingencies</td>
<td>(647)</td>
<td>2,143</td>
<td>(2,790)</td>
<td>0.1%</td>
<td>4,980</td>
<td>(3,719)</td>
<td>(3,719)</td>
<td>(3.7)%</td>
</tr>
<tr>
<td>Total Expenditure</td>
<td>381,641</td>
<td>382,198</td>
<td>(556)</td>
<td>(0.1)%</td>
<td>512,793</td>
<td>516,259</td>
<td>(3,466)</td>
<td>(0.7)%</td>
</tr>
<tr>
<td>Revenue Resource</td>
<td>381,641</td>
<td>381,641</td>
<td>0</td>
<td>0.0%</td>
<td>512,794</td>
<td>512,794</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>Net Surplus/Deficit</td>
<td>0</td>
<td>557</td>
<td>(556)</td>
<td>(0.1)%</td>
<td>(1)</td>
<td>3,465</td>
<td>(3,466)</td>
<td>(0.7)%</td>
</tr>
</tbody>
</table>

1. The total expenditure for the 9 months was £382,198k against the budget of £381,641k, an over spend of (£557k) (0.1%).

2. Performance against the Prescribing budget has improved further with a forecast underspend of £800K by year end.

3. Performance against the acute contracts budget has improved by £1,372k due to the release of the emergency threshold monies into the financial position.
4. The Non Acute figures show a small under spend of £63k (0.8%) in month and a year to date underspend of £257k (0.4%).

5. NCB Shadow budgets were overspent by £1,151k (1.8%). The key impact comes from Specialist Commissioning particularly Special Care Baby Unit activity.

6. Public Health costs show a saving to date against budget of £202k (7.0%).

7. Operating costs show a saving against budget of £1,612k (12.5%) to date, primarily from estates costs (under budget by £898k) and capital charges (depreciation for owning assets) – a saving of £576k for the nine months.

8. Finally ‘Reserves and contingencies’ show an over spend against budget of £2,790k. This relates to unallocated QIPP of £4,580k offset by £1,791k of contingency, the total available at month 9.

QIPP
The Enfield QIPP target is £31.6m of which £6.5m has been addressed through non-recurrent support, leaving a target of £25.1m. The QIPP schemes identified have been successful, though currently there is still an unallocated QIPP target of £6.1m.

RUN RATE
The run rate is being monitored closely and the current estimate is that it will be at £19.2m as at 31 March. A plan to eliminate the run rate by 2014/15 is currently being prepared.

Richard Quinton,
Director of Finance and Commissioning – Enfield
### EXECUTIVE SUMMARY:

1.1 This report provides an update on the work of joint commissioning across health and social care in Enfield.

1.2 Updates for all key commissioning areas are included, as are relevant updates on commissioning activity from Partnership Boards.

1.3 At the Health and Well Being Board and CCG briefing event on 28 January the alignment between the JSNA, Draft Health and Well Being Strategy and CCG Integrated Commissioning Plan was reviewed and agreed for recommendation to the 14 February Health and Well Being Board meeting.

1.4 The report notes that:

- the NHS Social Care Grant will continue in 2013 / 2014 and Enfield Council has been allocated £4,300,000;

- work is underway to recruit a Local Healthwatch Chair and establish a Local Healthwatch Steering Group, following consultation feedback that indicates a preference for developing a new single independent Healthwatch organisation for Enfield,
• an expression of interest has been submitted to the Department of Health seeking £350,000 capital funding to improve the environment of care for people with dementia in Enfield;

• the Department of Health has allocated the local authority £882,000 non-recurring Winter Capacity funding for social care for the 2012/2013 winter period;

• the Council and its partners have provided a range of schemes through the (part-Department of Health funded) £225k Warm Homes & Healthy People Fund specifically to assist vulnerable people keep warm in the winter of 2012/13;

• borough specific and tri-borough Commissioning Intentions for Mental Health services have been produced and are currently informing contract negotiations with the Mental Health Trust;

• the Council and its partners have submitted bids to the Mayor’s Care & Support Specialist Housing Fund for capital funding of over £900,000 to improve specialist accommodation for people with disabilities in the borough;

• on Wednesday 23rd January Cabinet approved the Voluntary & Community Sector Strategic Framework (VCSSF) and the Joint Carers Strategy (which was also approved at the CCG Governing Body meeting on 16th January);

• progress is being made on the implementation of Joint Commissioning Strategies, in particular the Joint Intermediate Care & Reablement Strategy;

• work is underway to ensure the smooth transition of NHS Public Health contracts to the local authority: contracts from the NHS will be transferred or waived as at 1st April 2013;

• NHS Enfield CCG has developed Commissioning Intentions that span six key themes to guide commissioning activity in 2013/2014: joint commissioning activity is central to the delivery of these key commissioning intentions, particularly in relation to Integrated Care, Children and Young People and Mental Health;

• the preparation of the Joint Strategic Needs Assessment and Health & Wellbeing Strategy is underway: development of these documents is a joint responsibility and appropriate joint commissioning representation, including representation from the Clinical Commissioning Group, is being secured throughout.

• the Joint Commissioning Board is now established to implement priorities within the framework set by the Joint Strategic Needs
Assessment, Health & Wellbeing Strategy and CCG Integrated Commissioning Plan and terms of reference and governance structures have been agreed.

SUPPORTING PAPERS:

APPENDIX A : Joint Strategy Implementation Progress Update
APPENDIX B: Mental Health Commissioning Intentions (available as extract from CCG Operating Plan)
APPENDIX C: NHS Enfield CCG Commissioning Intentions (available extract from CCG Operating Plan)
APPENDIX D: Joint Commissioning Board Terms of Reference and Governance Structure

RECOMMENDED ACTION:

The Governing Body is recommended to:

NOTE the content of this report.

NOTE that the Finance Recovery and QIPP Committee will receive regular reports from the Joint Commissioning Board and that the Governing Body will receive at least an annual report on Joint Commissioning, including performance and review of Section 75 agreements.

Objective(s) / Plans supported by this paper:

<table>
<thead>
<tr>
<th></th>
<th>Enable the people of Enfield to live longer fuller lives by tackling the significant health inequalities that exist between communities</th>
<th>Yes - Duty to reduce Inequalities</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>Provide children with the best start in life</td>
<td>Yes - Duty to reduce Inequalities</td>
</tr>
<tr>
<td>3</td>
<td>Ensure the right care in the right place, first time</td>
<td>Yes – Duty to promote Innovation</td>
</tr>
<tr>
<td>4</td>
<td>Deliver the greatest value for money for every NHS pound</td>
<td>Yes - Duty to ensure efficiency and effectiveness</td>
</tr>
<tr>
<td>5</td>
<td>Commission care in a way which delivers integration between health, primary, community and secondary care and social care services</td>
<td>Yes – Duty to promote integration</td>
</tr>
</tbody>
</table>

Patient & Public Involvement (PPI):

The Joint Commissioning Board enables both the CCG and HWBB to combine patient and public engagement activities to reduce the duplication in public engagement activities by targeting communications, engagement and consultations through existing channels and optimise initiatives targeted at including those communities and individuals who may be excluded from existing arrangements.
Equality Impact Analysis: NR

Risks:

Risk management arrangements are contained with Section 75 Agreements.

Resource Implications:

Joint Commissioning capacity is included within the CCG and Council’s respective management structures.

Audit Trail:

Joint Commissioning Board.
Finance Recovery and QIPP Committee
Health and Well Being Board

Next Steps:

the Joint Commissioning Board is now established to implement priorities within the framework set by the Joint Strategic Needs Assessment, Health & Wellbeing Strategy and CCG Integrated Commissioning Plan and terms of reference and governance structures have been agreed.

1. INTRODUCTION

1.1 This report provides an update on the work of joint commissioning across health and social care in Enfield.

1.2 Updates for all key commissioning areas are included, as are relevant updates on commissioning activity from Partnership Boards.

2. JOINT COMMISSIONING SERVICE

2.1 Interim Commissioning Manager (Public Health) Christine Williams commenced her role within the Joint Commissioning Team in November 2012. The post is contracted for six months and the post holder will have the responsibility of leading on the transition of NHS Public Health contracts to the local authority (see 8.11).

3. SECTION 75 AGREEMENT – COMMISSIONED SERVICES FOR ADULTS

3.1 A comprehensive review of the Section 75 Agreement relating to commissioned services for adults is scheduled for March 2013. A supplementary note will be agreed between the Parties prior to April 2013 to highlight variations to the Agreement in 2013/2014. This will include changes relating to the transfer of the Agreement from the Primary Care Trust to the Clinical Commissioning Group.
4. SECTION 75 AGREEMENT – COMMISSIONED SERVICES FOR CHILDREN, YOUNG PEOPLE AND FAMILIES

4.1 The Section 75 Agreement relating to commissioned services for children was signed under seal in November 2012 and is now operational. The Agreement will be in place until 31st March 2013. The Clinical Commissioning Group have not issued notice, so the Agreement will continue over 2013-2014. The Agreement will be subject to a review at the end of March 2013.

5. NHS SOCIAL CARE GRANT

5.1 The Department of Health has announced that the NHS Social Care Grant will continue in 2013/2014. Enfield Council has been allocated £4,300,000 from this funding source. The Council and NHS Enfield / Enfield Clinical Commissioning Group are compiling an indicative spending plan for approval. This will outline how this funding will be used to support joint priorities across health and social care.

6. THE IMPLEMENTATION OF JOINT COMMISSIONING STRATEGIES

6.1 Good progress is being made on the implementation of Joint Commissioning Strategies, in particular the Joint Intermediate Care & Reablement Strategy. Early indications signify improvement in relation to a number of key outcomes, for example, the proportion of people who choose to die in a place of their choice (End of Life Strategy).

6.2 A summary of progress made against objectives set out Enfield’s Joint Strategies, including the Dementia Strategy, End of Life Strategy, and Intermediate Care & Reablement Strategy and can be located in Appendix A.

7. ENFIELD HEALTHWATCH

7.1 Following a programme of consultation and engagement regarding Healthwatch in Enfield, the views of key stakeholders and residents have now been analysed. Feedback indicates a preference for developing a new single independent Healthwatch organisation for Enfield. Based on this, and in order to progress with establishing a Healthwatch in Enfield, the Council has agreed to:

- the recruitment of a Local Healthwatch Chair and Board members;
- establish a Local Healthwatch Steering Group reporting to the Joint Commissioning Board;
- procure the services of an organisation to support the development of a new independent Healthwatch organisation and, on an interim basis, deliver the functions of Healthwatch as directed by the Chair and Board.
7.2 The Council’s Director of Health, Housing and Adult Social Care has acknowledged that aspects of this process have not been handled or communicated as well as they should have been. A new lead officer is in place and constructive dialogue with local stakeholders is ongoing and continues to inform future plans.

8. COMMISSIONING ACTIVITY

The scale of joint commissioning activity is significant. This report seeks to update the Clinical Commissioning Group on key areas of commissioning activity worth particular note.

8.1 Older People

8.1.1 Dementia Care Environments

In January 2013 an expression of interest was submitted by the Joint Commissioning Team to the Department of Health seeking funding to improve the environment of care for people with dementia. This expression of interest was for £350,000 against the £25,000,000 capital investment to create dementia-friendly environments in care homes. North Middlesex University Hospital NHS Trust also bid £32,000 against the NHS capital to improve toilet facilities in their outpatient department. Enfield should hear whether this bid is successful by the end of February 2013.

