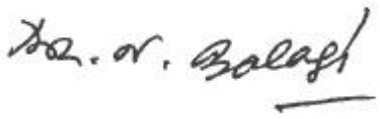
A meeting of the NHS Barnsley Clinical Commissioning Group Governing Body will be held on Thursday 12 March 2015 at 9.30 am in the Lower Hall, St John's Community Centre, Church Street, Penistone, Sheffield, S36 6AR.

AGENDA
(Public)

Item	Session	GB Requested to	Enclosure Lead	Time
1.	Apologies			09.30 am
2.	Patient Story			09.30 am 10 mins
3.	Declarations of Interest Relevant to the Agenda		Nick Balac	09.40 am
4.	Questions from the Public on Barnsley Clinical Commissioning Group Business		Nick Balac	09.40 am 10 mins
5.	Minutes of the Meeting held on 12 February 2015	Approve	**GB/Pu/15/03/05** Nick Balac	09.50 am 5 mins
6.	Matters Arising Report	Note	**GB/Pu/15/03/06** Nick Balac	09.55 am 5 mins
	Strategy			
7.	Report of the Chief Officer	Information	**GB/Pu/15/03/07** Lesley Smith	10.00 am 10 mins
8.	Update Report – Commissioning Support Unit, Lead provider Framework	Information	**GB/Pu/15/03/08** Jamie Wike	10.10 am 5 mins
9.	Commissioning Strategy 2014/19	Approve	**GB/Pu/15/03/09** Jamie Wike	10.15 am 15 mins
	Quality Governance			
10.	Cancer programme Board – Cancer Plan Objectives 2015/16	Approve	**GB/Pu/15/03/10** John Harban	10.30 am 10 mins
11.	Planned Care Programme Board Update Report	Approve	**GB/Pu/15/03/11** James Barker	10.40 am 10 mins
12.	CQUINS	Information	**GB/Pu/15/03/12** Brigid Reid	10.50 am 10 mins

13.	Child Sexual Exploitation Update	Information	**GB/Pu/15/03/13** Brigid Reid	11.00 am 10 mins
14.	Yorkshire Ambulance Service (YAS) Action Plan Update	Information	**GB/Pu/15/03/14** Brigid Reid	11.10 am 10 mins
15.	Risk and Governance Exception Report	Information & Approval	**GB/Pu/15/03/15** Jamie Wike	11.20 am 10 mins
	Finance and Performance			
16.	Integrated Performance Report	Information	**GB/Pu/15/03/16** Jamie Wike	11.30 am 15 mins
17.	Contracts – Updates on new guidance	Information	Verbal Heather Wells	11.45 am 10 m ins
	Committee Reports and Minutes			
18.	Minutes of the Finance and Performance Committee held on 5 February 2015	Information	**GB/Pu/15/03/18** Nick Balac	11.55 am 5 mins
19.	Minutes of the Patient and Public Engagement Committee meeting held on 29 January 2015	Information	**GB/Pu/15/03/19** Chris Ruddlesdin	12.00 noon 5 mins
20.	Minutes of Health and Well Being Board held on 3 February 2015	Information	**GB/Pu/15/03/20** Nick Balac	12.05 noon 5 mins
21.	Minutes of the formal Management Team held on 4 February 2015 and current Action Log	Information	**GB/Pu/15/03/**21 Lesley Smith	12.10 pm 5 mins
22.	**Date and Time of the Next Meeting:** Thursday 9 April 2015 at 09.30 am in the Boardroom Hillder House, 49/51 Gawber Road, Barnsley S75 2PY			12.15 pm Close

Signed



Dr Nick Balac – Chairman

Exclusion of the Public:

The CCG Governing Body should consider the following resolution:
***"That representatives of the press and other members of the public be excluded from the remainder of this meeting due to the confidential nature of the business to be transacted -* publicity on which would be prejudicial to the public interest"**
Section 1 (2) Public Bodies (Admission to meetings) Act 1960

NHS
Barnsley Clinical Commissioning Group

Putting Barnsley People First

Minutes of the Meeting of the BARNSLEY CLINICAL COMMISSIONING GROUP GOVERNING BODY (PUBLIC SESSION) held on Thursday 12 February 2015 at 9.30 am in the Boardroom, Hillder House, 49/51 Gawber Road, Barnsley, S75 2PY.

MEMBERS PRESENT:

Dr Nick Balac (in the chair)	Chair
Ms Anne Arnold	Lay Member
Dr Clare Bannon	Member
Dr Robert Farmer	Member
Dr Mehrban Ghani	Medical Director
Dr John Harban	Member
Ms Cheryl Hobson	Chief Finance Officer
Ms Marie Hoyle	Member
Dr Sudhagar Krishnasamy	Member
Dr Nick Luscombe	Member
Ms Brigid Reid	Chief Nurse
Mr Chris Ruddlesdin	Lay Member
Mr Mike Simms	Secondary Care Clinician
Mrs Lesley Smith	Interim Chief Officer

IN ATTENDANCE:

Ms Kay Morgan	Governing Body Secretary
Mrs Vicky Peverelle	Chief of Corporate Affairs
Mr Richard Kennedy	Senior Account Officer Yorkshire and Humber Commissioning Support
Mr Jamie Wike	Head of Performance

APOLOGIES:

Mr James Logan	Member

MEMBERS OF THE PUBLIC:

Ms Louise Coetser-Reynolds	Member of the Public
Mr Nadeem Ghani	Member of the Public
Mr Chris Millington	Member of the Public
Mrs Gillian Pepper	Designated Nurse Safeguarding Adults CCG
Mrs Claire Tabb	Member of the Public
Miss Heather Wells	Member of the Public
Mrs Faye Wilkinson	Member of the Public

The Chairman welcomed members of the public to the Governing Body meeting.

UNADOPTED

Agenda Item	Note	Action	Deadline
GB 15/31	**PATIENT STORY**		
	The Patient Story reflected the experiences of an elderly gentleman being diagnosed by his GP with cellulitis in the first instance, followed by deterioration in his condition and hospital admission. The family were concerned about how the patient was looked after in hospital. In particular why the care provided and general culture within the ward area appeared much better when the ward sister was on duty.		
	The gentleman's daughter could not understand why her father remained in bed whilst in hospital despite being mobile throughout his illness at home. Nursing staff advised that there was no reason why the patient should not be out of bed, he just needed encouragement. The gentleman was discharged but was readmitted via A&E with an overwhelming infection of sepsis and died.		
	The Chairman requested the thoughts of the Governing Body on the Patient Story. The following observations and comments were put forward: • It appeared that whilst in hospital patients were not encouraged to move around leading to loss of muscle tone. • Hospitals were not generally good at recognising sepsis which can ultimately lead to multi organ failure. • Hospital staff failed to listen to the views of the patient's daughter about the patient. • Health professionals quickly accept someone being in bed. Why had staff not encouraged patient to walk? • Was the patient's hospital admission necessary in the first place could the antibiotics have been administered in the home setting? • Shift leadership was important and ever team member mattered. • The Sepsis bundle is being progressed at Barnsley Hospital • Elderly people generally reiterate the message that they will only go into hospital if absolutely necessary. Elderly patients can become isolated in hospital.		

UNADOPTED

Agenda Item	Note	Action	Deadline
	The Chairman concluded, indicating that the key messages from the discussion had been around communication with and empowerment of patients. He further asked the Governing Body to keep these key messages in mind whilst considering all other agenda items.		
	The Governing Body noted the Patient Story.		
GB 15/32	**DECLARATION OF INTERESTS RELEVANT TO THE AGENDA**		
	The Chairman invited declarations of interest relevant to the meeting agenda it was noted that: • All Elected members and the Practice Manager members declared that they had an interest in agenda items 9 and 10. The Chairman agreed that it was in the interests of the CCG for these members to be allowed to participate in the discussion due to their clinical expertise in the area under discussion. In addition agenda item 9 was for information only, not decision. Agenda item 10 although for approval related to all GP practices and improved Primary Care services for the people of Barnsley.		
GB 15/33	**QUESTIONS FROM THE PUBLIC ON BARNSLEY CLINCIAL COMMISSIONING GROUP BUSINESS**		
	The Chairman invited questions from Members of the Public.		
	A Member of the Public introduced herself as Miss Heather Wells a chartered accountant who had undertaken work on behalf of the CCG leading on the Mid-Year Financial Review, the application for delegated co-commissioning and submission of a business case to NHS England (NHSE) for draw down of surplus. Miss Wells asked if the CCG had received notification from NHSE about drawn down of surplus. The Interim Chief Officer responded indicating that NHSE was in favour of supporting 75% of the business		

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Agenda Item	Note	Action	Deadline
	case submitted for surplus back to the CCG which equated to £2.1m. This was good news for the CCG, acknowledging that the business case would have been pitched against a limited pot of money and a background of resource shortage within the NHS generally. The Interim Chief Officer thanked Miss Wells for her work which would be picked up in plans going forward.		
	A Member of the Public commented that there were a number of questionnaires on the CCG website which had been there for some time. He further queried how long the questionnaires would be on the website, what was the level of response to the questionnaires and how would this be used. The Chief of Corporate Affairs agreed to determine the response rates from the questionnaires outside of the meeting and report back to the next meeting of the Governing Body on 12 March 2015. The Chief of Corporate Affairs clarified that the End of Life engagement and questionnaire did not close for another few weeks. The end of life website would become live at the end of March 2015 and the End of Life Strategy was close to being finalised. It was noted that the CCG generated engagement via social media. The CCG was ranked 35th in the top 50 organisations for use of twitter.	**VP**	**12.03.15**
	The Governing Body noted the questions raised by members of the Public.		
GB 15/34	**MINUTES OF THE PREVIOUS MEETING HELD ON 15 JANUARY 2015**		
	The minutes of the previous meeting were verified as a correct record of the proceedings.		
GB 15/35	**MATTERS ARISING REPORT**		
	The Governing Body considered the Matters Arising Report and the following main points were noted: • **Minute reference GB 15/10 Quality Highlights Report – Intermediate Care Services**		

UNADOPTED

Agenda Item	Note	Action	Deadline
	It was noted that a Member of the Public had cancelled her requested meeting with the Medical Director to discuss the Intermediate Care Service. The Chairman requested that the rearrangement of the appointment be actively followed up.	**MG**	**12.03.15**
	• **Minute reference GB 15/10 Quality Highlights report – D1 Discharge letters** Dr John Harban reported that a meeting to agreed improvements to D1 letters was being arranged. It was agreed that Ms Chris Lawson Medicines Optimisation should attend this meeting.	**JH**	**12.03.15**
	The BHNFT Medical Director had been informed about the information required by Primary Care on D1 letters. It had also been made clear to the BHNFT that contract penalties will be applied where DI standards were not achieved. An action plan had been produced by the BHNFT and would be monitored by the Area Prescribing Committee and Quality and Patient Safety Committee. The poor quality D1s was a patient safety issue. A recent audit of D1s identified that only 40% accuracy was being achieved. This was not acceptable and greater accountability was required.		
	• **Minute reference GB 14/320 Formal Management Team – IT Meeting** The Chief of Corporate Affairs informed the Governing Body that a meeting to consider IT issues had been rearranged and will take place following the Governing Body (private session) on 12 February 2015.		
	• **Minute reference GB 14/280 YAS** This action was deemed complete. The new Chief Executive of YAS and his team will meet with the Governing Body on 26 March 2015 at 1.00 pm.		
	• **Minute reference GB 14/174 – Sound Doctor** The Medical Director reported that a patient had tried to log into the Sound Doctor system without the		

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Agenda Item	Note	Action	Deadline
	appropriate code. The Governing Body deemed that this action was now complete. • **Minute reference GB 14/350 Questions From the Public – BHNFT Pharmacy Robot** The Chief Finance Officer informed the Governing Body that a full discussion about the Pharmacy Robot had been undertaken at the Contract Monitoring Meeting. The Pharmacy Robot had been in implementation stage until full operational status in December 2014. A report about utilisation of the Pharmacy Robot and realisation of benefits as listed in the original business case will be submitted to the Contract Monitoring meeting in March 2015 and then Governing Body. The Chief Finance Officer indicated that she would circulate the detailed benefits of the Pharmacy Robot with the minutes of the Governing Body Meeting.	**CH**	**12.03.15**
	The Governing Body noted the Matters Arising Report.		
STRATEGY			
GB 15/36	**REPORT OF THE INTERIM CHIEF OFFICER**		
	The Interim Chief Officer referred to her Report which updated the Governing Body with the key issues and developments relevant to the strategic direction of the CCG namely: • Summary Report of Quarterly Assurance Review Q2 – Letter • Intermediate Care – Community Beds • New Models of Care – Multi Specialty Community Provider Model (MCP) • Commissioning Support Unit - Lead Provider Framework		
	The Interim Chief Officer provided some good news, that the CCGs application to the Prime Ministers Challenge		

UNADOPTED

Agenda Item	Note	Action	Deadline
	Fund had been shortlisted to the last 24. Barnsley and Sheffield were the only two regional applications to have been shortlisted. It was noted that the application to the Prime Ministers Challenge Fund had been a good example of colleagues in Primary Care working with and being supported by the CCG to produce a high quality piece of work. The outcome of the application was expected by week ending 21 February 2015.		
	Summary Report of Quarterly Assurance Review Q" – Letter The Governing Body noted the letter from NHS England summarising the positive outcome of the Quarterly Assurance Review. The Governing Body recognised that the CCG should improve its public relations to raise the profile of the CCG.		
	Intermediate Care – Community Beds The Governing Body were pleased to note that funding for intermediate care beds had been secured from the Better Care Fund. There was still a slight funding gap to address; however, the expected return of surplus would alleviate this position. It was noted that the Barnsley Metropolitan Borough Council (BMBC) had no statutory duty to fund intermediate care beds and there had been some media activity around the decommissioning and closure of tier 1 beds.		
	New Models of Care – Multi Speciality Community Provider The Interim Chief Officer reported that an expression of interest had been submitted for the CCG to become a Multi-Speciality Community Provider vanguard site.		
	Commissioning Support Unit – Lead Provider Framework The Interim Chief Officer explained that NHS England had developed a Lead Provider Framework to support CCGs in securing legally binding contracts for commissioning support services from April 2016 and provided an update on the procurement process.		

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Agenda Item	Note	Action	Deadline
	It was noted that the Yorkshire and the Humber Commissioning Support Unit would be on the lead provider framework for Continuing Health Care, and individual funding requests but not for all the other support services they currently provide to the CCG.. The Interim Chief Officer advised that discussions were taking place with other CCGs within South Yorkshire and the CSU about future procurement options. The Interim Chief Officer with the Management Team and in conjunction with neighbouring CCGs was to review the list of services to determine what functions could be provided in house, shared or procured via the lead provider framework. It was noted that all projects and required functions were IT dependent. Reservation was expressed that should another CCG become lead provider for a service (for example IT) then Barnsley should not lose out in terms of service provision. Ms A Arnold commented that a strategic financial and staff review was already being undertaken within the Yorkshire and Humber Commissioning Support Unit and questioned whether that would still proceed. The Interim Chief Officer confirmed that work currently underway to make the CSU financially viable would continue. The Interim Chief Officer agreed to provide an update report about the Commissioning Support Unit – Lead Provider Framework and ongoing work by the Chief Officers Group to the next meeting of the Governing Body.	**LS**	**12.03.15**
	Chief Finance Officer The Interim Chief Officer announced that Mrs Cheryl Hobson Chief Finance Officer was to take up a twelve month secondment with the 'Working Together' Programme' commencing on 23 February 2015. The Interim Chief Officer was seeking to provide cover during Mrs Hobson's period of secondment, from a list of individuals in the accredited pool at NHS IMAS.		
	Mr C Ruddlesdin commented that it reflected well on Barnsley CCG when other organisations wished to employ our staff. The Chairman advised that the CCG expected to hear the outcome of the application for delegated commissioning by the 28 February 2015.		

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Agenda Item	Note	Action	Deadline
	The Governing Body noted the Report of the Interim Chief Officer.		
GB 15/37	**FIVE YEAR STRATEGIC PLAN**		
	The Governing Body received a presentation from the Head of Planning and Performance about the 'Forward View into Action – Planning for 2015/16. The presentation was intended to provide assurance to the Governing Body about the CCGs response to planning and current progress.		
	The Governing Body considered the planning timetable, milestones and next steps. The Governing Body highlighted that the Membership Council and partners should be fully informed about the CCG Plans. Of equal importance was public engagement around the plans.		
	The Chief of Corporate Affairs commented that a programme of public engagement was being established. It was noted that there would be an opportunity for Governing Body Members to further consider the final plan on 9 April 2015. The Chairman suggested a Practice Engagement around strategic planning.		
	The Governing Body agreed: • **To submit the next submission of the draft performance, activity and finance templates to NHS England on 27 February 2015.** **Additional actions agreed:** • **When draft plans are submitted to NHS England on 27 February 2015, these plans to be also submitted (in suitable format) to the Membership Council, Governing Body and partners.** • **Consider arrangement of a Practice Engagement Event around strategic planning**	**VP** **VP** **VP**	**27.02.15** **27.02.15** **27.02.15**
GB 15/38	**MULTI-SPECIALITY COMMUNITY MODEL UPDATE**		

UNADOPTED

Agenda Item	Note	Action	Deadline
	The Chief of Corporate Affairs introduced her report which informed the Governing Body about the progress towards an expression of interest in being a vanguard site for the new model of care, 'Multi-Speciality Community Provider (MCP).' The Chief of Corporate Affairs tabled a copy of the Registration of Interest, submitted on the 9 February 2015. It was noted that if the registration of interest was successful at initial screening then the CCG (as facilitator and system leader) together with partners, would be invited to present their proposals to NHS England.		
	Discussion took place and the following main points were raised: • With regard to the (MCP) model it was queried how this would affect practices not in the Barnsley GP Federation. It was clarified that Practices may not be sustainable out of the Federation. The opportunities of being in a Federated model to deliver services at scale were huge. • As at 12 February 2015 twelve practices had signed up to the Federation. The Chief of Corporate Affairs agreed to ascertain the population list size of the 12 practices. • Dr Clare Bannon questioned the implications of there being two or three federations in Barnsley. The Interim Chief Officer indicated that all Practices were eligible to form Federations. Though more than one Federation would prove complex in Barnsley and also for the MCP. The CCG would need to be assured that the Federation(s) and other organisations with which the CCG commissions could deliver the required services to improve outcomes for the people of Barnsley. • It was noted that the Federation would be a community interest company. • National teams would support the MCP vanguard sites to pilot services, through contracting and legal and financial advice and support. • The CCG had worked to engage with the Barnsley	**VP**	**12.03.15**

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Agenda Item	Note	Action	Deadline
	Hospital NHS Foundation Trust and South West Yorkshire NHS Partnership Trust who were partners in the MCP application.		
	The Chairman commented that the CCG had to improve the outcomes for the people of Barnsley and if the CCG did not reach out to new national initiatives then Barnsley may be left behind leading to reputational issues. A number of primary care initiatives were now coming together to deliver better outcome for the people of Barnsley.		
	The Governing Body noted the Update Report. **Actions Agreed** **The Chief of Corporate Affairs agreed to ascertain the population list size of the 12 practices signed up to the Federation.**	**VP**	**12.03.15**
QUALITY AND GOVERNANCE			
GB 15/39	**PRIMARY CARE DEVELOPMENT – PRACTICE DELIVERY AGREEMENT 2015/16**		
	The Chief of Corporate Affairs presented the Governing Body with an update on the 2014/15 Practice Delivery Agreement (PDA) and proposals for the 2015/16 PDA between the CCG and each of its member practices. A Practice Engagement Event had been held on 14 January 2015 to develop light touch governance arrangements, a common set of outcomes with key performance indicators and prioritisation of potential tier two services. Practices were required to sign up the PDA by 28 February 2015.		
	In response to a question raised it was noted the PDA had been submitted to a Practice Engagement Event, the Governing Body and Membership Council again on 24 March 2015.		
	The Practice Manager Member commented that the CCG and Practice Managers had worked collaboratively on the development of the PDA. It was highlighted that PRIMIS were taking a role in setting up practice systems to deliver PDA performance information requirements.		

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Agenda Item	Note	Action	Deadline
	Mechanisms were being put in place to support practices with achievement of the PDA.		
	The Chief of Corporate Affairs clarified that if Practices did not perform and or deliver on the PDA there was an option to claw back of monies and this was detailed within the PDA Agreement. The support available to practices to achieve the PDA requirements and arrangements for 'claw back' of monies would be further considered at the next Meeting of the Membership Council on 24 March 2015**.**		
	The Governing Body noted the PDA update. **AGREED** • **The Governing Body agreed the proposals for the 2015/16 PDA between the CCG and each of its member practices.** **ACTIONS** • **To submit the PDA to the next meeting of the Membership Council on 24 March 2015, highlighting provision of support to practices to achieve the PDA requirements and if required arrangements for claw back of monies, through the disputes process outline within the PDA Agreement in Section 10.** • **The practice support unit and contact to be issued with the PDA to practices rather than semi-formal links.**	**VP** **VP** **VP**	**28.02.15** **24.03.15** **24.03.15**
GB 15/40	**PLANNED CARE PROGRAMME BOARD – PHYSICAL ACTIVITY CARE PATHWAY**		
	Dr Clare Bannon presented her paper to the Governing Body about the Physical Activity Care Pathway and proposed extension of the pilot. An evaluation of the initial one year Physical Activity Care Pathway pilot had been undertaken providing positive feedback. The Governing Body was asked to consider continued funding of the pilot for a further year and confirm approval to enter competitive tender process.		
	Discussion took place and the following main points		

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Agenda Item	Note	Action	Deadline
	were noted : • It was clarified that the evaluation questionnaire was varied measuring all aspects of the pathway with some specific to individuals. The outcomes of the Pathway appeared woolly, hard evidence of improved outcomes for the people of Barnsley was required. • Public Health was advocating a move away from individual to community wide exercise promotion. • There was disparity between Practice referrals to the service. A big issue related to awareness of the Pathway by practices. Any rollout of the Pathway must be accompanied by a robust promotion plan. • The projected 800 referrals to the pathway although based on previous schemes appeared ambitious. The business case needed to be really clear on uptake. • Dr Robert Farmer commented that there were barriers to referral for example form filling. Self-referral options may be preferable. • Patients may take the pathway seriously because their GP had prescribed/referred them. Levers could be applied to generate additional activity after completion of pathway for example reduced costs for exercise classes/swims • Public health had stop funding a previous exercise referral scheme and it appeared that the CCG was picking up the costs. The pathway needed to be prioritised appropriately against available resource. The Chairman advised that clarification should be sought on the prioritisation of the Physical Activity Care Pathway. Additionally the funding contribution from Public Health should be determined.		
	Members' considered the table of expenditure for the Pathway. In response to a questions raised it was noted that inflation had been included in the costings and that estimates were based on 800 up to 1000 referrals. The cost increase was a step change in terms of staffing. The Chief of Corporate Affairs commented that the		