8.1.2 Winter Capacity Funding

In late December 2012, the Department of Health announced Enfield’s allocation for non-recurring Winter Capacity funding for social care as £882,000 for 2012/13. Decisions are being finalised about the transfer of monies between NHS Enfield Clinical Commissioning Group and the London Borough of Enfield to increase social care and intermediate care capacity during the winter, and to improve prevention for this, and next, winter. NHS London have announced additional funding to acute Trusts to maintain or improve A&E performance, ambulance handover times, or provision of community-based beds in the winter. Both North Middlesex University Hospital and Barnet & Chase Farm acute Trusts have had their bids approved (total: £2,200,000).

8.1.3 Warm Homes Initiative

The Council and its partners have provided a range of schemes through the (part-Department of Health funded) £225,000 Warm Homes & Healthy People Fund, specifically to assist vulnerable people keep warm in the winter of 2012/13. This is a 46% increase on the previous year. A total of 16 organisations were supported through this initiative.
8.1.4 My Home Life (MHL)

Work continues to implement Phase Two of the My Home Life programme. Four meetings of the Quality Counts Focus Group have now taken place, focussing on safeguarding issues and the transition of residents between care homes and hospitals. The next meeting will be held on Monday 18th March 2013. A My Home Life (MHL) celebratory event is scheduled for Tuesday 12th February 2013 from 10am to 4pm at the Dugdale Centre. The one day event will provide an opportunity to celebrate the achievements of care homes who have participated in the programme, share learning and good practice and discuss how partners can work together to further improve the quality of life of older people in care homes.

8.2 Mental Health

8.2.1 Commissioning Intentions for Mental Health

Commissioning Intentions for Mental Health in Enfield have been produced and are currently being used as part of the contracting negotiations with the Mental Health Trust. Two sets of Commissioning Intentions have been developed. The first details Enfield (specific) Commissioning Intentions and the second details Tri Borough Commissioning Intentions (these are an extract from the CCG Operating Plan, available on request as Appendix B).

8.2.2 Section 117 – Continuing Care

Rising demand for S117 placements (aftercare following inpatient mental health treatment under a section) is being experienced with limited discharges from the section. This is creating a significant financial and capacity issue for local services. It is proposed that all cases are now reviewed using the Care Funding Calculator and Richmond Model to identify efficiencies and apportion 50% costs between Health and Social Care. This will generate efficiencies and create a fairer allocations process.

8.2.3 Improved Access to Psychological Therapies (IAPT) – Talking Therapies

A demand and capability exercise has been proposed to look at the current capacity utilisation of IAPT services and the potential to increase it to a more optimum level. This will inform a re-procurement of the provision of talking therapies. IAPT provision under AQP has been recommended by the Department of Health as a way to achieve better quality outcomes for patients, cap and control costs associated with delivering psychological therapies and increase patient choice – in particular for those from BME groups. The CCG is reviewing the most appropriate and effective way to re-procure the provision of IAPT talking therapies.

8.2.4 Return to Employment

A procurement exercise to commission work opportunities, support and associated employment activity for people with mental health issues is
nearing completion. Submissions have now been received and evaluated by the project group. A service provider has been selected and notified at the end of January 2013.

8.3 Learning Disabilities

8.3.1 Learning Disabilities Self Assessment

The National Commissioning for Quality Learning Disabilities Health Self Assessment was submitted on the 1st of August 2012 in accordance with the programme timeline. The locality has now received formal feedback which indicates significant improvement from last year’s submission across all areas. A formal report on feedback received is now being finalised. An implementation plan will be drafted and implemented by the LD Partnership Boards Health Sub Group by March 2013.

8.3.2 Autism Action Plan

Development of the Autism Action Plan in response to the government’s strategy for adults with Autism - Fulfilling and Rewarding Lives 2010 is progressing. A final draft version of the proposed Action Plan has been written and will be ready for consultation launch by mid-February 2013. The official launch of the Action Plan is anticipated to take place in July 2013.

8.4 Carers

8.4.1 Carers Direct Payment Scheme

The Carers Direct Payment Scheme continues to be a success with 41 carers having received the Direct Payment. As the pilot year ends in April, meetings will take place in January and February to undertake a full evaluation of the scheme. This will include feedback from Carers.

8.4.2 Carers Rights Day

Carers Rights Day took place on Friday 30th November at the Civic Centre, organised by the Council, Enfield Carers Centre and the Carers Hub. Approximately 70 carers attended the day. The event included presentations on the upcoming Enfield Joint Carers Strategy, Financial Assessment, Welfare Benefits Reform and Enfield Carers Centre services.

8.4.3 Primary Care Strategy

Joint working has led to a bid being submitted between NHS Enfield, the Council and Enfield Carers Centre for additional carer focused posts – namely a Carers Nurse to undertake health checks and support carers with their health and a Primary Care Development Officer to work with GPs and pharmacists to identify, refer and support carers. The first stage bid has been successful and will be taken to the North Central London NHS
Programme Board before the end of the financial year. If successful, recruitment will begin immediately.

8.4.4 The Joint Carers Strategy

The Joint Carers Strategy was approved at Cabinet on Wednesday 23rd January. The document provides a framework for improving carer services in Enfield. The Strategy was approved at the CCG Governing Body’s meeting on 16th January. A formal event to launch the Joint Carers Strategy is planned for February 2013.

8.5 Specialist Accommodation

8.5.1 Mayor’s Care & Support Specialist Housing Fund

In January 2013 the Joint Commissioning Team, in partnership with housing colleagues, submitted two bids to the Mayor’s Care & Support Specialist Housing Fund for capital funding to improve specialist accommodation for people with disabilities in the borough. If the Council is successful in its application, funding obtained will support the development of:

- accessible shared ownership opportunities for people with disabilities;
- specialist rented accommodation for people with physical disabilities, who require accessible, suitably adapted housing (including family housing) to live independently within the community.

The Council has further supported the submission of a bid from Newlon Housing Trust, to improve specialist accommodation for adults with learning disabilities in the borough. Should the bid be successful, funding will support the improvement of specialist services for older people with learning disabilities and dementia care needs, people with Profound and Multiple Learning Disabilities (PMLD) and people with Autism.

8.6 Children

8.6.1 The Health Visiting Service

Changes in the NHS London definition of who to include in the Health Visiting count mean that the BEH MHT are now reporting a funded workforce of 55.14, target for 2012/13 of 48.7 and number of Health Visitors in post as 43.54. Caseloads remain high and in order to ensure that progress can be accurately tracked, they will be monitored against old and new definitions. Since the last report, and confirmation of the upgrade, two new Health Visitors have been appointed and dates have been set to interview a further three candidates. Responsibility for commissioning Health Visiting Services passes to the National Commissioning Board from April 2013.
8.6.2 Occupational Therapy Service

A Serious Incident Report, including action plan, on the backlog of OT cases will be discussed at the Clinical Quality Review Group on the 23rd January 2013. A joint service review has been agreed and is in progress. Enhanced activity and KPI reports are being negotiated as part of the 2013/14 contract.

8.6.3 Paediatric Integrated Care

BCF and NMH have agreed to participate in the Primary Care paediatric pilot and are currently reviewing expressions of interest from GPs to host the service.

8.6.4 Maternity Services

A second children’s health commissioner has started work and will lead on maternity. Initial focus will be on the Early Access to Maternity Services target, supporting the implementation of the new maternity tariffs and reviewing pathways into the maternity day unit at Chase Farm Hospital.

8.6.5 CAMHS

Consideration is being given to making an application for CAMHS IAPT, which unlike the adults programme, is a training and transformation support scheme, with a small amount of funding for backfill of existing staff. The scheme is evidence based, focussed on improved outcomes, and will support PbR implementation.

8.7 Drug and Alcohol Team (DAAT)

8.7.1 Successful Treatment Completion

The PbR providers have undertaken a comprehensive review of service users in Quarter 3 and local analysis of Successful Treatment Completion data is indicating that the DAAT Partnership’s performance is now on target to be in line with the National Average.

8.7.2 Assessment and Care Review Team

The DAAT managed Assessment and Care Review Team has experienced a 53% growth in new assessments over 2011/2012 performance levels and the Number in Effective Treatment forecast is showing that the DAAT remains on target to meet the end of year position. Performance for alcohol users in treatment continues to show an upward trend with providers achieving above target performance.

8.7.3 Alcohol Liaison at Chase Farm Hospital
The Alcohol Liaison post at Chase Farm Hospital became operational at the start of July 2012. The specialist nurse has now trained 90% of A&E staff and patients are screened using the Paddington Alcohol Test. To date, of the 1184 patients screened, 101 were provided with a full assessment and 66 of these referred onto community services for treatment interventions in more appropriate settings. It is anticipated that this provision will have significant cost benefits for the CCG with reduced pressures on acute presentations.

8.7.4 Sort it! Compass

The young people’s substance misuse service (Sort it! Compass) has made good progress with establishing a new Hidden Harm Service for children affected by parental drug or alcohol misuse. Services of this nature have demonstrated efficacy for reducing fostering/adoption pressures and also increasing safety through reduced repeat incidents of drug or alcohol related domestic violence. Sort it! Compass have also seen more young people in the previous 12 month rolling period than in any comparative period in the previous 5 years; with 116 using the treatment services this year. The active caseload is now 73 and Sort it! Compass are working in partnership with the Youth Offending Service to ensure that between 12 and 20 young drug/alcohol offenders are appropriately supported each week.

8.8 Safeguarding

8.8.1 Safeguarding Adults Board

The Board has reviewed its governance structure and four sub-groups have been agreed to support both strategic and operational developments for safeguarding adults. These four sub groups are chaired by Board partners and consist of 1.) Quality, Performance and Safety group 2.) Policy, Procedure and Practice group 3.) Learning and Development group and 4.) Service Users, Carers and Patient group.

8.8.2 Winterbourne View Hospital

A report on Winterbourne View Hospital was presented in December 2012 to the Board, outlining the recommendations made from the Serious Case Review, Care Quality Commission Internal Review and Inspections, Department of Health Interim Report and the Mencap Report. The response that Enfield Council has made to these recommendations and actions to prevent this level of abuse were outlined. All Board partners have agreed to provide a response to the recommendations from their organisations at the Board in March 2013.

8.8.3 External Audit

To provide assurance that the response to reports of abuse continues to be robust and in line with the pan London policy and procedures on safeguarding adults, an external audit of case practice and organisational
learning is being completed in March 2013. This audit will ensure that service user participation is being promoted and evidenced, and that timescales are adhered to in the best interest of the service user.

8.8.4 Quality Checker Programme

The Quality Checker programme has 35 volunteers and is in the process of recruiting and training 50 volunteers by the end of March 2013 who will visit services and give their view on the quality of care. To date, the quality checkers have visited 20 sites covering In-house Provider services and Community Equipment Retailers (TCES).

8.9 Voluntary & Community Sector Strategic Commissioning Framework (VCSSCF)

8.9.1 The framework was presented to Cabinet on Wednesday 23rd January 2013, where approval for implementation was agreed. Work plan priorities to take this forward include:

- publication and dissemination of the final framework;
- phased implementation of the ‘third sector review’ to ensure that the current suite of grants are strategically relevant and provide value for money;
- the commissioning of information, advice, advocacy and a range of preventative services

8.10 Personalisation

8.10.1 Enfield’s E-market place

The development of Enfield’s social care E-market place continues. The e-market place enables people to view clear, accessible information on services and providers, and allows individuals to purchase services using a personal budget or their own funds. It will substantially increase the availability of information and therefore choice in the social care market.