UNADOPTED

Agenda Item	Note	Action	Deadline
	Governing Body should carefully consider agreement to fund the pathway for 2 years when there was uncertainty about CCG funding allocations in 2016/17.		
	It was noted that should the Governing Body decide not to approve the continued funding of the Physical Care Pathway pilot then referrals to the service should cease with immediate effect and this must be communicated to Practices.		
	The Governing Body agreed to: • **Defer approval of the Physical Activity Care Pathway until responses are received to the concerns raised by the Governing Body. Following which resubmission of the Pathway to the Finance and Performance Committee for prioritisation of resources.**	**CB**	
GB 15/41	**CHILD SEXUAL EXPLOITATION UPDATE**		
	The Chief Nurse introduced her report and updated the Governing Body with regard to Child Sexual Exploitation (CSE) in Barnsley. The Chief Nurse advised the Governing Body of the Louise Casey Report, 'Inspection of Rotherham Metropolitan Borough Council'. The Report highlighted that even after the JAY Report the Council had failed in terms of its governance and culture. The Chief Nurse advised that the Report would be discussed at the next Barnsley Safeguarding Children Board and commended the Report to the Governing Body.		
	The Governing Body recognised that Rotherham was a neighbouring town and Perpetrators of CSE would not respect boundaries. Assurance should be constantly sought that CSE was not happening in Barnsley and the Dearne. The Chairman and the Interim Chief Officer agreed to raise the Louise Casey Report and assurances about CSE activity in a supportive way with the Council.		
	The Chief Nurse advised that the Police shared information with the Barnsley Safeguarding Children Board. She would suggest to the Director of Children's Services that the Barnsley Safeguarding Children Board undertake observation time with police in localities.		

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	The Governing Body noted the CSE Update. **Actions agreed:** • **To circulate the Louise Casey Report, 'Inspection of Rotherham Metropolitan Borough Council' to Governing Members. Time to be allocated/protected in Governing Body members Diaries for reading of the Report.** • **To share the Louise Casey Report and assurances about CSE activity in a supportive way with the Council.**	**BR** **NB/LS**	**13.02.15**
GB 15/42	**TERMS OF REFERENCE CLINICAL SENATE**		
	The Medical Director provided the Governing Body with the terms of reference for the Clinical Senate., indicating that the terms of reference had been revised to include a representative from Public Health in the membership of the Clinical Senate.		
	The Governing Body considered the membership of the Clinical Senate. It was noted that the Chairman, Medical Director, Chief Nurse and Dr John Harban were the CCG members at the Clinical Senate. Other attendees were co-opted to the Senate as required. It was important for members of the Clinical Senate to provide the clinical direction for the best outcomes for the people of Barnsley over and above organisational objectives. Also for the Clinical Senate to link and work with the Health and Wellbeing Board.		
	It had previously been queried by the governing Body if the CCG representation at the Clinical Senate should be opened up to GPs. The Chairman indicated that roles of the Chief Nurse, Medical Director were integral to the work of the Clinical Senate. However, he would email GPs after April 2014 to ascertain any interest in the membership of the Clinical Senate.		
	It was highlighted and queried if other local providers for example the Federation and Hospice would be invited to the Clinical Senate.		
	The Governing Body noted the revised terms of		

UNADOPTED

Agenda Item	Note	Action	Deadline
	reference. **Actions Agreed** • **The Chairman to ascertain interest in the membership of the Clinical Senate from GPs.** • **The Interim Chief Officer to share the terms of reference and minutes of the Clinical Senate with the Health and Wellbeing Board.** • **To request the Health and Wellbeing Board to forge links with the Clinical Senate.**	**NB** **LS** **NB/LS**	**09.04.15**
GB 15/43	**RISK AND GOVERNANCE EXCEPTION REPORT**		
	The Chief of Corporate Affairs presented the Risk and Governance Exception Report to the Governing Body. The Governing Body noted the three risks currently rated as red (extreme) on the Assurance Framework.		
	Members considered the Risk Register. John Harban proposed to the Governing Body that the ratings for the risks relating to the Yorkshire Ambulance Service (YAS) be increased to the maximum risk score. The risks were a huge patient safety and reputational risk for the CCG. In addition YAS needed to be aware of the CCGs view point on these risks.		
	Governing Body Members referred to a tabled paper intended for the Integrated Performance Report about YAS response time performance and queried what were YAS doing to address their poor performance in Barnsley. The Governing Body agreed that the rated score for the risk reference CCG 14/5b be increased to 25. The Quality and Patient Safety Committee would address risk CCG 14/5a at their next meeting on 12 February 2015 taking into account available information and views of the Governing Body.	**MG**	**12.02.15**
	The Interim Chief Officer emphasised that poor ambulance response times were a reputational risk but the key consideration was potential risk to safety of patients. Further consideration about the performance of YAS would be discussed in the private session of the Governing Body on 12 February 2015. A member of the public commented that he was relying on the CCG to		

UNADOPTED

Agenda Item	Note	Action	Deadline
	safeguard patients, the performance of YAS needed to be addressed as a matter of urgency.		
	The Governing Body noted the Risk and Governance Exception Report. **Agreed Actions:** • **The Quality and Patient Safety Committee to assess risk CCG 14/5a on 12 February 2015 taking into account available information and views of the Governing Body**	MG	**12.02.15**
FINANCE AND PERFORMANCE			
GB 15/44	**INTEGRATED PERFORMANCE REPORT**		
	The Chief Finance Officer and Chief of Corporate Affairs introduced the Integrated performance Report to the Governing Body.		
	Finance The Chief Finance Officer reported that the CCG was expected by NHS England to deliver a revised surplus of £10,480k an increase of £840k on the surplus planned for. The CCG was currently forecasting an overspend of £2.073k before risk adjustment.		
	The Chief Finance officer drew members' attention to the financial risk Assessment, showing a risk adjusted forecast overspend of £434k. She further commented that the risk-adjusted forecast overspend could be managed appropriately to year end.		
	The Governing Body considered section of the Finance report relating to potential additional income streams and reductions in forecast; in particular it was noted that • Rebate from the CSU for non-delivery of the IT Strategy and IT equipment would be transferred and documented within the CCG 2014/15 year end accounts. • The Chief Finance Officer would continue to press for		

UNADOPTED

Agenda Item	Note	Action	Deadline
	financial penalties to be applied in respect of the YAS contract.	**CH**	**12.03.15**
	Performance The Chief of Corporate Affairs reported that licence conditions had been lifted from the Barnsley Hospital NHS foundation Trusts (BHNFT) A&E Department. The A&E 4 hour wait target had been met in Quarters 1 and 2 but not quarter 3. Barnsley was sixth in country nationally in terms of performance. Year to date performance against the A&E 4 hour wait was 96%. Mr Chris Ruddlesdin reported that Karen Kelly Director of Operations at the BHNFT had given a presentation on A&E performance to the Patient Council. Serious cases were prioritised and managed; delays were attributed to the minor injuries. Dr Sudhagar Krishnasamy commented that there was still no front of service triage at the A&E Department.		
	The Governing Body noted the contents of the Integrated Performance Report. **Agreed Actions:** • **To press for financial penalties to be applied in respect of the YAS contract.**	**CH**	**12.03.15**
COMMITTEE REPORTS AND MINUTES			
GB 15/45	**MINUTES OF THE MEMBERSHIP COUNCIL 20 JANUARY 2015**		
	The Governing Body received the Minutes of the Membership Council held on 20 January 2015. The following amendments were noted in respect of meeting attendance: • The Governing Body Practice Manager Member had attended the meeting. • Dr Clare Bannon had submitted apologies for the meeting.	**KM** **KM**	**12.03.15** **12.03.15**
	The Governing Body noted the Minutes of the		

UNADOPTED

Agenda Item	Note	Action	Deadline
	Membership Council.		
GB 15/46	**MINUTES OF THE FINANCE AND PERFORMANCE COMMITTEE HELD 8 JANUARY 2015**		
	The Governing Body noted the minutes of the Finance and Performance Committee held on 8 January 2015.		
GB 15/47	**MINUTES OF THE QUALITY AND PATIENT SAFETY COMMITTEE HELD ON 8 JANUARY 2015**		
	The Governing Body received the minutes of the Quality and Patient Safety Committee held on 8 January 2015. It was noted that the Committee had considered the D1 Discharge Letter Audit in detail.		
	Attention was drawn to minute reference QPSC 01/15/14 Quality Assurance report – Acute medical Until (AMU) and provision of consultant cover. It was highlighted that the CCG had previously approved a business case to fund consultant cover for the AMU. The Medical Director commented that he had raised this with the Medical Director at the BHNFT who was addressing the issue. There was also a CCG quality visit planned to the AMU.		
	The Governing Body noted the minutes of the Quality and Patient Safety Committee held on 8 January 2015.		
GB 15/48	**MINUTES OF THE EQUALITY STEERING GROUP HELD ON 8 JANUARY 2015**		
	The Governing Body considered the Minutes of the Equality Steering Group held on 8 January 2015. The Governing Body Practice Manager Member referred to the Equality Delivery System (EDS2) indicating that this was fundamental to service delivery. Further guidance will be issued and support provided to providers including primary care.		
GB 15/49	**MINUTES OF THE FORMAL MANAGEMENT TEAM HELD ON:** • **7 JANUARY 2015** • **21 JANUARY 2015**		
	The Governing Body noted the Minutes of the Formal		

UNADOPTED

Agenda Item	Note	Action	Deadline
	Management Team held on 7 January 2015 and 21 January 2015.		
GB 15/50	**QUESTIONS FROM THE PUBLIC**		
	The Chairman invited further questions from members of the public. A member of the public raised the following two issues: • A concern had been picked up from the BHNFT about the funding of patient transportation. The Chief of Corporate Affairs explained that the CCG funds a a patient discharge transport ambulance on a recurrent and had funded additional transport on a non-recurrent basis. This recurrent funding will continue. • A conduit in the Rotherham child sexual exploitation had been the use of taxis. Barnsley closely borders Rotherham. What and where is the separation between sexual abuse and sexual exploitation? The Chief Nurse advised that the Louise Casey report provided a definition of sexual abuse and sexual exploitation. Sexual exploitation was a process by which people were actively identified, sought out and groomed for exploitation. In sexual abuse the perpetrators are known to the victims. The Chief Nurse also advised that additional sexual abuse training had been provided for staff in Barnsley care homes. Social care staff, teachers and Youth workers were also at the fore front of spotting the signs of sexual abuse and exploitation. The important point is that Safeguarding was everyone's business.		
GB 15/51	**CHIEF FINANCE OFFICER**		
	On behalf of the Governing Body, the Chairman took the opportunity to express appreciation to Mrs Cheryl Hobson for her work as the CCGs Chief Finance Officer and wished her well in her secondment role with the Working Together Programme.		

UNADOPTED

Agenda Item	Note	Action	Deadline
GB 15/52	**DATE AND TIME OF THE NEXT MEETING**		
	The next meeting of the Governing Body will be held on: • Thursday 12 March 2015 at 09.30 am St John's Community Centre, Church Street, Penistone, Sheffield, S36 6AR		

UNADOPTED

Barnsley Clinical Commissioning Group

Putting Barnsley People First

MATTERS ARISING REPORT TO THE GOVERNING BODY

12 March 2015

1. MATTERS ARISING

The table below provides an update on actions arising from the previous meeting of the Governing Body (public session) held on 12 February 2015.

Table 1

Minute ref	Issue	Action	Outcome/Action
GB 15/33	**Questions from the Public** To determine the response rates from the CCG website questionnaires and report back to the Governing Body.	**VP**	**COMPLETE**
GB 15/36	**Report of Interim Chief Officer** To provide an update report about the Commissioning Support Unit – Lead Provider Framework and ongoing work by the Chief Officers Group to the Governing Body.	**LS**	**COMPLETE** – On Agenda for 12 march 2015
GB 15/37	**Five Year Strategic Plan** • To submit the next submission of the draft performance, activity and finance templates to NHS England on 27 February 2015. • Plans to be also submitted (in suitable format) to the Membership Council, Governing Body and partners by 27 February 2015 • Consider arrangement of a Practice Engagement Event around strategic planning	**VP** **VP** **VP**	**COMPLETE** The submission is currently templates, narrative will be set out in readiness for membership Council Meeting Considered Yes – To be progressed as part of PEP

Minute ref	Issue	Action	Outcome/Action
GB 15/38	**Multi-Speciality Community Model** To ascertain the population list size for the 12 practices signed up to the Federation.	**VP**	**COMPLETE** - As at 5 March 2015 there are nine practices signed up to Federation with a total list size of 69,212 (weighted January 2015). There are a further four practices who have expressed an interest in joining the federation which would bring the list size to 102325. The total list size for Barnsley is 283,744.
GB 15/39	**Primary Care Development – Practice Delivery Agreement** • To submit the PDA to the next meeting of the Membership Council on 24 March 2015, highlighting provision of support to practices to achieve the PDA requirements and if required arrangements for claw back of monies, through the disputes process outline within the PDA Agreement in Section 10 **.** • The practice support unit and contact to be issued formally to practices rather than semi-formal links.	**VP** **VP**	**COMPLETE** – Scheduled agenda item for Membership Council meeting on 24 March 2015. **COMPLETE** – Via letter highlighting In progress
GB 15/40	**Planned Care Programme Board – Physical Activity Care Pathway** Defer approval of the Physical Activity Care Pathway until responses are received to the concerns raised by the Governing Body. Following which resubmission of the Pathway to the Finance and Performance Committee for prioritisation of resources.	**CB**	

Minute ref	Issue	Action	Outcome/Action
GB 15/41	**Child Sexual Exploitation Update** • To circulate the Louise Casey Report, 'Inspection of Rotherham Metropolitan Borough Council' to Governing Members. Time to be allocated/protected in Governing Body Members Diaries for reading of the Report. • To share the Louise Casey Report and assurances about CSE activity in a supportive way with the Council**.**	**BR/KM** **LS/NB**	Report Circulated Refer to the CSE Report agenda item 13. Chief Nurse to request BSCB for a 'True for us' review.
GB 15/42	**Terms of Reference Clinical Senate** • The Chairman to ascertain interest in the membership of the Clinical Senate from GPs. • The Interim Chief Officer to share the terms of reference and minutes of the Clinical Senate with the Health and Wellbeing Board. • To request the Health and Wellbeing Board to forge links with the Clinical Senate.	**NB** **LS** **LS**	Pending **COMPLETE** Pending
GB 15/43	**Risk and Governance Exception Report** • The Quality and Patient Safety Committee to assess risk CCG 14/5a on 12 February 2015 taking into account available information and views of the Governing Body	**MG**	Refer to agenda item 14 YAS Report
GB 15/43	**Integrated Performance Report** To press for financial penalties to be applied in respect of the YAS contract	**(CH) HW**	Ongoing

Minute ref	Issue	Action	Outcome/Action
GB 15/45	**Minutes of the Membership Council held on 20 January 2015** Amendments in respect of meeting attendance: • The Governing Body Practice Manager Member had attended the meeting. • Dr Clare Bannon had submitted apologies for the meeting.	**KM**	**COMPLETE** **COMPLETE**

2. ITEMS FROM PREVIOUS MEETINGS CARRIED FORWARD TO FUTURE MEETINGS

Table 2 provides an update/status indicator on actions arising from earlier Board meetings held in public.

Table 2

Minute Ref	Issue	Action	Outcome/Actions
GB 14/320 & GB 14/335	**Formal Management Team** To set up a meeting with IT leads, the Practice Manager Member and Chief Finance Officer to look at all issues around IT support to avoid becoming a reputational issue for the CCG. Drs Harban and Luscombe to raise a new issue relating to access to Practice local systems by EMIS and System1. Access had to be requested and gained from the Yorkshire and Humber Commissioning Support Unit IT helpdesk.	**VP**	Meeting established for 12 February 2015 .
GB 14/163	**Strategic Commissioning Plan 2014/15** To consider the expected shift in workforce in consequence to the Commissioning Plan.	**VP**	There would be no action progress with this action until the CCGs Strategic Commissioning Plan had been developed.
GB 14/108	**Report of the Chief Officer** Identify the individual(s),	**VP**	In Progress

Minute Ref	Issue	Action	Outcome/Actions
	organisation(s) responsible for ensuring that actions from the External Verification Cancer Peer Review Visit 2014 were completed.		
GB 14/309	**Anaesthetists Bid** Work up a range of cost options around the Anaesthetists Bid and submit to the next meeting of the Finance and Performance Committee on 4 December 2014.	**(CH) HW**	Discussions are ongoing through contracting with involvement of Dr Harban
GB 14/310	**Child Sexual Exploitation** **1.** Deputy Chief Nurse to look into issues around the 'flagging up' of safeguarded children when registering at GP practices.	**KM**	Jane Wood currently taking this forward - completed
GB 14/338	**Care Quality Commission Children Looked After and Safeguarding Review** To ascertain and ensure that 'Safeguarding flags' on the BHNFT's Lorenzo system were appropriately highlighted to staff.	**KM**	Ongoing
GB 14/340	**BUPP Report, Winterbourne View – Time for Change** Management Team to consider the proposed savings in the significant commissioning area of Learning Disabilities for the CCG.	**Man. Team**	
GB 14/347	**Minutes of the Quality and Patient Safety Committee** The D1 audit and considerations of this by the Area Prescribing Committee and Quality and Patient Safety Committee to be discussed at the 12 February 2015 meeting of the Governing Body. Development of an action plan to improve the quality and timeliness of DI information to Practices.	**MG** **MG**	The DI Audit was being considered and monitored by the Area Prescribing Committee and Quality and Patient Safety Committee. It was also included in the Quality Highlights Report.

Minute Ref	Issue	Action	Outcome/Actions
GB 14/350 & GB15/35	**Questions from the Public** The Medicines Optimisation Team and Quality and Patient Safety Committee to explore whether the BHNFT's Pharmacy Robot is being utilised to its full potential and reflect findings back to the BHNFT. A Report about utilisation of the Pharmacy Robot and realisation of benefits as listed in the original business case will be submitted to Contract Monitoring Meeting in March 2015 and then Governing Body. Circulate the detailed benefits of the Pharmacy Robot.	**MG/(CH) HW** **(CH) HW** **(CH) HW**	The Pharmacy Robot had been in implementation stage until full operational status in December 2014. A report will be produced by the BHNFT 12 weeks following full implementation. **COMPLETE**
GB 15/08	**Report of Interim Chief Officer – Multi Speciality Community Provider Model** Submit an expression of interest to NHS England by 9 February 2015 to be part of the first cohort (a vanguard site) to develop new models of care with a view to exploring further the opportunity offered by MCPs	**VP**	**COMPLETE**
GB 15/10 & GB 15/35	**Quality Highlights Report** The Medical Director and Member of Public to meet outside of the meeting to discuss the Intermediate Care Service. Rearrangement of the appointment to be actively followed up.	**MG**	**COMPLETE** Meeting arranged for 18 March 2015.
GB 15/10 & GB 15/35	**Quality Highlights Report** Determine CCG levers to affect improvement in D1 letters and report back to next meeting of the Governing Body on 12 February 2015**.**	**(CH) HW**	Discussed at BHNFT contract meeting on 6 February 2015. BHNFT to produce a timeline of actions to address issues. To be taken forward by the Director of Nursing

Minute Ref	Issue	Action	Outcome/Actions
	Meeting being arranged to agree improvements to D1 Letters - Ms Chris Lawson Medicines Optimisation to attend the meeting		BHNFT.
GB 15/16	**Minutes of the Audit Committee – 4 December 2015** The Chairman to discuss minute reference AC 14/70 with the Governing Body Secretary outside of the meeting.	**NB/KM**	

Barnsley GP Practices Federation Applications for Membership			
Practice Details	Practice Code	Date Signed	Weighted Practice List size (As at Jan 2015)
Ashville Medical Practice	C85003	23/12/2014	12,863
Chapelfield Medical Centre	C85013	01/12/2014	10,917
Hollygreen Practice	C85023	15/12/2014	10,689
The Kakoty Practice	C85009	01/12/2014	6,420
Monk Bretton Health Centre Dr A Munzar	C85622	21/11/2014	2,241
Royston Group Practice	C85005	29/10/2014	8,857
St Georges Medical Practice	C85619	19/12/2015	6,827
Grimethorpe Surgery Dr S V Sriramulu & Dr J Maters	C85018	24/12/2014	7,816
Hollygreen Practice T/A Oakhaven Partnership (Formerly Dr Neogy's Practice - Great Houghton)	C85023	09/02/2015	2,582
			69212
		Total Practice List size at as January 2015 (wieghted)	283744

Practices who have expressed an interest in joining the federation

Practice Details	Practice Code	Date Signed	Weighted Practice List size (As at July 2014)
Hoyland Medical Centre			11,784
Woodland Drive Medical Centre			5689
Lundwood Medical Centre			5619
White Rose Medical Centre			10021
		Total	33113
			69212
		Total if sign up	**102325**

NHS
Barnsley Clinical Commissioning Group
Putting Barnsley People First

GOVERNING BODY

12 March 2015

REPORT OF THE CHIEF OFFICER

1.	**PURPOSE OF THE REPORT**
	To update the Governing Body on key issues and developments relevant to the strategic direction of the CCG.
2.	**EXECUTIVE SUMMARY**
	This report provides an update on the following issues: • New Care Models Review • Programme Board Review • Commissioning Working Together Programme Update • Sustainable Treat and Return Service Model • Barnsley Hospice Annual Grant • Primary Care Co-Commissioning
3.	**THE GOVERNING BODY IS ASKED TO:** • Note the outcome re our Vanguard application and partners agreement to continue to progress our approach to developing a Multispecialty Community Provide model of care for Barnsley. • Confirm agreement to establishing a single Clinical Transformation Board, replacing our current Programme Boards from 1 April 2015. • Note progress with the Working Together Programme and agree to the proposal to stand down the SYCOM and SYCOM + Providers meeting with a refreshed role for CCGCOM as the overarching Working Together Programme Board. • Support the proposal for a Sustainable Treat & Return Service Model for Non-ST Elevation Myocardial Infarction Patients in South Yorkshire & Bassetlaw • Agree to contribute the same level of grant allocation to Barnsley Hospice in 2015/16 as in 2014/15. • Authorise the Chair and Chief Officer to sign the delegation agreement on the CCG's behalf for Primary Care Co-Commissioning