8.10.2 MySupportBroker

In 2012 the commissioning team worked with MySupportBroker to develop a cohort of peer-brokers. These brokers have now been trained and accredited and are starting to receive their first referrals. This new external brokerage service provides service users with increased choice and control over their support planning and brokerage services whilst utilising peer experience / skills and developing community employment opportunities.

8.11 Public Health Transition

8.11.1 Work is underway to ensure the smooth transition of NHS services to the local authority. This includes the safe transition of sexual health contracts to ensure minimal disruption to service users. Communications with North
Central London have improved and information/contracts are being filtered to the local authority. However, there remain significant information gaps. A meeting has taken place between with North Central London Cluster (NCL) Director of Contracts, LBE, Public Health, CCG & CSU senior management to discuss the transition of contracts and agree next steps to ensure that the local authority can influence the contract(s) that it will take over. Contracts from the NHS will be transferred or waived as at 1st April 2013 and work is underway to ensure appropriate governance arrangements are in place.

8.12 Integrated Care

8.12.1 Integrated Care is a key strategic programme within Enfield. Current work within the Enfield Integrated Care for Older People Programme focuses on three core work streams: Primary Care Development, Specific Strategies for Older People and Admission Avoidance/ Early Supported Discharge (as set out below).

<table>
<thead>
<tr>
<th>Enfield Integrated Care for Older People Programme</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Primary Care Development</strong></td>
</tr>
<tr>
<td>Specific Strategies for Older People</td>
</tr>
<tr>
<td>Admission Avoidance &amp; Early Supported Discharge</td>
</tr>
<tr>
<td>Primary Care Networks</td>
</tr>
<tr>
<td>MDT Case Management</td>
</tr>
<tr>
<td>Risk Stratification</td>
</tr>
<tr>
<td>IT Solution to Integrated Care</td>
</tr>
</tbody>
</table>

8.12.2 The Joint Commissioning Board has received an initial update on progress across these three work streams. A second progress update will be provided to the Joint Commissioning Board in February.

9. ENFIELD’S JOINT STRATEGIC NEEDS ASSESSMENT (JSNA)

9.1 A Head of Public Health Strategy has been recruited to coordinate the preparation of the Joint Strategic Needs Assessment (JSNA) and the development of the Health and Wellbeing Strategy and a Project Manager specifically for the JSNA is now in post.

9.2 Additional data analyst capacity will also be in place by mid-February and there have already been two meetings of the JSNA project steering group with a project planning document and appropriate terms of reference prepared.
9.3 The preparation of the JSNA and HWS is a joint responsibility and appropriate representation from the Clinical Commissioning Group will be secured throughout.

9.4 The project planning work that has been done has highlighted the tight deadlines that need to be met to deliver the core data refresh and the other agreed outputs, including ‘on line access’ to the data, information for local residents and drill down factsheets in key areas, by the end of April 2013.

9.5 This clear risk of slippage will be closely monitored and mitigated by:

- prioritising those deliverables essential to inform the development of the health and wellbeing strategy and the accompanying consultation exercise
- securing additional external capacity as identified as needed as the work proceeds.

10. NHS ENFIELD CCG COMMISSIONING INTENTIONS

10.1 NHS Enfield CCG Commissioning Intentions 2013/2014 have been developed, spanning six key themes, specifically, Prevention, Primary Care, Integrated Care, Clinical Cost and Effectiveness, Children and Young People and Mental Health (these are an extract from the CCG Operating Plan, available on request as Appendix C). The Commissioning Intentions detail joint commissioning ambitions (for example a 19% reduction in emergency admissions for people aged 65 years and above) in addition to the implementation of transformational change programmes, such as the Joint Dementia Strategy. Joint commissioning activity is - and will continue to be - central to the delivery of these key commissioning intentions, particularly in relation to Integrated Care, Children and Young People and Mental Health.

10.2 At the Health and Well Being Board and CCG briefing event on 28 January the alignment between the JSNA, Draft Health and Well Being Strategy and CCG Integrated Commissioning Plan was reviewed and agreed for recommendation to the 14 February Health and Well Being Board meeting.

11. JOINT COMMISSIONING BOARD

11.1 The Joint Commissioning Board met 20th December 2012. Terms of Reference were approved and updates were provided to the Board on joint commissioning activity in respect of Childrens services and Learning Disability services. Joint Commissioning Strategy updates were provided and the Board received progress reports on the transition of Public Health services to the local authority, and the development of integrated care. The Joint Commissioning Board Terms of Reference and Governance Structure is located in Appendix D).
12. PARTNERSHIP BOARD UPDATES (COMMISSIONING ACTIVITY)

12.1 Learning Difficulties Partnership Board (LDPB)

The last Learning Disabilities Partnership Board, held Monday 19th November, considered setting up a Learning Disability Parliament including the advantages and disadvantages of a parliament and how it might be developed in Enfield. A full proposal will be presented at the next Partnership Board in February. A review of the LDPB two year plan was also undertaken. Initial priorities were considered for the next two years. Work to set future priorities shall continue at the next Board.

12.2 Carers Partnership Board

The Carers Partnership Board, held on 12th November 2012, welcomed a new carer representative, and the Board look forward to welcoming a further two new carer representatives to the group in January 2013. At least one other carer has expressed an interest in joining the Board. The Board discussion focussed on the Joint Carers Strategy, including the set up of a Carers Strategy Implementation Group, which will focus on the delivery of objectives detailed in the strategy.

12.3 Mental Health Partnership Board

The last Mental Health Partnership Board, held Tuesday 4th December 2012, received a commissioning update on the development of advocacy services. The Board were asked to feed into a paper being developed on advocacy in the borough, which will be finalised in February 2013. The Board considered bids received for IAPT grant funding. The grant funding made available will support people experiencing mental ill health to access IAPT and participate in complementary activities that promote recovery. Feedback was received on the Partnership Board’s Suicide Prevention work stream. BEHMHT intend to review their suicide strategy following an analysis of Appleby’s ten year review of suicides in the UK.

12.4 Older People Partnership Board

The last Older People Partnership Board was held Wednesday 12th December. The Board was updated on the Department of Health’s Warm Homes Healthy People Fund and a briefing was given on Personal Independent Payments (PIPs). An update was provided on the implementation of Joint Strategies for Intermediate Care, End of Life Care and Dementia, and members of the Board were invited to attend a Partnership Board Focus Group to inform and shape Commissioning Intentions relating to specialist accommodation services for older people.
SUMMARY:
This paper provides details of the progress made to date on the implementation of the above strategies since their implementation.

It shows that good progress is being made on most of the objectives across all of the strategies, particularly within the Intermediate Care/Reablement Strategy, although there is a need to more systematically monitor key outcomes of all strategies’ implementation, i.e. its impact on customer and organisational outcomes. Nonetheless, early indications are there was an improvement in some key outcomes, e.g. the proportion of people who choose to die in a place of their choice in the End of Life Strategy.

Despite this progress, key challenges remain, and where progress has been slow, this is often because of the complexities of working in a multi-disciplinary environment and in embedding practise consistently in the Borough. Nonetheless, where progress is slow, steps have been put in place to appropriately address the underlying issues.

SUPPORTING PAPERS:
Enfield Joint End of Life Care Strategy 2012 – 16
Enfield Joint Intermediate Care/Reablement Strategy 2011 – 14
Enfield Joint Dementia Strategy 2011 – 2016

RECOMMENDED ACTION:
To note the contents of this report.
Progress against Intermediate Care/Reablement Strategy

NHS Enfield and Enfield Council identified Intermediate care and Enablement services as a key priority within the over-arching personalisation agenda. The development of Intermediate Care and its integration with Enablement is seen as essential to the transformation of health and social care and to maximising people’s independence. The implementation of the Strategy will lead to the commissioning of effective multi-agency pathways, including a single point of access and care closer to home to help people avoid hospital admission and/or facilitate hospital discharge so people can return home as soon as possible. In doing so, this will help reduce utilisation of costly acute beds and delay or prevent transfer to long-term residential and nursing care. Table 1 summarises progress against key objectives in the Strategy.

<table>
<thead>
<tr>
<th>Objective</th>
<th>Progress</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Prevent avoidable admissions to hospital and support timely discharge</td>
<td>Care Pathways for Intermediate Care now in place to ensure support available to people at the right place &amp; time. Service now has single point of access. Awareness-raising events were held with health colleagues in primary care and acute Trusts. This includes an increase in the number of step-down beds available, with arrangements in place for additional spot placements in Enfield.</td>
<td></td>
</tr>
<tr>
<td>2. Decrease the number of people unnecessarily admitted to long-term care following a hospital stay</td>
<td>Enablement Service ensures individuals have the opportunity to work on a time-limited ability with professionals to improve their ability, where possible, to regain or maintain skills of daily living, such as getting dressed, washing and bathing, after a period of illness. Following enablement, individuals can undertake a social care assessment &amp; if eligible, Personal Budgets &amp; Direct Payments as part of care planning.</td>
<td></td>
</tr>
<tr>
<td>3. Improve quality and maximise independent living</td>
<td>Enablement Service established &amp; integrated into overall multi-disciplinary, co-located Intermediate Care pathway. One area for improvement remains the number of people provided with Tele-care support within this pathway – Tele-care is the provision of electronic personal and household alarms &amp; sensors which, if an individual triggers them, can be responded to through suitably trained individuals.</td>
<td></td>
</tr>
<tr>
<td>4. Improve the skills and competencies of the workforce</td>
<td>Appropriate workforce development included as a requirement in the contracts for all organisations providing Intermediate Care, including training about working for people with dementia.</td>
<td></td>
</tr>
<tr>
<td>5. Deliver more cost-effective services 6. Robust performance management</td>
<td>Services monitored via performance measures. These suggest some improvement in key areas, such as reduced hospital discharges; more people able to undertake tasks of daily living for themselves; and a greater number of people being supported at home 3 months after hospital discharge etc. Such options are not just better outcomes for individuals, but are usually less expensive than the alternatives for organisations (e.g. admission to hospital), which allows more people to be supported more appropriately.</td>
<td></td>
</tr>
</tbody>
</table>
Progress against Joint Dementia Strategy

The Joint Dementia Strategy sets out the local direction for dementia services from 2011-2016 built on an analysis of current and predicted future need and has been guided by input from local stakeholders who have contributed to our understanding of the priorities for improving services for people with dementia and carers in Enfield. Table 2 summarises progress against key objectives.

The strategy is underpinned by the National Dementia Strategy (and latterly the Prime Minister’s Dementia Challenge), which aims to improve dementia services to improve awareness, provide early diagnosis and higher quality of care; and is set in the context of the vision for transforming the adult care system from one intervening at crisis to one helping people to remain healthy and independent and maximises choice and control.