Agenda Item – Allocation of Time 10 Minutes

Report of: Lesley Smith

Designation: Chief Officer

1.	**SUPPORTING INFORMATION**	
1.1	**Links to the Assurance Framework**	
	Objective 1, threat 1.1 – risk the CCG will fail to work effectively with its key providers resulting in a failure to commission high quality health care that meets the needs of individuals and groups Objective 1, threat 1.5 – provider financial risks may lead to a deterioration in the quality and safety of services provided Objective 3, threat 1.5 – failure to align operational planning with long term objectives Objective 4, threat 4.1 – failure to deliver joined up services for the people of Barnsley	
1.2	**Links to Objectives**	
	Highest quality governance and processes.	**X**
	Commission high quality health care that meets the needs of individuals and groups.	**X**
	Bring care closer to home.	**X**
	To support safe, sustainable and accessible local hospital services.	**X**
	To develop services through real partnerships with mutual accountability and strong governance.	**X**
1.3	**Links to NHS Constitution**	
	Comprehensive service to all.	**X**
	Based on clinical need, not ability to pay.	**X**
	Highest standards of excellence.	**X**
	Reflect the needs and preferences of patient's families and carers.	**X**
	The NHS works in partnership with other organisations.	**X**
	Best value for taxpayers' money.	**X**
	Accountable to the public and patients that it serves.	**X**
1.4	**Equality and Diversity**	**X**

2.	**INTRODUCTION / BACKGROUND INFORMATION**
3.	**DISCUSSION / ISSUES**
3.1	**Expression of interest to join the New Care Models Programme** Following 269 expressions of interest to join the New Models of Care programme we have heard that our Multispecialty Community provider application has not been successful. However we have been advised not to reduce the pace or scale of our ambition. The response from NHS England outlined: "We are not just giving you permission to proceed further with your ambitions to redesign care but are strongly encouraging you to do so alongside your local system partners, and to do so at the same pace as the vanguards if you so wish and are able to do so. In addition to providing focused national support to the vanguard sites, as the first specific cohort of partners to test defined new care models, we are working in partnership with a wide range of stakeholders to develop a support package that will be available to other localities committed to and able to demonstrate capability to deliver the changes required. The exact nature of this offer to local partners is currently being worked through, but we will be collaborating with the King's Fund and others at a national and local level. To help develop this offer we will invite a number of you to join us at events designed to capture opportunities for how the New Care Models programme can impact beyond the vanguard sites. We welcome your input in working with us in this, and will be in touch with next steps. We would like to reiterate that the future sustainability of the NHS depends on all organisations, not just a small number of sites, engaging their communities, patients and partners on bold plans to redesign care - to improve health and wellbeing, improve the quality of care, and deliver better value." Provider partners in BHNFT and SWYFT have already indicated that they are keen to progress this work locally and a follow up meeting is being set up to explore how we will take this forward.
3.2	**Programme Board Review – Next Steps Update** In August 2014 the Governing Body requested that a review of the current functioning of Programme Boards be undertaken. A short life working group reported back to the Governing Body in January 2014. The report included a number of options with a recommendation that consolidation of the CCG's service development and commissioning activity under one board would be the best option for the future. Further work has now been undertaken on the work involved in establishing a Clinical Transformation Board underpinned by central programme management. This has been circulated to Governing Body Members

	separately and will form the basis of a development workshop early in 2015/16. In the meantime the Governing Body is asked to agree to: • Establish a Clinical Transformation Board to replace our current programme boards from April 2015 • Establish a central programme management team approach and health intelligence group that will work with the Clinical Transformation Board to provide public health intelligence, business intelligence, evidence, performance and outcomes for strategic planning, commissioning and de-commissioning decisions • Agree that Terms of Reference for the Clinical Transformation Board be drafted for consideration Finally the establishment of a Clinical Transformation Board has the potential to ensure that our work to progress service integration is prioritised consistently across the organisation and embedded as business as usual for the CCG; promoting more effective engagement with a range of related initiatives, for example, Stronger Barnsley Together, the Integration Pioneer programme and Integrated Personal Commissioning. Members are asked to mandate the Chief Officer to progress discussions with colleagues in BMBC on how the establishment of the Clinical Transformation Board can positively contribute to joint programme activity undertaken as part of Stronger Barnsley Together, the Integration Pioneer and the Promoting Independence Board.
3.3	**Commissioning Working Together Programme Update** The programme is now embarking on phase two and a full report on the progress of each work-stream for phase one will be reported before the end of March 2015. Phase two will be underpinned by a strategic review of health and care in the context of the NHS 5 Year Forward View, The Dalton Review and planning guidance for 2015/16. The output of the review will inform local planning, the development of a Working Together Strategy and provide the basis of a collective CCG response to the Five year Forward View and the Dalton review. The Urgent Care work-stream is now live and initially includes establishment of an Urgent and Emergency Care Network with membership drawn from local Chairs and leads of System Resilience Groups. The Network will enable sharing of information and best practice and will also develop thinking to effect transformational system change. Work is continuing within the Children's work-steam as the project moves into its second phase. This next phase will focus on consolidating the case for change, seeking input and views form key stakeholders, and developing a regional service specification for the commissioning of safe and sustainable Children's Surgery and Anaesthesia. Following successful workshops through October, November and December negotiations are taking place to reach an agreement to support a rota sharing system which would ensure 24/7 consultant cover for Acute Cardiology. A

	final meeting of cardiologists and managerial leads from participating Trusts will take place over the coming months to finalise detail. A project Lead has now been appointed to take establish a Yorkshire and the Humber approach to a review of HASU services. Clinical options for new service models within the smaller specialities work-stream have been developed and reviewed by the Clinical Senate which will inform the case for change. Working Together has established Patient and Public Advisory Forum, which will meet every six weeks. Terms of Reference for the forum has been drafted, in partnership with local Healthwatch officers, to enable it to advise on the appropriate level of patient and public engagement/consultation across the Commissioners Working Together Programme. The CCGs in SYB have established good arrangements for collaborative commissioning creating a space for work between the CCGs, CCGs, NHSE and providers. In light of changes to NHSE management structures, publication of the FYFV and development of the Working Together programme, we have agreed to review those arrangements to ensure we have a decision making and development process that is both fit for purpose and flexible to respond to the necessary changes set out in FYFV. A paper attached at Appendix 1 outlines the preliminary conclusions of that review. These suggest standing down the SYCOM and SYCOM + Providers meeting with a refreshed role for CCGCOM as the overarching Working Together Programme Board. Members are asked to endorse this approach which may require a change to the current Memorandum of Understanding for CCGCOM. If so this will be brought back to Governing Body for approval.
3.4	**Proposal for a Sustainable Treat & Return Service Model for Non-ST Elevation Myocardial Infarction Patients in South Yorkshire & Bassetlaw** A Working Together paper is attached at Appendix 2 seeking support from commissioners to a change in the acute cardiology pathway for treatment of non-ST elevation myocardial infarction which will reduce inequity of provision within an existing commissioned pathway. This proposal is to improve the currently configured and commissioned NSTEMI pathway by avoiding STH bed occupancy for DGH patients. This is termed '*Treat-and-return'*, whereby patients will be brought by ambulance in the morning to NGH Cath Lab, have their coronary angiogram and PCI (or PCI alone if the angiogram has been done at DGH), and are returned to their DGH bed by ambulance later in the day. This will avoid most of the delays for DGH patients currently experienced by having to wait for a Sheffield bed to become available. The service will be independent of Sheffield beds, provide clinical benefit to the patients, improvement in patient satisfaction and a more efficient and economical service for all stakeholders. Commissioners are asked:

	• To support the change in pathway and establishment of a T&R service out of Sheffield for NSTEMI patients. • Support the commissioning of additional transport via YAS. • Seek clarity from within respective organisation as to the current level of PCI activity associated the treatment of nSTEMI to clarify the actual cost to commissioners of the overall change.
3.5	**Barnsley Hospice Annual Grant** Barnsley Hospice has received an annual grant to support the delivery of their services for a number of years. In recent years the CCG have provided a grant to the value of £1,589,086 per annum. The CCG's grant allocation supports the Hospice in their provision of inpatient care, day hospice services, outpatient clinics, family support and bereavement services, complimentary therapies, clinical advice and support and lymph oedema services for the population of Barnsley. Informal discussions have taken place with the Hospice Chief Executive who is in agreement with the proposal to retain the grant at the same financial value. The grant is not linked to a contract, and in fact NHS England guidance suggests that such arrangements should not normally be supported by a contract. It is however important to have a specific link between elements of provision and the funding provided, therefore a service level agreement could provide a mechanism to support this. The Cancer Programme Board is leading on the development of the End of Life Strategy which should identify the services to be commissioned. This will provide the basis for a SLA with the Hospice moving forward.
3.6	**Primary Care Co-Commissioning** At its meeting on 8 January 2015 the Governing Body provided a mandate to the Chief of Corporate Affairs to submit the CCG's application for Primary Care Co-commissioning on 9 January 2015. The application was then subject to a local, regional, and national review process by NHS England. On 17 February 2015 NHS England wrote to the CCG confirming that the CCG has been approved to take on delegated responsibility for NHS England specified general medical care commissioning functions from 1 April 2015. The Governing Body will recall that a number of changes to the CCG's Constitution were required to support the application, including the creation of a new Primary Care Commissioning Committee and an updated Conflicts of Interest Policy. All the proposed changes to the Constitution have been approved by NHS England. The revised Constitution will be placed on the CCG's website as soon as possible. NHS England will provide the CCG with a delegation agreement specifying the functions delegated to the CCG. The CCG is asked to sign and return the delegation agreement to NHS England by 5pm on 12 March 2015. Once the

	CCG has returned the signed agreement, NHS England will then issue the final delegation and signed agreement that will formalise the delegation.

Appendix 1

Collaborative Commissioning in South Yorkshire and Bassetlaw – Working Arrangements

The CCGs in SYB have established good arrangements for collaborative commissioning, building on the arrangements that were in place for PCTs, creating a space for work between the CCGs, CCGs, NHSE and providers. In light of changes to NHSE management structures, publication of the FYFV and development of the Working Together programme, we have agreed to review those arrangements to ensure we have a decision making and development process that is both fit for purpose and flexible to respond to the necessary changes set out in FYFV.

Purpose of collaborative commissioning: "By working together we are on a mission to improve patient outcomes for all our patient populations"

Recognising the sovereignty and statutory responsibilities of individual CCGs, we should commission collectively rather than separately when to do so will:

- Help us achieve better outcomes for our total population – through
    - Better design of services
    - Agreement of aligned, best practice, pathways where elements of the pathway are shared (e.g. with tertiary services)
    - Maximised negotiating power – contractual and clinical – with providers
    - Maximised negotiating power with external bodies or with NHSE
- Achieve more efficient use of our running costs
    - Doing something once rather than five times
    - Sharing intelligence and best practice (e.g. CFO network)
    - Joining forces to create more robust capacity where this cannot be delivered effectively through CSU arrangements

What should we therefore decide together?