<table>
<thead>
<tr>
<th>Objective</th>
<th>Progress</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Improve professional &amp; public awareness of dementia</td>
<td>Training programmes, incorporating dementia awareness, are in place in health open to all disciplines and in Council workforce training plans. Comprehensive catalogue of services produced, including across Voluntary &amp; Community Sector.</td>
<td>Green</td>
</tr>
<tr>
<td>2. Improve early diagnosis and treatment</td>
<td>Group established to develop Memory Treatment Service &amp; draft produced. Next meeting Dec-12 with view to rapid commissioning thereafter</td>
<td>Yellow</td>
</tr>
<tr>
<td>3. Increase access to a flexible day, home based and residential respite options</td>
<td>Council continues to roll out Personal Budgets &amp; Direct Payments to individuals with ongoing care needs, including those with dementia and carers, and established brokerage &amp; e-marketplace to promote choice &amp; control as part of personalisation, alongside procurement of domiciliary care providers. Appropriate respite available</td>
<td>Green</td>
</tr>
<tr>
<td>4. Develop services that support people to maximise their independence</td>
<td>Number of people provided with ongoing adult social care and Tele-care needs to improve. Council &amp; Health colleagues exploring Tele-care options to make better use of technology to meet this objective. Support for a number of Voluntary &amp; Community Sector solutions for people with dementia and their carers ongoing and will form part of the refresh of the Voluntary &amp; Community Sector Framework in 2013</td>
<td>Green</td>
</tr>
<tr>
<td>5. Improve workforce skills and competencies</td>
<td>Developed &amp; implemented training programmes for health &amp; social care and ancillary staff well-established across agencies</td>
<td>Yellow</td>
</tr>
<tr>
<td>6. Improve access to support and advice following diagnosis for people with dementia and their carers</td>
<td>Dementia Advisor Service in place and recently discussed at the OP MH Group – service is providing some outcomes, but took longer to establish against its original remit, and period of its funding was extended by 9 months to Dec-12. One option is to remodel approach to advice &amp; support for those with dementia as part of VCS Framework in 2013/14.</td>
<td>Yellow</td>
</tr>
<tr>
<td>7. Reduce avoidable hospital and care home admissions and decrease length of stay</td>
<td>Development of Council re-provision &amp; commissioning of supported accommodation, including residential/nursing care and Extra Care continues, with the latter out to tender. Mental Health Liaison Service in place at both hospitals and Dementia champions in place for each appropriate ward in North Middlesex &amp; Chase Farm. Both Trusts identified senior clinical leads to aid development of services for those with dementia. A multi-disciplinary team is working with care homes to improve the support offered to staff to manage challenging behaviour and medication, including anti-psychotic drugs.</td>
<td>Green</td>
</tr>
<tr>
<td>8. Improve the quality of dementia care in care homes and hospitals</td>
<td>North London Hospice have been commissioned to provide training to care homes (15) &amp; domiciliary care (4) providers in implementing the Department of Health's Gold Standard Framework for end-of-life care, including for those with dementia. Quality payments to care homes achieving the GSF is in development</td>
<td>Yellow</td>
</tr>
<tr>
<td>9. Improve End of Life Care for People with Dementia</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 2 - Summary of Progress against Dementia Strategy Objectives
Progress against End-of-Life Strategy

The Strategy sets out how Enfield will develop and deliver health and social care services to better meet the needs of people nearing end of life 2012-16. It outlines 11 strategic objectives developed in partnership with local stakeholders, but aligned with the National End of Life Care Strategy. The strategy aims to ensure improved quality and greater choice of end-of-life care at all points from diagnosis to dealing with bereavement, but a primary focus is on ensuring more people are able to exercise a positive choice about their place of death.

Table 3 summarises progress against key objectives in the Strategy.

<table>
<thead>
<tr>
<th>Objective</th>
<th>Progress</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Encourage people to discuss death and dying</td>
<td>End of Life Strategy launched in the national Dying Matters Awareness Week in May-12 through a multi-agency event chaired by the Mayor at the Dugdale Centre. Different approaches are being explored in Steering Group to raise awareness amongst public about end-of-life, coping with bereavement &amp; counselling, linked to a social marketing campaign aimed at professionals and the public (Mar-13). This includes development of a directory of services integrated with wider approaches the Council &amp; its partners are exploring. NHS London commissions Gentle Dusk, to raise awareness within local communities about death and to train &amp; support volunteers to cascade messages in communities.</td>
<td></td>
</tr>
<tr>
<td>2. Identify all people nearing end of their life</td>
<td>Limited progress in improving the number of people on end of life care GP registers, a vital element of the end-of-life pathway: work is continuing through GP &amp; nurse-led training to surgeries. However, there has been better progress in assuring that more GP practices routinely hold multi-disciplinary review meetings hosted through surgeries; and in improved engagement with out-of-hours process established in 2012.</td>
<td></td>
</tr>
<tr>
<td>3. Effective Care Planning &amp; Coordinated care across organisations</td>
<td>Much progress made in training for individuals in coordinating &amp; planning care, including training programmes in both acute Trusts &amp; community services, with input from specialist palliative care consultant. Multi-disciplinary North London Hospice-led team plans are progressing to work with 18 homes &amp; 4 domiciliary care providers to train staff in end-of-life care by Mar-13 (Dementia Objective 10), including in Advanced Care Planning &amp; Liverpool Care Pathway, the latter setting out the support provided in the last days of life.</td>
<td></td>
</tr>
<tr>
<td>4. Develop rapid access to care</td>
<td>The multi-disciplinary nurse-led Palliative Care Support Service (implemented Jun-12) provides support quickly to individuals at crisis and to facilitate hospice/hospital discharge to enable patients to remain in/move to their preferred place of care and death. Since the scheme’s implementation, all patients it supported who died have done so in their preferred place of death, with two-thirds dying at home. An evaluation of the service is being planned.</td>
<td></td>
</tr>
<tr>
<td>5. Ensure all services are providing a high quality end of life care</td>
<td>Roll out of national good practise, the Gold Standard Framework training for care homes &amp; domiciliary care, is progressing. Service specifications for supported accommodation, including care homes, will include appropriate reference to end-of-life requirements, e.g. in commissioning Extra Care facilities. Approach to Do Not Attempt Resuscitation (DNAR Notices) agreed through End-of-Life Steering Group in 2012 and approach incorporated into training described above, including through GP-led development.</td>
<td></td>
</tr>
<tr>
<td>6. Good care in last days &amp; after death</td>
<td>Workforce training strategy for next 5 years developed &amp; training started to be implemented. Service specifications &amp; outcomes framework is being developed for care homes to include GSF accreditation or proof of working towards the accreditation as a requirement.</td>
<td></td>
</tr>
<tr>
<td>7. Involve &amp; support friends &amp; families</td>
<td>Outcomes-based Framework currently being developed: over-arching approach accepted by End of Life Steering Group in Nov-12</td>
<td></td>
</tr>
<tr>
<td>8. Develop workforce competencies</td>
<td>Inpatient hospice care commissioned from St Josephs and Marie Curie now moved to different contractual arrangements. Increased funding for North London Hospital agreed.</td>
<td></td>
</tr>
</tbody>
</table>

Table 3 - Summary of Progress against End-of-Life Strategy Objectives
Commissioning-Related Next Steps for 2012/13

Intermediate Care/Reablement Strategy
- Formal integration of Health and Social Care teams;
- Complete development of unified assessment process with information sharing across partners;
- Explore the potential for developing an integrated health and social care IT system;
- Pathway development to enable Intermediate care to support the needs of people with long term conditions including dementia and mental health needs;
- Review capacity of Intermediate Care Team; in particular the Rapid Response component

Dementia Strategy
- Complete reconfiguration of Memory Treatment Clinic model, including implementation of referral from primary care and its implementation to provide integrated assessment and treatment;
- Better define & implement dementia care pathway spanning early diagnosis to the end of life.
- Better deploy use of assistive technology as an enabler to support people to remain at homes;
- Expansion of Mental Health Liaison services within acute trusts;
- Review the provision of Continuing Health Care;
- Continue current re-provision of in-house care homes and commissioning of supported specialist accommodation for people with dementia;
- Continue roll-out of Personal Budgets for people who need ongoing adult social care;
- Commission services specific to younger people with dementia;
- Review current provision to ensure it meets the needs of black and minority ethnic groups.

End of Life Strategy
- Continued roll out of Gold Standard Framework in primary & domiciliary care and consider options for future sustainability of training;
- Implement Do Not Attempt Resuscitation Policy across the borough and continue to develop training with professionals, particularly GP surgeries;
- Develop & implement social marketing approach to raising awareness about end-of-life issues;
- Development of directory for Palliative and End-of-Life Care services, building on existing material, and link with the introduction of 111 contact point;
- Implement a robust integrated performance management system across health and social care that enables us to monitor quality, outcomes and expenditure.

END OF REPORT
Joint Commissioning Board

TERMS OF REFERENCE
FINAL

Purpose

The purpose of the Joint Commissioning Board is to provide a forum for health and social care commissioners to develop, agree, and govern joint commissioning initiatives that aim to improve quality and deliver efficiency savings through an integrated approach to the delivery of health and social care services for children and adults; and education services for children. The Joint Commissioning Board will report directly to the Health and Wellbeing Board and Clinical Commissioning Group Finance Recovery and QIPP Committee; decision making will be through the Clinical Commissioning Group Governing Body and Council Cabinet.

The Joint Commissioning Board will:

• Identify, develop and initiate service re-design and improvement projects that aim to integrate the delivery of health and social care services for children and adults with long term conditions and complex needs and ensure a co-ordinated approach across health and social care commissioning in partnership with the Clinical Commissioning Group.

Examples might include:

• multi-professional teams
• link social care professionals in primary care
• closer working with public health medicine
• personalised care planning for high risk patients to reduce admissions to hospital
• redesigning care pathways so they include social care as well as primary and hospital care
• shared assessment and information sharing.

• Lead on the development and implementation of integrated care pathways for agreed conditions in order to reduce bureaucracy and overlaps, ensure patients and their families get the care that will improve their health outcomes, and deliver efficiency savings.

• Monitor implementation of joint commissioning strategies (Stroke, Dementia, Intermediate Care and Re-ablement, and End of Life Care) and receive reports on the development of new joint Strategies (for example, Autism, Mental Health, and Carers).

• Provide leadership and guidance on certain agreed commissioning intentions set out in Joint Commissioning Strategies, for example:

  o Joint Dementia Strategy: Reducing inappropriate prescribing of anti-psychotic drugs for people with dementia.
  o Joint Stroke Strategy: Introduction of ambulatory blood pressure monitors to reduce inappropriate prescribing of antihypertensive drugs.
• Monitor performance of jointly commissioned services and highlight cost pressures or risks as they arise.

• Ensure that robust integrated performance management systems across health and social care are developed that enables us to monitor quality, outcomes and expenditure. The initial focus will be on ensuring integrated performance frameworks that measure the impact of joint commissioning strategy implementation are in place.

• Report through the Chair to the Health and Wellbeing Board and CCG on the performance of jointly commissioned services, the further development of integrated services and pathways, and the implementation and development of joint commissioning strategies.

Structure and Membership

The Joint Commissioning Board will report to the Health and Wellbeing Board and Clinical Commissioning Group. Decision making will be through the Clinical Commissioning Group Governing Body and Council Cabinet. Membership will be drawn from the Local Authority and CCG.

Membership:

<table>
<thead>
<tr>
<th>Name</th>
<th>Position and Lead Role</th>
<th>Organization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bindi Nagra</td>
<td>Joint Chief Commissioning Officer (Co-Chair)</td>
<td>LBE &amp; CCG</td>
</tr>
<tr>
<td>Richard Quinton</td>
<td>Chief Finance Officer and Director of Commissioning (Co-Chair)</td>
<td>CCG</td>
</tr>
<tr>
<td>Kate Charles</td>
<td>Deputy Joint Chief Commissioning Officer (Health, Housing and Adult Social Care)</td>
<td>LBE</td>
</tr>
<tr>
<td>Shahed Ahmed</td>
<td>Director of Public Health</td>
<td>LBE</td>
</tr>
<tr>
<td>Doug Wilson</td>
<td>Head of Performance</td>
<td>LBE</td>
</tr>
<tr>
<td>Eve Stickler</td>
<td>Assistant Director - Commissioning &amp; Community Engagement, Schools and Children’s Services</td>
<td>LBE</td>
</tr>
<tr>
<td>Anshumen Bhagat</td>
<td>CCG Board Member (Mental Health lead)</td>
<td>CCG</td>
</tr>
<tr>
<td>Dr Tim Fenn</td>
<td>CCG Board Member (Children’s lead)</td>
<td>CCG</td>
</tr>
<tr>
<td>Malcolm Smart/Amer Akbar</td>
<td>Deputy Joint Chief Commissioning Officers (Mental Health)</td>
<td>CCG</td>
</tr>
<tr>
<td>Graham MacDougall</td>
<td>Head of Commissioning Acute and Integrated Care</td>
<td>CCG</td>
</tr>
<tr>
<td>Claire Wright</td>
<td>Head of Children’s Commissioning</td>
<td>CCG</td>
</tr>
</tbody>
</table>

Relevant members of the CCG will be co-opted on to the Board as required.