- Contracts with any shared providers, including our interest in specialised or other tertiary services
- Response to national policy where a collective response will have more impact than five individual ones
- Pathways and service specifications where the pathway usually or often lead to a shared provider – e.g. cancer, CVD
- Agree whether or not to implement commissioning recommendations of joint clinical work, e.g. on cancer, CVD, or on national guidance, where a collective response is needed or is in the best interest of our populations
- Configuration of services, and development of new models of service, where there is interdependency between local services or where continuation of local services in all five areas might be unsustainable
- Co-commissioning specialised services and primary care with NHSE
    - Agreeing the mechanisms
    - Acting together where the above applies

What else should we do together?

- Share thinking and best practice on common local challenges and problems
    - Organisational development
    - Emergency planning

- Co-commissioning

Arrangements to help us to the above

Primarily, we need a place where the five CCGs can agree upon a common view and actions in relation to the above, reducing duplication and ensuring there is clarity about where authority for decisions lie.

We also need to have arrangements in place to both develop and share strategic thinking.

Which suggests we need:

1. A decision making body (acting on authority individuals carry, with issues being referred to Governing Bodies whenever appropriate)

Making decisions about:

- Working Together programme
- Actions coming out of Specialised Commissioning Oversight Group
- Collective contracts – YAS, STH, others where we are associates to each other's contracts
- Opportunities to achieve economies of scale on running costs (either with CSU or outside of that)
- Business cases – from providers or CCGs – that affect more than one of us and are interdependent (i.e. it makes no sense to make separate decisions)
- Collective actions (e.g. emergency planning) and interactions with other bodies (e.g. city-region wide partnership issues)
- Interaction and membership of various national collaborations and networks such as SCNs and AHSN's

2. OD/shared thinking networks

At least for clinical leads and AOs, and possibly networks for other functions (finance, contracting, quality, planning)

How well does what we've got fit with the above?

CCGCOM	Bi-monthly meetings provide the clinical lead/AO development space. Could be expanded to include more clinical leaders?
SYCOM	More of a collective performance management and information sharing arena with NHSE than any of the above?
SYCOM + providers	Useful and necessary place for collective provider engagement on shared pathways – remit could be clearer?
Working Together Board	Could be replaced by a single decision making meeting, with clinical and managerial input as determined by each CCG
Chief Officers	
Chief Nurses, CFOs	Meets need for shared thinking. Need similar for other Directors?

Conclusion

This initial analysis suggests that:

- CCG COM becomes the Working Together "board" for all our collaboration decision making

- We establish an Executive function to oversee implementation of agreed actions and activities
- We stand down SYCOM and SYCOM Provider
- NHS E are invited to attend Working Together Board and the Executive at appropriate levels of seniority
- The work done by SYCOM requiring collaboration is viewed as part of our Working Together
- The provider interface is through the Executive function with a clearer emphasis on the common collaborative purpose at an operational level
- The Executive Function will manage any networks across CCG functions that are required – e.g. finance, nursing planning etc.
- The Working Together Board has a split agenda across the year to focus on development, and decision making subsuming the work currently done in CCG COM

Tim Furness, Ian Atkinson, NHS Sheffield CCG.

APPENDIX 2

South Yorkshire Leaders Forum
2nd March 2015, 1:30 – 3:30
Rotherham CCG, Oak House, Willow Rm

Proposal for a Sustainable Treat & Return Service Model for Non-ST Elevation Myocardial Infarction Patients in South Yorkshire & Bassetlaw

Purpose

The purpose of this paper is to seek support from commissioners to a change in the acute cardiology pathway for treatment of non-ST elevation myocardial infarction which will reduce inequity of provision within an existing commissioned pathway.

Background

The original proposal was brought to SYCOM Commissioners and Providers in November 2014 seeking support for an enhanced 'Treat and Return Service' (CCG's already commission the pathway) to respond to the inequities of provision for PCI from district residents as a result of delays in accessing treatment due to insufficient beds at STH and long waits in DGH hospitals.

PCI as opposed to PPCI under the 'nationally defined I.D.rules' sits with the commissioning responsibility of CCGs. During the course of validating the STH initial proposal it became clear that during the transfer of commissioning responsibilities unplanned PCI in addition to PPCI is currently being paid for by NHSE.

There are cost implications to commissioners of implementing the enhanced pathway . In addition to the transport cost which were highlighted in the initial proposal. These are largely due to inequality of provision with the districts.

Discussions are already underway between NHSE and CCG commissioners with regards to resolve the issue of 'who' commissions and the potential movement of funding back to CCG for existing contracted activity, this exercise will be completed as part of wider financial reconciliation process during 2015-16.

Context

The acute cardiology work-stream of the South Yorkshire & Bassetlaw

Commissioners' Working Together Programme has identified a number of acute service elements where hospitals are challenged in meeting the agreed service quality standards in full on a 24/7/365 basis. Given available resources it is not feasible to address every facet of the identified shortcomings. However, through facilitating a continuing discussion between trusts via two workshops held in November and December, commissioners are hopeful that appropriate mutual support arrangements can be agreed between cardiology departments to offset some these shortcomings.

One outstanding area of concern remains, however, that is not amenable to mutual support arrangements, which is in relation to the timely treatment of patients having suffered a non-ST elevation myocardial infarction or NSTEMI (a type of heart attack). Present arrangements result in delays, missed treatments and inequalities between CCG populations. The proposed amendment to the existing treatment pathway set out here would in effect eliminate these disparities and inequalities across the South Yorkshire, Bassetlaw and North Derbyshire area.

In the attached paper (Appendix, A), Dr Julian Gunn and Nathan Timmis summarise the problems with the current pathway and propose a same-day treat & return model.

Summary of the problem from a CCG standpoint

At present NSTEMI patient transfers to STHFT for PCI treatment (percutaneous coronary intervention) from outlying DGHs occupy at least one overnight stay at the NGH. In most cases a combination of ambulance and bed availability at STHFT will determine the timeliness of treatment. In contrast, ST elevation heart attacks are not taken to the DGH but are conveyed from the scene directly to the cardiac catheter laboratory at the NGH for primary PCI, involving no delays. Consequent delays at the DGH for NSTEMI can be significant, such that only 30% of non-Sheffield NSTEMI patients are treated within the NICE recommended 96 hours, in contrast to 84% of Sheffield patients treated within this threshold time. Indeed, many DGH NSTEMI patients are returned home without PCI treatment on account of the extended waits. We know from trial evidence that NSTEMI treatment outcomes are sensitive to the timeliness of receiving PCI (NSTEMI has about 12% one-year mortality, reduced to about half by timely intervention). So these stark differences between Sheffield and DGH patients are expected to contribute to downstream outcome inequalities between CCGs in terms of re-infarction and death (although hard to measure directly).

Proposed change and implication for commissioners

The attached proposal would see DGH NSTEMI patients receive PCI at the NGH on a day-case Treat and Return (TaR) basis. Following diagnosis of NSTEMI at the DGH, this would involve ambulance conveyance from the DGH directly to the catheter lab trolley bay at NGH; the patient being returned to the DGH the same day.

The proposed new regimen has been pilot tested following agreement at the former North Trent Cardiac Network. From May 1st 2014 when the pilot started one or two cases per day from DGHs have been treated on a TaR basis and as at 14 December

2014 a total of 341 NSTEMI patients from DGHs had received PCI at the NGH of which 89 had been treated on a TaR basis. In comparison 330 Sheffield NSTEMI patients had been treated in the same period.

It is expected that 80% of NSTEMIs would be eligible for PCI (26% treated under as TaR under the pilot) and therefore eligible for TaR. On this basis, in due course once the TaR service is working at full capacity, we could expect to see circa 600 TaR NSTEMI treatments from within the South Yorkshire, Bassetlaw and Chesterfield DGH catchments (excluding Sheffield, which would remain much the same).

There are therefore three implications for South Yorkshire (excluding Sheffield), Bassetlaw and North Derbyshire CCGs:

Potentially 260 more PCI treatments for NSTEMI than are currently treated (~40% increase overall for the whole NGH catchment). These are presently sent home without receiving PCI with 96 hours as per best practice.

Day-case trolley treatment rather than bed-based inpatient and so reduced STHFT per-patient tariff. Patients typically have extended DGH inpatient waits under the present regimen, whilst waiting for an overnight bed to become free at NGH and an ambulance for transfer. Under a TaR service we anticipate a sizeable reduction in overall bed-nights. An audit of Barnsley patients for the TaR pilot between May and August demonstrated 22% fewer bed-nights at Barnsley DGH and a 33% shorter stay overall including the NGH period.

It would require predictable and fast ambulance response times to facilitate same-day conveyance and repatriation. Commissioner would need to seek assurance that the requirement for fast ambulance response to support this change would not negatively impact on current YAS services to localities.

Additional benefits

More NSTEMI patients receiving PCI, plus shorter DGH waits and shorter overall stays for DGH patients would eliminate present inequalities in access to effective evidence-based treatments between CCGs across the patch, in the same way that was achieved with introducing primary PCI for STEMI.

Improved patient satisfaction with the heart attack service.

A TaR service would release inpatient beds both within the DGH and within STHFT, and an anticipated positive impact on A&E trolley waits.

Financial/contracting implications

Implementing the change in pathway will result in the region of an additional 260 PCIs performed across the region (excluding Sheffield), within a urgent spell which is validated against expected numbers in addition to return ambulance costs. A proportion of these patients may receive PCI as a planned procedure.

There are potential savings as a result of reduction in LoS and fewer bednights

which have not been included in the financial analysis.

In addition to the additional costs outlined below there is a level of contracted activity which is being paid for by NHSE. Together this will give a full picture of both contracted activity and finance. This is currently being worked though with CCG and NHSE contracting teams.

In addition there is a need to further understand the tariff and income flows and any potential to split the tariff as a result of essentially a day-case service. The current tariff includes overnight stay.

Table one summarised the additional cost to commissioners as a result of the change both from the increase in PCI and transport journey. The prices uses for calculation are indicative and may be subject to change following national guidance.

Table, 1

Additional costs of implementing T&R services to commissioner's** **PCI based on EA312 PCI 1-2 stents*15/16 pending approval 14/15 tariff prices included for information.** **YAS costs based on return journey cost of £210 per journey based on additional 600 return journey's**					**Best Case Scenario** **Total Cost per CCG**	**Worst Case Scenario** **Total Cost per CCG**
CCG	**Population Share**	**PCI costs 14/15 Tariff £3765**	**PCI costs 15/16 Tariff £3499***	**YAS return Journey Costs**	**Based on 15/16 Planned PCI tariff costs £2587**	**Based on 15/16 PCI costs**
Barnsley	**19.4**	**189,907**	**176,489**	**24'444**	**70,445**	**200,933**
Bassetlaw	**8.6**	**84,185**	**78,238**	**10'863**	**31,255**	**89,095**
Doncaster	**23.8**	**232,978**	**216,518**	**29'998**	**86,432**	**246,516**
Rotherham	**19.3**	**188,927**	**175,580**	**24'318**	**70,082**	**199,898**
North Derbyshire	**21.0**	**205,569**	**191,045**	**26'460**	**76,255**	**217,505**
Hardwick	**8.0**	**78,312**	**72,779**	**10'080**	**29,049**	**82,859**
	100%	**978,900**	**909,740**	**126'000**	**339,806**	**1,035,74**

***The table above present the best and worst case scenario on the basis that some patients may get a PCI electively charged at planned tariff rate. Also STH have been piloting the scheme since May 2014 and have seen 89 patients up to December 2014 under the new scheme. It is unclear where these sit in commissioned activity and therefore may still present a cost increase to commissioners. We know that all CCGs are paying for some planned PCI activity including Sheffield CCG. At best this could represent the potential 260 additional activity under the scheme which could be netted off. Savings from length of stay or an emergency spell for those patient that receive planned PCI have not been included and would therefore further reduce the additional cost of implementing this change.*

Recommendation

Commissioners are asked support the change in pathway and establishment of a T&R service out of Sheffield for NSTEMI patients.

Support the commissioning of additional transport via YAS.

Seek clarity from within respective organisation as to the current level of PCI activity associated the treatment of nSTEMI to clarify the actual cost to commissioners of the overall change.

Will Cleary-Gray
Working Together Director
27 February 2015

Appendix, A
Original Case presented to SYCOM – November 2014

***'Treat and Return' (TaR)* for patients with NSTEMI**
Julian Gunn (Clinical Lead, NSTEMI) and Nathan Timmis (Specialised Rehab Services), STHFT

INTRODUCTION

Chest pain is one of the commonest reasons for admission to hospital. There are 3 groups: non-cardiac chest pain; ST-elevation myocardial infarction (STEMI); and non-ST elevation myocardial infarction and unstable angina (lumped together as 'NSTEMI'). Non cardiac patients are managed via their local A&E and hospital. Patients with STEMI are brought by ambulance directly to the Cardiac Cath Lab at NGH for immediate percutaneous coronary intervention (PCI) and 'repatriated' to their DGH afterwards; a system which works extremely well, and is a good model. Patients with NSTEMI, which outnumber those with STEMI by 3:2, are admitted locally to their DGH and brought over to NGH for PCI, which should be within 96h of admission (NICE). This system is not working well, for reasons outlined below. We propose an improvement for patients with NSTEMI in our DGHs, in which we will provide a *'treat-and-return'* (*TaR*) service. This would enable all patients sent to STH (2-3 per day, Monday-Friday) to receive their treatment and return to their base on the same day, so that they receive their revascularisation in a more timely way than at present.

CURRENT SITUATION

Local partner Trusts stabilise their NSTEMI patients and then refer them to STH to receive invasive management for their NSTEMI (either coronary angiogram + PCI, or just PCI, if the angiogram is done locally). These Trusts have stated that access to NSTEMI treatment at STH is sub-optimal. At peak times of the year, patients have to wait up to a week. The cause of this delay is access to STH Cardiology beds, which are subject to the usual pressures (emergency admissions from STH A&E being the main one). DGH patients are only accepted for transfer to STH if there is a free bed for them to occupy the night after their procedure. Therefore a Sheffield patient, already in an STH bed, usually reaches the Cath Lab within 48h; whereas the majority of DGH patients wait >96h. Furthermore, they stay in Sheffield if there is a problem or other medical issues to deal with, further reducing the capacity to accept new NSYEMI patients.

This is unacceptably bad medical practice, inequitable, bad for patient experience, inefficient to all stakeholders, costly to the CCG/DGH and wasteful of beds at both DGH and STH. Also, DGH Cardiologists have become frustrated with the delay, and discharged patients home without revascularisation, exposing the patients to the risks of complications (further MI or even death). They then clog the system with outpatient visits, investigations, and downstream invasive procedures which could have been done at the time of the first presentation. In S Yorkshire, this is part of the reason that we are still 37% below the national average in terms of the number of PCIs performed: in the UK in 2012, the rate was 1451 per million p.a., in contrast to our rate of 919 pm (1600 PCIs a year in total).

SERVICE DEVELOPMENT PROPOSAL

With *TaR*, patients will be admitted to their own DGH and stabilised, as at present, but they will be transported (ideally the next day) to STH by ambulance to the trolley bay of the Cath Lab. They will

undergo their cardiac procedure, return to the trolley and be supervised until they are stable. They will then be transported by ambulance back to their bed at the DGH the same day, in the afternoon or early evening, to complete their medical care for another day or two. They will not require admission to an STH bed, which will remove this specific delay.

The resources required to enable this to happen are largely already in place. STH have the Cath Lab infrastructure (Trolley Bay, staffing, protocols, information packages, audit forms) ready. The journey from DGH to Sheffield already occurs, albeit with a 4h inter-facility transfer time. The only new addition, which needs to be commissioned, is the return ambulance; and for both transfers to occur within a 2h window, rather than the current 4h.

RESULTS Of PILOT SCHEME

We started a pilot scheme on May 1st 2014, in which 1 patient a day was enrolled in TaR. This has been most successful, and uncovered no major problems, complications or dangers. It was also well received by the patients themselves. The only issue identified was the reliance upon the 4h ambulance callout time, which meant that sometimes patients were kept waiting a long time for transport, and moved from their hospital bed, and back to it, very early in the morning or late in the evening. There was also demonstrated a small reduction in overall length of stay for all patients (as well as those on the TaR pathway, of course), accompanied by increased Cath Lab throughput.

TIMETABLE

We are ready for full implementation of *TaR* as the default pathway for patients with NSTEMI from our partner Trusts ***as soon as the increased ambulance service can be commissioned***. No expansion in *TaR* can be undertaken until that is in place because timely patient movement is essential for TaR to work. We have explored the feasibility of this with the Yorkshire Ambulance Service, and have confirmed that it is possible.

FINANCIAL PLAN

About 900 patients have NSTEMI in our region p.a, of which only about 500 are currently being transferred to Sheffield for PCI. We would not expect a sudden increase, but successful establishment of *TaR* would encourage more referrals. Nor would all NSTEMI patients be eligible for *TaR*; 20-30% will need to be admitted to a Sheffield bed because of frailty and co-morbidity. If we enrolled 600 onto the TaR pathway (an average 2-3/day, 5 days a week, less 20% patients who would have to stay at Sheffield due to complications etc.), the net new cost would be the cost of about 500 return ambulance journeys (costed at £300 = £150K). That cost, divided according to the number of patients expected from each district, would amount to approximately: Rotherham £31K, Chesterfield £39K, Doncaster and Bassetlaw £49K and Barnsley £31K. Note that the savings in length of stay and downstream procedures have not been calculated, but are likely to far outweigh this cost pressure.

SUMMARY

This proposal is to improve the currently configured and commissioned NSTEMI pathway by avoiding STH bed occupancy for DGH patients. This is termed '*Treat-and-return'*, whereby patients will be brought by ambulance in the morning to NGH Cath Lab, have their coronary angiogram and PCI (or PCI alone if the angiogram has been done at DGH), and are returned to their DGH bed by ambulance later in the day. This will avoid most of the delays for DGH patients currently experienced by having to wait for a Sheffield bed to become available. The service will be independent of Sheffield beds,

provide clinical benefit to the patients, improvement in patient satisfaction and a more efficient and economical service for all stakeholders. Specifically, all that needs commissioning are 500 ambulance journeys with a 2h callout time.

Barnsley Clinical Commissioning Group
Putting Barnsley People First

GOVERNING BODY

12 March 2015

COMMISSIONING SUPPORT UNIT
LEAD PROVIDER FRAMEWORK

1.	**PURPOSE OF THE REPORT**
	To provide the Governing Body with an update about the Commissioning Support Unit, Lead Provider Framework.
2.	**EXECUTIVE SUMMARY**
	Further to last month's Chief Officers report when it was reported that the Yorkshire and Humber Commissioning Support Unit had not been accepted onto the Lead Provider Framework (LPF), the CCG is continuing to work with other CCGs across Yorkshire and Humber to assess possible solutions to include: either; CCG collaborations, in house or continue to contract commissioning support functions through the LPF Framework A Transitional Board has been established at which the CCG is represented as well as a local working group to undertake options appraisals/ cost benefit analysis across the different service lines. A more detailed document will be presented to the Governing Body in April to discuss proposals around preferred options. The working group will liaise closely with Governing Body clinical leads to develop the proposals.
3.	**THE GOVERNING BODY IS ASKED TO:** • Note the update about the Commissioning Support Unit, Lead Provider Framework.

Agenda time allocation for report: 5 minutes.

Report of: Vicky Peverelle

Designation: Chief of Corporate Affairs

Report Prepared by: Kay Morgan

Designation: Governing Body Secretary

1.	**SUPPORTING INFORMATION**	
1.1	**Links to the Assurance Framework**	
	This report links to Assurance framework, risk reference 5.2 – Highest quality governance processes.	
1.2	**Links to Objectives**	
	To have the highest quality of governance and processes to support its business	√
	To commission high quality health care that meets the needs of individuals and groups	
	Wherever it makes safe clinical sense to bring care closer to home	
	To support a safe and sustainable local hospital, supporting them to transform the way they provide services so that they are as efficient and effective as possible for the people of Barnsley	
	To develop services through real partnerships with mutual accountability and strong governance that improve health and health care and effectively use the Barnsley £.	√
1.3	**Governance Arrangements Checklist**	**Has the area been considered (yes / no / not relevant)?**
	Financial Implications	N/A – Report for information only
	Contracting Implications	N/A
	Quality	N/A
	Consultation / Engagement	N/A
	Equality and Diversity	N/A
	Information Governance	N/A
	Environmental Sustainability	N/A
	Human Resources	N/A

Barnsley Clinical Commissioning Group
Putting Barnsley People First

GOVERNING BODY

12 February 2015

Commissioning Strategy 2014/19

1.	**PURPOSE OF THE REPORT**
	To update the Governing Body on progress made in refreshing the current Commissioning Strategy and provide an overview of the key performance measures and planned trajectories submitted to NHS England on 27 February 2015.
2.	**EXECUTIVE SUMMARY**
	The report provides an update on the development of the refreshed Commissioning Strategy. It also provides detail of the operational planning templates that have been submitted to NHS England. The operational planning templates include planned performance against: • Waiting time measures including Referral to Treatment (RTT), diagnostics and cancer. • A&E attendance and waiting time measures. • Mental health access and waiting time measures. • Healthcare associated infection trajectories • Dementia diagnosis measures. • Primary Care satisfaction measures In addition to the performance plans, a draft financial planning template was also submitted. The submission date for the final operational plans to be submitted is 10 April 2015. The refreshed Commissioning Strategy will also be submitted on this date and therefore following finalisation of the draft, this will be circulated to Governing Body members and the Membership Council for comment and consideration. A summary overview of the Strategy will be presented to the Membership Council on 24 March for approval and then to Governing Body on 9 April for final sign off prior to submission.
3.	**THE GOVERNING BODY IS ASKED TO:** • Review and provide feedback on the draft operational planning

	targets. • Note the progress in refreshing the Commissioning Strategy and proposed approach and timescales to finalising this.