Relevant NHS Commissioning Board and LBE Officers will be invited to join the Board as required.

Clinical Governance

Clinical governance will be assured by the CCG Quality and Safety Committee.

Operation
1. Meetings will be held on a monthly basis, with working groups meeting more regularly as agreed by the group.

2. The group will be jointly chaired by the Joint Chief Commissioning Officer, London Borough of Enfield and the Chief Finance Officer and Director of Commissioning NHS Enfield CCG.

3. Minutes will be taken and distributed no longer than 2 weeks after meetings.

4. The Chair will submit regular reports on the work of the Board to the Health and Wellbeing Board and the Clinical Commissioning Group Finance and Recovery and QIPP Committee, through the report of the Joint Chief Commissioning Officer.

5. Decision making will be through the Clinical Commissioning Group Governing Body and Council Cabinet.

6. The Terms of Reference, membership and meeting frequency will be reviewed after 6 months and thereafter on an annual basis.
Prior to the Governing Body meeting on 16 January 2013, the CCG received a petition from representatives of 38 Degrees. Some questions were answered by the Chair and other Governing Body members at the meeting in two sessions for members of the public at the beginning and end of the meeting.

The Governing Body undertook to consider the proposals set out in the 38 Degrees document Protecting Our NHS Together.

The substantial majority of the proposals set out in the Protecting Our NHS Together have already been incorporated in the CCG’s Constitution. Annex 1 to this report provides a comparison with the relevant sections of the Constitution which is accessible on the CCG’s website. At the time of writing this report the CCG is obtaining legal advice to CCGs on the extent to which the 38 Degrees proposals relating to tendering and contracting by the CCG can be met within NHS procurement policy and guidance, for the benefit of the population served by the CCG. This is likely to be reported to the March Governing Body meeting together with any proposed changes to the CCG’s Constitution.

Members of the public recorded their comments, concerns and questions as part of the petition submitted to the CCG. These have been reviewed and the CCGs’ responses are provided to concerns and questions in Annex 2. We welcome the opportunity the 38 Degrees petition has had for members of the public to put these issues to the CCG and for the CCG to be able to offer clarifications and responses and to explain how we want to develop the Communications and Engagement work of the CCG with patients and the public over the next six months.

SUPPORTING PAPERS:
Constitution, with Annexes
Response to questions from members of the public submitted prior to the 16 January Governing Body meeting.
RECOMMENDED ACTION:

To Receive and communicate the response to the proposals set out in the 38 Degrees document Protecting Our NHS Together

To Receive and communicate the response to the concerns and questions raised by members of the public as part of the petition submitted to the CCG

To Note that advice is being taken and considered on the 38 Degrees proposals relating to tendering and contracting by the CCG and is planned to be reported to the next public meeting of the Governing Body.

Objective(s) / Plans supported by this paper:

<table>
<thead>
<tr>
<th></th>
<th>Plan Description</th>
<th>Yes/No</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>Ensure the right care in the right place, first time</td>
<td>Yes – Duty to promote Innovation</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Deliver the greatest value for money for every NHS pound</td>
<td>Yes - Duty to ensure efficiency and effectiveness</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Commission care in a way which delivers integration between health, primary, community and secondary care and social care services</td>
<td>Yes – Duty to promote integration</td>
<td></td>
</tr>
</tbody>
</table>

Patient & Public Involvement (PPI):

The Constitution provides the governance framework for PPI, in particular by establishing a Patient and Public Engagement Committee of the Governing Body and including the Terms of Reference for this Committee.

Equality Impact Analysis:

Equality Impact Assessment Tool

To be completed and attached to any procedural document as part of main document sited between version control sheet and contents page

<table>
<thead>
<tr>
<th></th>
<th>Question</th>
<th>Yes/No</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Does the document/guidance affect one group less or more favourably than another on the basis of:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Race</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Ethnic origins (including gypsies and travellers)</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Nationality</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Gender</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Culture</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>----------------------</td>
<td>----</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Religion or belief</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sexual orientation including lesbian, gay and bisexual people</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disability - learning disabilities, physical disability, sensory impairment and mental health problems</td>
<td>No</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2. Is there any evidence that some groups are affected differently? No

3. If you have identified potential discrimination, are there any exceptions valid, legal and/or justifiable? N/A

4. Is the impact of the document/guidance likely to be negative? No

5. If so, can the impact be avoided? N/A

6. What alternative is there to achieving the document/guidance without the impact? N/A

7. Can we reduce the impact by taking different action? N/A

For advice in respect of answering the above questions, please contact the Directorate of Service Quality and Integrated Governance. If you have identified a potential discriminatory impact of this procedural document, please contact as above.

<table>
<thead>
<tr>
<th>Names and Organisation of Individuals who carried out the Assessment: Please give contact details</th>
<th>Date of the Assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Andrew Williams, Authorisation Programme Office</td>
<td>01/02/12</td>
</tr>
</tbody>
</table>

**Risks:**

The Constitution seeks to ensure that the CCG’s patient and public engagement and procurement processes are both effective and comply with best practice and/or NHS policy.

**Resource Implications:**
None associated with the current version of the Constitution.

**Audit Trail:**

The Constitution has been developed through engagement by the Chair with GB members and the Enfield LMC, GB approval for consultation with the membership practices and advice and guidance from Beachcroft Solicitors and NHSCB.

**Next Steps:**

The Constitution has been placed on the CCG web site and disseminated to member practices.
Annex 1: Comparison of NHS Enfield CCG Constitution with 38 Degrees document “Protecting Our NHS Together”

<table>
<thead>
<tr>
<th>38 Degrees</th>
<th>NHS Enfield CCG</th>
<th>Section of Constitution</th>
</tr>
</thead>
</table>
| 38 Degrees believes it is crucial that CCGs do as much as they can to:  
  • uphold the principle of “first do no harm” and proceed with caution in making any changes to NHS services  
  • spend money wisely and responsibly and avoid giving contracts to irresponsible companies  
  • consult local patients properly before bringing in any changes that will affect us  
  • provide information which is accessible to local people about what is going on in the local NHS  
  • encourage access to meetings and other decision-making processes for local people  
  • adopt policies and a constitution which reflect these values or variations | NHS Enfield CCG supports these points, which are reflected in the CCG’s vision values and aims. | 5 |
| There are a series of duties imposed upon CCGs in the 2012 Act. Many of these duties mean that CCGs will have to listen to patients and local people. There is also an important duty to secure public involvement so that patients are consulted or provided with information about planning of commissioning, development of proposals, and decisions on commissioning which affect the group.  
  Importantly, the constitution must set out a description of these arrangements and a statement of the principles it will follow in implementing these arrangements. | The values that lie at the heart of the CCG’s work include:  
  • working in partnership with individuals and patients groups to ensure they are central to the CCG’s work; and  
  • ensuring the CCG works in an open and transparent way with the public and its stakeholders;  
  In discharging the CCG’s functions we will:  
  promote the involvement of patients, their carers and representatives in decisions about their healthcare; | Section 5.3.2 |
The CCG has decided to establish a committee as a Patient and Public Engagement Committee of the Governing Body which is accountable to the Governing Body who approves its terms of reference. The Patient and Public Engagement Committee shall have the following functions:

- oversee the development and implementation of the Engagement and Communication Strategy and Equality and Diversity Strategy and implementation plans;
- embed strategies with relation to equality and diversity, including informing the Governing Body of their responsibility with regards to the Equality Act 2010;
- address ways in which to increase wider patient and public involvement and engagement;
- monitor any patient participation sub-groups and their membership;
- promote and improve patients self management in both primary and secondary care interface.

The CCG recognises the importance in making decisions about the services it procures in a way that does not call into question the motives behind the procurement decision that has been made. The CCG will procure services in a manner that is open, transparent, non-discriminatory and fair to all potential providers. The CCG will publish a Procurement Strategy approved by its Governing Body which will

<table>
<thead>
<tr>
<th>The Group:</th>
<th>The CCG recognises the importance in making decisions about the services it procures in a way that does not call into question the motives behind the procurement decision that has been made. The CCG will procure services in a manner that is open, transparent, non-discriminatory and fair to all potential providers. The CCG will publish a Procurement Strategy approved by its Governing Body which will</th>
</tr>
</thead>
<tbody>
<tr>
<td>• will, consistently with its obligations under, inter alia, the Public Contracts Regulations 2006 and applicable Community law, ascertain whether it is necessary, desirable or appropriate to invite competition when purchasing in order to ensure it will incur only budgeted, approved and necessary spending</td>
<td></td>
</tr>
<tr>
<td>• will seek value for money for all goods and services by reference</td>
<td></td>
</tr>
</tbody>
</table>

6.2.16

28

Annex 8
Terms of Reference
to the optimum combination of whole life cost and quality;
• shall ensure that, subject to the threshold provisions of the Public Contracts Regulations 2006, competitive tenders are invited for the supply of goods, materials and manufactured articles;
• the rendering of services including all forms of management consultancy services (other than specialised services sought from or provided by the Department of Health); and
• for the design, construction and maintenance of building and engineering works (including construction and maintenance of grounds and gardens) for disposals
• will, in relation to each purchasing decision concerning health care and social services
• consider the extent to which the Public Contract Regulations 2006 require any form of competition and consider the most appropriate process and procedure for awarding the relevant contract or contracts; and
• in that regard give consideration to whether the use of a framework agreement, including the use of approved lists, is the most appropriate means of appointing providers;
• shall, wherever possible and where it is consistent with legal requirements, ensure that contractual provisions, procurement procedures and selection and award criteria are designed to ensure that contractors and providers are:
• good employers who comply with all relevant employment legislation, including the Public Interest Disclosure Act 1998;

<table>
<thead>
<tr>
<th>Ensure that:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• all relevant clinicians (not just members of the group) and potential providers, together with local members of the public, are engaged in the decision-making processes used to procure services;</td>
</tr>
<tr>
<td>• service redesign and procurement processes are conducted in an open, transparent, non-discriminatory and fair way</td>
</tr>
</tbody>
</table>

Copies of the CCGs Procurement Strategy will be available on the CCG’s website.

The CCG is awaiting legal advice on the extent to which the 38 Degrees proposals can be met within NHS procurement policy and guidance for the benefit of the population served by the CCG.
• maintain acceptable standards of health and safety and comply fully with all legal obligations;
• meet all tax and National Insurance obligations;
• meet all equal opportunities legislation;
• are reputable in their standards of business conduct;
• respect the environment and take appropriate steps to ensure that they minimise their environmental impact.

The primary role of CCGs is the commissioning of services. Commissioning decides who will actually provide services to patients and who will get paid for doing this. In Schedule E the CCG has to set out the commissioning policy it will follow. Lawyers have drafted .... wording, which, while legally robust, also addresses some of the ethical and moral concerns that members of the public may have about commissioning (although it does not cover all the different ways in which a constitution might be drafted).

The Policy for Tendering and Contracting states that the CCG will ensure proper competition that is legally compliant within all purchasing to ensure only budgeted, approved and necessary spending is incurred. The CCG will seek value for money for all goods and services.

The CCG uses the NHS model contract, which specifies terms equivalent to those proposed by 38 Degrees.

The CCG has approved the Sustainability Strategy.

The values that lie at the heart of the CCG's work are:
(a) A commitment to providing the best healthcare to those living in the CCG's area.
(b) A commitment to commissioning and procuring services in a fair and ethical manner.
(c) A commitment to the optimum involvement of local people and service users in the group’s decision-making processes and service planning.
(d) A commitment to openness

The values that lie at the heart of the group’s works are:
(a) A commitment to providing the best healthcare to those living in the group’s area.
(b) A commitment to commissioning and procuring services in a fair and ethical manner.
(c) A commitment to the optimum involvement of local people and service users in the group’s decision-making processes and service planning.
(d) A commitment to openness

5.3.2
and transparency in the group’s decision-making processes, and service planning.
(e) A commitment to equality and fairness in considering the healthcare needs of different groups in the CCG’s area.

- ensuring the optimum use of all available resources; and
- ensuring the CCG works in an open and transparent way with the public and its stakeholders;

These values are incorporated in and supported through the CCG’s communications and engagement, equality and diversity, procurement and sustainability plans and policies.

<table>
<thead>
<tr>
<th>The National Commissioning Board draft constitution seems to provide a high degree of accountability. It is also possible to include additional items in the section on accountability such as a commitment to: (a) disclose upon request all information that can lawfully be disclosed, rather than simply all such information that must be disclosed. (b) publish all commissioning decisions and consultation exercises on its website. (c) hold a number of events each year with local people and organisations to explain the progress and work of the CCG. (d) publicise meetings of the CCG well in advance on the CCG’s website, the local press and in local libraries and GPs’ surgeries.</th>
<th>These all form part of the CCG’s governance framework for how we work in ways that demonstrate our commitment to public accountability, whilst complying with individuals’ data protection rights. To promote transparency, we make information available through the CCG’s website, supported by the opportunity for people to be assisted to access this information at the CCG’s office, member practices’ surgeries and Patient Participation Groups and libraries.</th>
</tr>
</thead>
<tbody>
<tr>
<td>The CCG will endeavour to work with as wide as possible cross-section of the people who use or who may use the services provided, and the groups which may represent such people, to provide them with information about the services provided by the CCG.</td>
<td>At the January Governing Body meeting attended by 38 Degrees, the CCG’s Consultation and Engagement Strategy and Equality and Diversity Strategy was agreed as the basis for a six month engagement exercise with...</td>
</tr>
</tbody>
</table>
CCG in a variety of ways, tailored to the needs of the local community. The CCG will consult as widely as it can on planning and development of services, and take into account the views expressed when making decisions. The CCG will take all steps that it can to ensure that engagement is adapted to meet the needs of various groups and service users. The CCG will monitor on a regular basis its compliance with this statement of principles.

Patients, public and partners. This will be overseen by the Patient and Public Engagement Committee and we will welcome feedback on our proposals for how best to involve patient, carer and public voices and views in engagement, consultation and implementation of service re-design for patient benefits and improving value for money. We will endeavour to extend the reach of these activities into as wide a cross-section of the population as possible. The Edmonton Partnership and our work with Somali Families on maternity checks already offer evidence of our intentions.

It is important to check that the CCG has included all the categories [of Conflicts of Interest] in its list. The list is not exhaustive and if there are any other conflicts which could arise locally then these could be proposed to be added to the list. It is also important that the list of conflicts of interest are accessible for the public to see, both on the CCG’s website and by other means.

The Conflict of Interest Policy includes all of the categories listed and how any other potential conflict should be declared and reported. The CCG Governing Body members’ register of interests was presented at the January Governing Body meeting attended by 38 Degrees and is published on the CCG’s website.

### Annex 2: Responses to Comments received with the 38 Degrees Petition

<table>
<thead>
<tr>
<th>Insert comments and questions, grouped as follows:</th>
<th>NHS Enfield CCG’s Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I am concerned as doctors are not trained in financial affairs and I have also had great help from the despised Managers in hospital departments. Please protect the local NHS. Of course it needs improving -- what doesn't? -- but doctors are NOT STRATEGISTS. However, they SHOULD be listened to. GPs are not capable of commissioning services. Please protect the NHS services in our</td>
<td>NHS Enfield CCG’s Governing Body includes both GPs and Senior Managers, as well as lay members, a nurse and a hospital doctor. They are supported by an experienced management team. All are committed to NHS public service values and contribute expertise together with local knowledge from member general practices and patient participation. Governing body GPs and other members are participating in a comprehensive</td>
</tr>
</tbody>
</table>
Without an NHS where would we be? We have paid in all our working lives now we are retired you what to scare us to death. How would we pay for private treatment. WHY should we we have already paid. The NHS is the greatest creation of the last 60 years. They are throwing the baby out with the bath water. Why can't they look at keeping it NHS AND rooting out corruption and inefficiency which exist in any large organisation private or public!

The CCG has the same duties as all other NHS organisations to maintain safe, competent and patient-focused services. Plans, policies and reporting systems based on NHS good practice are being put in place through the Governing Body meetings between January and April to be able to monitor, improve and, where necessary, remedy care quality and safety.

The CCG is an NHS organisation and as such must comply with UK and European procurement law as it relates to public services contracts, guided by NHS policies on procurement, competition, co-operation and choice.

---

**2**

I am concerned by the nature and thrust of the proposed changes and consider it's essential to maintain safe, competent and patient-focused services. I really am worried that reorganisation of how NHS works, especially at this local level, will harm my access to good care and treatment. Please think before you tinker.

The CCG has the same duties as all other NHS organisations to maintain safe, competent and patient-focused services. Plans, policies and reporting systems based on NHS good practice are being put in place through the Governing Body meetings between January and April to be able to monitor, improve and, where necessary, remedy care quality and safety.

---

**3**

Please fight to protect the interests of NHS patients as opposed to feather the nests of Private Companies when awarding contracts. We should be renationalising all our essential services and seizing the private providers for the good of the people. Our NHS must not be fragmented. Experience has shown that private companies do not do a good job of running GP Practices. Please protect our local practices in Enfield, do all you can to keep private companies OUT! Stop NHS being taken over by private companies. Please protect the NHS by stopping private companies taking it over. Please stop the privatisation of the NHS through Any Qualified Provider. I work in the NHS and can see the lowering of quality and standards this brings. Do not privatisate our health service, we do not want g4s and their ilk running our

The CCG is an NHS organisation and as such must comply with UK and European procurement law as it relates to public services contracts, guided by NHS policies on procurement, competition, co-operation and choice.
hospitals. Private and Public should remain separate. We must stop private companies from infiltrating public funded facilities. Stop breaking up our NHS and allocating bits of it to private partners and companies for whom profit comes before patient care.

Enfield CCG understands your concerns. However, we do believe firmly that the changes being implemented now actually address the needs that you highlight in your comment.

Local people who are ill and anxious to receive skilled care will have quick access to local urgent care services at Chase Farm Hospital. Local people who are very seriously ill, or who have had a serious accident, will be taken by a blue-light ambulance to a state-of-the-art A&E service.

We will continue to have high quality hospital services at Chase Farm, including brand new assessment units for older people and for children who need skilled care from healthcare professionals, as well as an Urgent Care Centre and planned care services.

---

4 I am most concerned at the widespread closure of local A and E Departments which are essential for the speedy help needed in a crisis and also available for quick advice in a crisis when local doctors are unable to offer to quick appointment or local triage. Also there seems to be a risk of specialist services in certain hospitals being lost in local closures with no guarantee of a local service for needy patients. A local clinic is no replacement for these specialist services.

Enfield CCG understands your concerns. However, we do believe firmly that the changes being implemented now actually address the needs that you highlight in your comment.

Local people who are ill and anxious to receive skilled care will have quick access to local urgent care services at Chase Farm Hospital. Local people who are very seriously ill, or who have had a serious accident, will be taken by a blue-light ambulance to a state-of-the-art A&E service.

We will continue to have high quality hospital services at Chase Farm, including brand new assessment units for older people and for children who need skilled care from healthcare professionals, as well as an Urgent Care Centre and planned care services.

---

5 I came to Enfield a year ago, and have had very good care from my GP practice; I'd like them to be able to carry on providing such care.

The NHS Commissioning Board is directly responsible for contracting for primary care medical services provided by GPs. This is not the CCG’s responsibility which means that GPs are not in charge of contracting for primary care medical services provided by GPs. The CCG does have a duty to support the NHS Commissioning Board area teams who manage these contracts to improve quality and access standards on a consistent basis across Enfield.

We are pleased you have experienced good quality care from one of Enfield CCG’s member practices.

---

6 I truly hope you will not close the AE at Chelsea and Westminster Hospital. It is a

This would be a decision for the local CCG that commissions A&E services from Chelsea and Westminster Hospital,
fantastic and vital emergency and it saved my newborn baby last april! Please do keep it live.

not Enfield CCG. We are pleased you received good care at the hospital.

<table>
<thead>
<tr>
<th>Enfield CCG is pleased that local services are going to be retained and developed so that we can be sure they can provide safe, effective and high quality services for local people.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Barnet and Chase Farm Hospitals have been given nearly £35 million to spend expanding the A&amp;E and maternity services at Barnet Hospital and creating an Urgent Care Centre and brand new assessment units for children and for older people at Chase Farm Hospital.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>They have already stolen our 24hr. A &amp; E despite Lansley promising on TV to save it when he was elected. Our MP, Nick de Bois, is with his constituents, the vast majority of whom have petitioned loud and very long to keep all our services. We do not want to travel to Edmonton or Barnet. We want OUR existing hospital to get the money stolen by the other two hospitals for their new buildings, and have Chase Farm restored in buildings and services. It is a damn sight better than the other two, despite being deliberately run down by the powers that be. The A&amp;E and the children's section are a very important and necessary of NHS services and these are to be closed. A big NO!!! Save Chase Farm Hospital, especially all the maternity services there. Please protect A&amp;E and maternity services at Chase Farm Hospital.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>8</th>
</tr>
</thead>
<tbody>
<tr>
<td>Our NHS is precious, and we're relying on you to protect it. Please do all you can to stop local health services being broken up or taken over by irresponsible private companies. Very worried about the proposed changes to the NHS. Why does each new government mess around with it? Surely for profit companies are not going to be unbiased about healthcare provision. Don't want to see a return to the days when only those who could pay were able to access treatment. I would like to see the doctors win their fight to protect the N.H.S and their patients from the teeth of privatisation. Please save the NHS. It is disgusting that we are being blamed for being a drag on the country's finances just because we have lived a healthy lifestyle and have</td>
</tr>
</tbody>
</table>

| The CCG’s commissioning plan actively promotes the commissioning of integrated care services. This means enabling partnerships to develop between providers that deliver these services in ways that are more responsive to the needs of patients, carers and their communities and – where necessary - which comply with NHS procurement policy. |

| 273 |
managed to survive so long. It is not so
great being old now and having to ask for
help from the NHS. We have always
been independent and coped until now.
I am fully in favour of any action that may
be required to save the NHS from
privatisation through the back door i.e.
through the GP surgeries.
How can you make a profit out of the
NHS?

<table>
<thead>
<tr>
<th>9</th>
<th>Protect local NHS services and consult patients properly before making changes. Patients must come first. Local CCG must be able to demonstrate how it has responded to patient and community needs and concerns. Protect local NHS services and consult us properly before making changes and involving private companies.</th>
</tr>
</thead>
<tbody>
<tr>
<td>10</td>
<td>We are pleased you have experienced good quality care from your general practice.</td>
</tr>
<tr>
<td>11</td>
<td>There is no shortage of money for the NHS there is a £64 billion surplus in the national insurance fund so demand enough to give your patients the treatment they need.</td>
</tr>
<tr>
<td>12</td>
<td>The CCG’s Constitution commits the CCG to the statutory duty to enable patient choice in all of our contracts. In addition we commission a range of services that offer the choice of accessing healthcare that can be appropriately provided in clinics that are close to patients’ homes.</td>
</tr>
<tr>
<td>13</td>
<td>I worked for the NHS for 25 years and witnessed the falling of standards when...</td>
</tr>
<tr>
<td>14</td>
<td>All NHS commissioners, including the CCG, must make prioritisation choices within the funds allocated annually to the NHS by government and then to each local CCG as the budget they must commission care within. NHS Enfield CCG’s Constitution sets out the vision, values and aims that will direct how we commission services on behalf of all 54 member general practices.</td>
</tr>
</tbody>
</table>
outside companies took over things such as cleaning in hospitals. preventing hospital acquired infections.
Meeting of the Joint Boards of NHS North Central London

DATE: 31st January 2013

TITLE: Enfield Professional Executive Committee report

LEAD DIRECTOR: Liz Wise, Chief Officer

AUTHOR: Dr Mohammed Abedi, Chair of Enfield Professional Executive Committee

CONTACT DETAILS: Mohammed.abedi@nclondon.nhs.uk

SUMMARY:
Enfield Professional Executive Committee (PEC) met on 24th September 2012. PEC received updates on the various services. An update of each of these is contained within the report.

SUPPORTING PAPERS:
- None

RECOMMENDED ACTION:
- Enfield Board is asked to note the contents of this paper

LINKS TO NHS NORTH CENTRAL LONDON STRATEGY
This section should summarise the report’s explicit links to the organisation’s Joint Strategic Needs Assessment and/or the Case for Change.

For example, authors could demonstrate how the report links to the Cluster’s aim to move care into the primary and community settings, or reference a specific health need such as prevalence of CVD.

GOVERNANCE:
Voting: Please indicate which Board(s) has voting rights on this matter (if applicable)

<table>
<thead>
<tr>
<th>Barnet</th>
<th>Camden</th>
<th>Enfield</th>
<th>Haringey</th>
<th>Islington</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paula Kahn</td>
<td>Paula Kahn</td>
<td>Paula Kahn</td>
<td>Paula Kahn</td>
<td>Paula Kahn</td>
</tr>
<tr>
<td>David Riddle</td>
<td>Caroline Rivett</td>
<td>Karen Trew</td>
<td>Cathy Herman</td>
<td>Anne Weyman</td>
</tr>
<tr>
<td>Caroline Rivett</td>
<td>Robert Sumerling</td>
<td>Caroline Rivett</td>
<td>Caroline Rivett</td>
<td>Caroline Rivett</td>
</tr>
<tr>
<td>Bernadette Conroy</td>
<td>Karen Trew</td>
<td>Deborah Fowler</td>
<td>Anne Weyman</td>
<td>Sorrel Brookes</td>
</tr>
<tr>
<td>Robert Sumerling</td>
<td>Caroline Taylor</td>
<td>Cathy Herman</td>
<td>Sue Baker</td>
<td>David Riddle</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

277
Objective(s) / Plans supported by this paper: This is explained within the paper

Patient & Public Involvement (PPI): None

Equality Impact Analysis: Not applicable

Risks: Not applicable

Resource Implications: None

Audit Trail: None

Next Steps: A report will be produced for the next Joint Board meeting highlighting further activities

UPDATE

Community Services:

The services currently operating and under review by PEC are gynaecology, ophthalmology, urology and phlebotomy. In addition, and as part of the Enfield Quality, Innovation, Productivity and Prevention (QIPP) initiative, PEC is also involved in work to develop community services in, anticoagulation, respiratory, cardiology, pain and musculoskeletal services and near patient testing of patients suspected of having a deep vein thrombosis.

Adult Safeguarding:

PEC reviewed the Enfield Safeguarding Adults Board report and collaborative work between NHS Enfield and the London Borough of Enfield continues in relation to adult safeguarding issues.

Children's Safeguarding:

PEC reviewed the Enfield Safeguarding Children’s Board report and the PEC Chair meets frequently with the Enfield Designated Nurse to discuss and ensure robust governance of children’s safeguarding arrangements.

Furthermore, the Board organises joint Quality Assurance visits to health providers including independent contractors and has worked in conjunction with NHS Enfield to ensure timely and effective reporting of safeguarding issues by these partners.
On a Primary Care level, funding has been secured (Munro Fund) to train GP staff and practices have been assisted in gaining future CQC registration using an audit designed by NHS Enfield of GP’s systems and safeguarding children arrangements that will need to be in place.

PEC has led the development of a Safeguarding Section on the Enfield CCG Website which includes named of contacts in case of safeguarding concerns.

**Enfield Primary Care Development Strategy:**

PEC members, Clinical Commissioning Group (CCG) leads and the North Central London (NCL) Deputy Medical Director continue to work closely on the Strategy alongside Project Leads and London Borough of Enfield representatives on the Primary Care Implementation Board. The strong clinical focus of this group provides leadership on the ground to ensure the full engagement of GP’s and other clinicians.

The Strategy is being implemented by 7 locality based Network Clinical Lead GP’s who have been successfully recruited from within Enfield. The Clinical Network Leads work in close conjunction with their Clinical colleagues on the Primary Care Implementation Board in delivering the Primary Care Strategy Implementation plan with a strong focus on public and patient involvement, improving quality, GP education and collaborative working within Primary Care.

Enfield has already begun an IT upgrade which will allow practices to work on the same web based clinical IT platform. Furthermore, NCL Estates have completed a premises survey within Enfield to guide Practices into achieving the core requirements for CQC Registration. Funding to support practices in the form of improvement grants has been utilised to carry out the necessary building works.

**Quality and Outcomes Framework (QOF)**

Enfield GP Practices approached the Quality and Productivity (QP) targets for the 2012/13 Quality Outcomes Framework (QOF) encompassing referrals to secondary care, emergency admissions and accident and emergency attendance, with a great deal of enthusiasm. Practices continue to meet individually and in groups of six or more under the supervision of the NHS Enfield Primary Care Team to review and discuss data. The aim has been to encourage practices to work together, to promote education and to share best practice. To this end, a Top Tips list has been compiled by PEC using information from these discussions and the list has been published on the Enfield CCG Website.

**Enfield Clinical Pathway Development:**

PEC continues to work closely with colleagues from the CCG Board to develop the Primary Care Clinical Pathways which encompass all of the common conditions encountered in Primary Care. These Pathways are ratified by clinical colleagues in Secondary Care and uploaded onto the Enfield CCG Website.

**Enfield Joint Carers Strategy:**


The Local Authority Joint Carers Strategy 2013-16 has now completed it public consultation and had been amended in light of the feedback from PEC and a variety of stakeholders. The strategy has recommended that carers be a part of GP patient groups and for front line staff and that GPs be trained in identifying carers and also for educational support for young carers. Furthermore, the core elements of the Strategy are being shared with Enfield GPs through Protected Learning Time.

The Strategy has been approved at the January CCG Board and will be monitored there annually.

**Autism Action Plan**

A briefing was PEC with an overview of the Autism Action Plan which focused on the large population of patients with undiagnosed autism.

PEC recommended that a clear care pathway for autism be developed focusing on a reporting mechanism before the patient falls into crisis. A training gap was highlighted in General Practice and it was suggested that a Lead GP for autism be identified to assist in pathway development and to coordinate training.

The Autism Action plan is going out for formal consultation and the formal sign off is expected to be March 2013. PEC recommended that the Plan be reviewed in lieu of the consultation process.

**Bowel Screening Plan**

The PEC Nurse presented a report on the National Bowel Cancer Screening Programme which showed that levels of participation in Enfield are below national targets and averages.

To address this, the PEC Nurse presented a proposal for an Enfield Bowel Cancer Screening Uptake Local Enhanced Scheme.

PEC recommended that the project be presented at the Primary Care Implementation Board where it was recently approved.

**Improving QOF Indicators CHD 6&8**

The Public Health team reported that in England 32% of men and 30% of women aged 16 years or over have hypertension and two thirds of the UK population have a serum cholesterol level greater than 5.2 mmol/L and that Enfield’s population is above the national average.

Cholesterol and blood pressure control is regarded as an essential part of the control of CHD, Stroke and Transient Ischaemic Attack. Diabetes, mental health, peripheral arterial disease, secondary prevention of CHD.

Until a person is diagnosed patients health cannot be improved. Reducing the gap is therefore a priority which can be achieved through healthchecks, opportunist screening, advising patients to have BP and/or cholesterol checked through posters and advertising.
PEC recognised that Enfield needs to improve performance and it was agreed that the Enfield Clinical Network Leads would target this with the GP practices.
Written Questions from Members of the Public:

PRIMARY CARE

1. Between eight and ten of the 54 Enfield surgeries continue to breach the GP contract by having an 0844 telephone number, despite the Department of Health and NHS North Central London ruling that people should not pay more to make relevant calls to a GP practice than they would to make equivalent calls to a geographical number. Premium rate 0844 calls can cost up to 13p a minute from a landline and anything from 12.5p to 41p from a mobile phone – from which the GP practice secures about 2p a minute. The Over 50s Forum believes the CCG has a duty to represent the interests of all patients. So will the CCG warn the guilty surgeries that unless they cease using an 0844 number an comply with the GP contract they will publicly name and shame them?
(Monty Meth)

11 practices in Enfield were using 084 numbers, 7 of the 11 have either switched to a local rate number, or have advertised the availability of a local rate contact number to run in parallel, until their 084 contract ends. Practices were advised to:

- Update the practice leaflet
- Update the telephone numbers advertised on the practice NHS choices page
- Update the telephone numbers advertised on the practice myhealthlondon page
- Update the telephone numbers advertised on the front page of the practice website (if applicable)
- Advise callers on 084 number welcome message
- Advertise the availability of the reduced rate number within the practice
- Ensure that the new local rate number is answerable and accessible to all

3 of the remaining 4 practices have assured us that their replacement/interim local number will be up and running before the end of the month. We are currently in discussions with the remaining practice to ensure that they either replace/renegotiate their 084 number.

14. Because surgery reception staff occupy a vital place in patient care, often they are our first point of contact, the Over 50s Forum is concerned to hear that some surgery staff are being paid below the national minimum wage. We therefore ask the CCG to seek assurances that all surgery staff are at least paid the minimum wage as a step towards paying the London Living Wage of £8.30 an hour as advocated by the Mayor of London and Enfield Council.
Response from Primary Care – With regards to the national minimum wage issue, this is not something that has been brought to our attention before. However should we be provided with further information, it is something we will investigate.
PATIENT/PUBLIC ENGAGEMENT

2. What substantive progress has been made to establish functioning and effective patient engagement groups attached to each surgery; what plans are there to coordinate these groups and will you consider a patient representing them on the CCG board?
(Monty Meth)
Please see response to question 9 below

7. How committed is Enfield CCG to ensuring that every GP practice has a patient forum?
(Harfiyah Haleem – 38 Degrees)
Please see response to question 9 below

9. Will Enfield CCG give a patient forum representative a place on its Board?
(Harfiyah Haleem – 38 Degrees)

We have a Practice Manager Representative on the Governing Body who has been working very hard over the last year to support practices in setting up and developing their own patient participation groups (PPGs). We are continuing this work and there is an upward trend in the numbers of practices with PPGs.

28 practices have PPGs and CCG was commended in recent authorisation visit for progress made.

8. Will Enfield CCG facilitate communications between members of the various patient forums, and how will this be done?
(Harfiyah Haleem – 38 Degrees)

Through the communications and engagement strategy

NHS BRANDING

3. Will you consider incorporating NHS into the CCG title, logo and all future publicity to demonstrate your continued commitment and support for the principles of the NHS – a service free at the point of use and available to everyone based on need, not on the ability to pay? Unless this is done, the planned closure of NHS Enfield in April will see the coveted NHS brand name disappear after 65 years, raising unnecessary fears, particularly among elderly patients that their health care will not be the same following the Government’s imposed reorganisation.
(Monty Meth)

Yes, the full and correct legal name of the CCG is NHS Enfield Clinical Commissioning Group.

AQP

5. Now that many CCGs in the London area and elsewhere have named their Any Qualified Provider (AQP) list, will Enfield CCG come into line and will you insist on giving prior approval of their marketing and advertising material to ensure that the NHS brand name is not misused and misleads patients?
(Monty Meth)
10. **What is happening with Any Qualified Provider (AQP) in Enfield, and how does the Board propose to safeguard the interests of patients in this process?**
(Harfiyah Haleem – 38 Degrees)

AQP is a national policy for NHS Commissioners. The existing AQP is adult hearing with plans for termination of pregnancy and continuing care. Safeguards via quality, commissioning strategy plan and procurement policy and the Commissioning Support Unit manages procurement processes for CCGs where GPs as primary care providers may have an interest.

As soon as the contract for audiology is signed then the list of providers will be published including on Choose & Book.

Providers have been sharing their patient leaflets with the CCG and the CCG has directed providers to the NHS identity website to ensure all literature compiles with NHS branding requirements.

**CONSTITUTION**

4. **Now that Enfield GPs have endorsed and approved the new CCG constitution, will you consider how ownership of it can be shared with Enfield residents by, for example, having a public consultation period with a view to strengthening the respect and status in which the CCG is held in the community?**
(Monty Meth)

The Constitution is determined by the Health and Social Care Act 2012 and by Department of Health guidance which we are bound to follow. The Constitution is an agreement between member GP practices. It will be published on the CCG website. The constitution includes the Committee for Public and Patient Engagement and this will bring the constitution to life.

6. **What consideration has the CCG Board given to the constitutional changes proposed by 38 Degrees?**
(Harfiyah Haleem – 38 Degrees)

Our response must be consistent with advice to all NHS Boards i.e. it must comply with European and national procurement law and guidance, as per statute, policy and guidance issued by the Department of Health to the NHS and by NHS Commissioning Board to NHS commissioners. This is a requirement of authorisation as a CCG by the NHS Commissioning Board.

11. **May we see the draft Enfield CCG constitution and if so, when and in what form?**
(Harfiyah Haleem – 38 Degrees)

The draft constitution is available on the CCG website as part of today’s Governing Body meeting papers. The final version will be published following revisions from decisions made today.

**SERVICES**

12. **Can you elaborate the sentence about health checks being extended to the west of the Borough. What health checks are they? Are they the same as the council funding through Innovision (not sure that’s the right name).**

NHS North Central London is a collaborative working arrangement between Barnet, Camden, Haringey, Enfield and Islington Primary Care Trusts.
The NHS Health Checks programme that was initially piloted in the south and east of the borough has been extended to the West of the borough. This is the same Local Enhanced Services (LES) that has now been offered to all practices. Community Health Checks are also being offered through Innovision (Healthcare Ltd). These checks are the same as the above but delivered in the community rather than at GP practices and are targeted at people who do not traditionally access primary care or who are unlikely to respond to an invitation letter from a GP practice.

13. Second point is on the reference to the minor ailment scheme being adopted by 51 pharmacies from January 2013, I haven’t seen the ailments listed or any explanation available to patients. Has any information gone out to voluntary sector or patient groups, have they been consulted? The Forum has a meeting planned with Sean Barnett for January 31 to express its concerns, so we’re surprised that it will be up and running by then.

The minor ailment scheme was discussed and agreed with local GPs and pharmacists and with the general public via neighbourhood area forums during 2012. The Primary Care Strategy Implementation Board (a sub group of the Health and Well Being Board) has patient representation via LiNKS, so the scheme has been approved through that board. There is a patient information leaflet that will be given to patients via their GP if they present with a minor illness covered by the scheme. Local GPs and pharmacists have just been invited to join the scheme with training dates published for them to attend. It is envisaged that only a small group will be up and running during mid to late January with the remainder starting early February. Sean Barnett (Primary Care Strategy Implementation Project Lead) invited the Over 50s Forum to a further update session at the end of January as a means of further discussion and awareness of schemes, not for the purpose of directly gaining consent for the scheme approval. If further information is required on the scheme Sean would be happy to assist further.

BEH

15. The Chief Executive’s blog for North Middlesex University Hospital (NMUH) for both 7th and 11th January is attached. NMUH have already contacted with Kier Construction and are on target, but two Barnet and Chase Farm Planning Applications B/03959/12 and B/03785/12 have STILL to be determined (as at 15th January) BEFORE a contract with Private Finance Initiative (PFI) holder can be let! (see also below)

The Chief Executive’s blog is a mechanism for keeping staff updated on Barnet Enfield Haringey clinical strategy as well as other issues at North Middlesex University Hospital.

I have been assured by the Trust lead for estates that the two Barnet and Chase Farm planning applications referred to are accounted for within the scheduled works and relate to car parking and CDM (Construction Design Management – Health and Safety).

16. The Barnet and Chase Farm Business Case was split by Mark Easton into two parts: changes at Barnet General Hospital (Business Case Approved) changes at Chase Farm site – Business Case has not seen light of day, so how can the Barnet Enfield Haringey clinical strategy be met by November 2013? So perhaps the Chief Officer can share the reason for her optimism with members of Enfield CCG?

The implementation of the Barnet Enfield Haringey clinical strategy required the full business case for capital investment at both Barnet Hospital and Chase Farm Hospital to be approved. There have always been plans for a second business case for further
consolidation of estate on the Chase Farm Hospital site. This will be developed by the Trust in coming months.

17. NHS North Central London held a 3-day Programme Review for the BEH Clinical Strategy at Stephenson House on 6th December 2012. Why does the Liz Wise report appear to give an over optimistic upbeat view as no new primary care sites such as Ordnance Road GP centre and 3 others will not be available before mid 2014 and these are part of the same BEH clinical strategy?

The implementation of the Barnet Enfield Haringey clinical strategy this year is about redesign of pathways for emergency care and maternity services and the improvements of primary care are part of a 3 year transformational strategy.
Appendix Bii

Oral Questions from Members of the Public:

Q1. How would a patient from a practice who did not have a Patient Participation Group (PPG) have the chance to be elected as the patient representative?

We will make allowances for patients whose practice does not currently have a PPG to be eligible to stand as a board representative. Patients can be networked to their nearest PPG. The election and selection process is still to be decided. Feedback from all PPGs will also be discussed into the Patient and Public Engagement Group which is a sub-committee of the Board.

Q2. Equality and Diversity /Employment policies applicable to all ECCG staff on NHS Terms and Conditions.

The Equality and Diversity policy was approved by the Governing Body on 16 Jan 2013. All other HR policies will be presented to a future Governing Body board meeting for approval. All Enfield CCG staff are on NHS contracts and will work within the Equality and Diversity policy.

Q3. Do the ECCG employment policies support Equality and Diversity NHS principles

Yes; all policies support Equality and Diversity principles in line with the NHS Constitution.

Q4. The CCG has emphasised the need for public engagement and I welcome that. However there can be no effective engagement without information.

We know from experience that, where services have been outsourced, commissioned, etc., requests for information are often refused on the grounds that information is commercially sensitive. Also, the Freedom of Information (FoI) Act cannot be used with private service providers because it does not apply to private companies.

Therefore, will the CCG undertake:
1. To publish in full all contracts with service providers including any subsequent variations in their terms?
2. To require, by contract, that service providers respond to requests for information from the public as if the FoI applied to them even when it does not?
3. To ensure through the contracts that the public is not denied important information, such as the payments being made for particular classes of work, on the grounds of commercial confidentiality?

We note that commercial interests have recently asked for a ‘level playing field’ in respect of tax. The three measures above would achieve just such a ‘playing field’ in respect of information provision.
In due course the CCG will seek to publish a full list of providers and services commissioned from these providers. This list will be populated on the website from 1st April 2013 once contracts are agreed. It will not be possible for Enfield CCG to apply FoI legislation to organisations where the legislation does not apply to as the FOI Act is specifically not designed for this. The CCG however as a statutory public organisation will be subject to FOI requests so will answer questions on services it commissions. There is no blanket ban on providing information in respect of contracts and in particular reference to commercial confidentiality and each FoI request will be assessed on its own merits.
Appendix O

Oral Questions from Members of the Public:

Q1. How would a patient from a practice who did not have a Patient Participation Group (PPG) have the chance to be elected as the patient representative?

We will make allowances for patients whose practice does not currently have a PPG to be eligible to stand as a board representative. Patients can be networked to their nearest PPG. The election and selection process is still to be decided. Feedback from all PPGs will also be discussed into the Patient and Public Engagement Group which is a sub-committee of the Board.

Q2. Equality and Diversity /Employment policies applicable to all ECCG staff on NHS Terms and Conditions.

The Equality and Diversity policy was approved by the Governing Body on 16 Jan 2013. All other HR policies will be presented to a future Governing Body board meeting for approval. All Enfield CCG staff are on NHS contracts and will work within the Equality and Diversity policy.

Q3. Do the ECCG employment policies support Equality and Diversity NHS principles?

Yes; all policies support Equality and Diversity principles in line with the NHS Constitution.

Q4. The CCG has emphasised the need for public engagement and I welcome that. However there can be no effective engagement without information.

We know from experience that, where services have been outsourced, commissioned, etc., requests for information are often refused on the grounds that information is commercially sensitive. Also, the Freedom of Information (FoI) Act cannot be used with private service providers because it does not apply to private companies.

Therefore, will the CCG undertake:

1. To publish in full all contracts with service providers including any subsequent variations in their terms?
2. To require, by contract, that service providers respond to requests for information from the public as if the FoI applied to them even when it does not?
3. To ensure through the contracts that the public is not denied important information, such as the payments being made for particular classes of work, on the grounds of commercial confidentiality?
We note that commercial interests have recently asked for a ‘level playing field’ in respect of tax. The three measures above would achieve just such a ‘playing field’ in respect of information provision.

In due course the CCG will seek to publish a full list of providers and services commissioned from these providers. This list will be populated on the website from 1st April 2013 once contracts are agreed. It will not be possible for Enfield CCG to apply FOI legislation to organisations where the legislation does not apply to as the FOI Act is specifically not designed for this. The CCG however as a statutory public organisation will be subject to FOI requests so will answer questions on services it commissions. There is no blanket ban on providing information in respect of contracts and in particular reference to commercial confidentiality and each FOI request will be assessed on its own merits.