Agenda time allocation for report: 15 Minutes

Report of: Vicky Peverelle

Designation: Chief of Corporate Affairs

Report Prepared by: Jamie Wike

Designation: Head of Planning and Performance

1.	**SUPPORTING INFORMATION**	
1.1	**Links to the Assurance Framework**	
	The Commissioning Strategy sets out the overall vision and objectives for the CCG and therefore relates to all areas of the Assurance Framework and will inform any future revisions to the Framework.	
1.2	**Links to Objectives**	
	To have the highest quality of governance and processes to support its business	X
	To commission high quality health care that meets the needs of individuals and groups	X
	Wherever it makes safe clinical sense to bring care closer to home	X
	To support a safe and sustainable local hospital, supporting them to transform the way they provide services so that they are as efficient and effective as possible for the people of Barnsley	X
	To develop services through real partnerships with mutual accountability and strong governance that improve health and health care and effectively use the Barnsley £.	X
1.3	**Governance Arrangements Checklist**	**Has the area been considered (yes / no / not relevant)?**
	Financial Implications	Yes
	Contracting Implications	Yes
	Quality	Yes
	Consultation / Engagement	Yes
	Equality and Diversity	Yes
	Information Governance	Yes
	Environmental Sustainability	Not Applicable
	Human Resources	Not Applicable

2.	**INTRODUCTION/ BACKGROUND INFORMATION**
	To update the Governing Body on progress made in refreshing the current Commissioning Strategy and provide an overview of the key performance measures and planned trajectories submitted to NHS England on 27 February 2015.
3.	**DISCUSSION/ISSUES**
3.1	As part of the planning process for 2015/16, the Governing Body have previously agreed that the Commissioning Strategy 2014 to 2019 should be refreshed and updated to ensure developments which have taken place in 2014/15 can be reflected and to ensure the Strategy provides a clear focus on providing care out of hospital where this is safe and appropriate.
3.2	The draft narrative of the Strategy is currently being finalised and will then be circulated to Governing Body members and the Membership Council for comment and consideration.
3.3	In addition to the refresh of the Commissioning Strategy, and as set out in the planning guidance for 2015/16 'The Forward View into Action' the CCG are required to submit operational plans setting out planned performance against a range of nationally prescribed measures. The draft plans were submitted on 24 February 2015.
3.4	The operational planning templates include planned performance against: • Waiting time measures including Referral to Treatment (RTT), diagnostics and cancer. • A&E attendance and waiting time measures. • Mental health access and waiting time measures. • Healthcare associated infection trajectories • Dementia diagnosis measures. • Primary Care satisfaction measures
3.5	The planned performance against these measures is set out in appendix 1 for review and consideration by the Governing Body to inform any revisions prior to the final submission. It should be noted that where any national standards are set, e.g. RTT, the plans set out expected levels of performance to ensure these are met.
3.6	In addition to the performance plans, a draft financial planning template was also submitted on 27 February 2015.
3.7	The development of plans has been undertaken alongside the ongoing contract negotiations with providers to ensure alignment of plans and contracts.
3.8	The submission date for the final operational plans to be submitted is 10 April 2015. The refreshed Commissioning Strategy will also be submitted on this date.

3.9	To ensure appropriate approvals, a summary overview of the Strategy will be presented to the Membership Council on 24 March for approval and then to Governing Body on 9 April for final sign off prior to submission.
4.	**IMPLICATIONS**
4.1	There are no implications arising from this report, however the final plans may have implications on future service delivery and capacity. Any implications will be included in the final report for approval in April.
5.	**RISKS TO THE CLINICAL COMMISSIONING GROUP**
5.1	There are no specific risks associated with this report, however risks may arise during the delivery of the Commissioning Strategy and operational plans if performance is not in line with expectations. These risks will be identified through the CCG risk management arrangements.
6.	**CONSULTATION**
6.1	Consultation has taken place with the relevant teams within the CCG on the development of the plans. Discussions have also taken place with NHS England to agree the proposed targets for the Primary Care satisfaction measures.
6.2	The development of the strategic and operational plans has taken account of the feedback received through engagement activity during 2014/15 and there will be an engagement event with public and patients on the refreshed Commissioning Strategy.
7.	**APPENDICES TO THE REPORT**
	Appendix 1- Planning Measures and Trajectories
8.	**CONCLUSION**
	The approach taken to developing the operational planning trajectories ensures that performance targets take account of national requirements but also reflect local ambition. The Commissioning Strategy will describe the strategic direction for the medium to long term and will set out the priorities for the CCG and our partners in improving health services and health outcomes. The plans will meet the nationally prescribed requirements set out in the 2015/16 planning guidance.

Clinical commissioning groups - Planning Template for 2015-16 Functional V 2.0

CCG Name:	CCG Code:	Validation Passed?
NHS BARNSLEY CCG	02P	YES

Please read the definitions in The Forward View into action: Planning for 2015/16 - Technical Definitions for commissioners before completing this template.

E.B.1			APRIL	MAY	JUNE	JULY	AUGUST	SEPTEMBER	OCTOBER	NOVEMBER	DECEMBER	JANUARY	FEBRUARY	MARCH
RTT - The percentage of admitted pathways within 18 weeks for admitted patients whose clocks stopped during the period, on an adjusted basis	2013-14	Completed pathways < 18 weeks	1288	1372	1410	1466	1316	1346	1465	1338	1116	1412	1244	1310
		Total Completed Pathways	1366	1434	1466	1552	1384	1423	1541	1435	1178	1500	1327	1428
		%	**94.3%**	**95.7%**	**96.2%**	**94.5%**	**95.1%**	**94.6%**	**95.1%**	**93.2%**	**94.7%**	**94.1%**	**93.7%**	**91.7%**
	2014-15	Completed pathways < 18 weeks	1180	1407	1445	1275	1129	1412	-	-	-	-	-	-
		Total Completed Pathways	1276	1511	1548	1389	1240	1568	-	-	-	-	-	-
		%	**92.5%**	**93.1%**	**93.3%**	**91.8%**	**91.0%**	**90.1%**	-	-	-	-	-	-
	2015/16 Plan	Completed pathways < 18 weeks	1120	1327	1359	1220	1088	1351	1314	1120	1008	1283	1135	1224
		Total Completed Pathways	1244	1474	1510	1355	1208	1501	1459	1244	1119	1425	1261	1359
		%	**90.0%**	**90.0%**	**90.0%**	**90.0%**	**90.1%**	**90.0%**	**90.1%**	**90.0%**	**90.1%**	**90.0%**	**90.0%**	**90.1%**

E.B.2			APRIL	MAY	JUNE	JULY	AUGUST	SEPTEMBER	OCTOBER	NOVEMBER	DECEMBER	JANUARY	FEBRUARY	MARCH
RTT - The percentage of non-admitted pathways within 18 weeks for non-admitted patients whose clocks stopped during the period.	2013-14	Completed pathways < 18 weeks	4735	4638	4276	4708	3887	4483	4794	4567	4223	4821	4454	4658
		Total Completed Pathways	4848	4719	4362	4810	3987	4587	4921	4693	4329	4946	4574	4777
		%	**97.7%**	**98.3%**	**98.0%**	**97.9%**	**97.5%**	**97.7%**	**97.4%**	**97.3%**	**97.6%**	**97.5%**	**97.4%**	**97.5%**
	2014-15	Completed pathways < 18 weeks	4779	4462	5056	5483	4366	5465	-	-	-	-	-	-
		Total Completed Pathways	4914	4585	5167	5601	4507	5634	-	-	-	-	-	-
		%	**97.3%**	**97.3%**	**97.9%**	**97.9%**	**96.9%**	**97.0%**	-	-	-	-	-	-
	2015/16 Plan	Completed pathways < 18 weeks	5267	4918	5573	6043	4812	6023	5386	5817	5130	5857	5411	5659
		Total Completed Pathways	5443	5079	5723	6204	4992	6240	5597	6027	5311	6068	5612	5861
		%	**96.8%**	**96.8%**	**97.4%**	**97.4%**	**96.4%**	**96.5%**	**96.2%**	**96.5%**	**96.6%**	**96.5%**	**96.4%**	**96.6%**

E.B.3			APRIL	MAY	JUNE	JULY	AUGUST	SEPTEMBER	OCTOBER	NOVEMBER	DECEMBER	JANUARY	FEBRUARY	MARCH
RTT - The percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the period.	2013-14	Incomplete Pathways < 18 weeks	11827	11567	11734	11692	11702	10444	11797	11583	11113	11299	10778	11821
		Total Incomplete Pathways	12266	12018	12230	12231	12338	10966	12416	12171	11671	11890	11382	12457
		%	**96.4%**	**96.2%**	**95.9%**	**95.6%**	**94.8%**	**95.2%**	**95.0%**	**95.2%**	**95.2%**	**95.0%**	**94.7%**	**94.9%**
	2014-15	Incomplete Pathways < 18 weeks	12463	12895	12159	12574	12803	12248	-	-	-	-	-	-
		Total Incomplete Pathways	13150	13571	12849	13284	13557	13010	-	-	-	-	-	-
		%	**94.8%**	**95.0%**	**94.6%**	**94.7%**	**94.4%**	**94.1%**	-	-	-	-	-	-
	2015/16 Plan	Incomplete Pathways < 18 weeks	13729	14205	13394	13852	14104	13492	14623	14666	13486	13712	13080	14345
		Total Incomplete Pathways	14693	15164	14357	14843	15148	14537	15894	15940	14571	14845	14211	15553
		%	**93.4%**	**93.7%**	**93.3%**	**93.3%**	**93.1%**	**92.8%**	**92.0%**	**92.0%**	**92.6%**	**92.4%**	**92.0%**	**92.2%**

E.B.4			APRIL	MAY	JUNE	JULY	AUGUST	SEPTEMBER	OCTOBER	NOVEMBER	DECEMBER	JANUARY	FEBRUARY	MARCH
Diagnostics Test Waiting Times	2013-14	Number waiting > 6 weeks	12	3	2	11	12	6	21	40	172	228	89	97
		Total Number waiting	2783	2962	2732	2584	2918	3007	3414	3564	3535	3670	3485	3583
		%	**0.4%**	**0.1%**	**0.1%**	**0.4%**	**0.4%**	**0.2%**	**0.6%**	**1.1%**	**4.9%**	**6.2%**	**2.6%**	**2.7%**
	2014-15	Number waiting > 6 weeks	174	274	275	222	215	77	-	-	-	-	-	-
		Total Number waiting	3747	3922	3827	3569	3389	3178	-	-	-	-	-	-
		%	**4.6%**	**7.0%**	**7.2%**	**6.2%**	**6.3%**	**2.4%**	-	-	-	-	-	-
	2015/16 Plan	Number waiting > 6 weeks	37	41	40	39	37	34	32	33	41	45	41	42
		Total Number waiting	4332	4534	4424	4126	3918	3674	3408	3610	4724	4905	4657	4788
		%	**0.9%**	**0.9%**	**0.9%**	**0.9%**	**0.9%**	**0.9%**	**0.9%**	**0.9%**	**0.9%**	**0.9%**	**0.9%**	**0.9%**

E.B.6			Quarter 1	Quarter 2	Quarter 3	Quarter 4
Cancer- All Cancer two week wait	2013-14	Number waiting < 2 weeks	1442	1491	1606	1563
		Total number waiting	1507	1553	1692	1650
		%	**95.7%**	**96.0%**	**94.9%**	**94.7%**
	2014-15	Number waiting < 2 weeks	1618	1716	-	-
		Total number waiting	1719	1837	-	-
		%	**94.1%**	**93.4%**	-	-
	2015/16 Plan	Number waiting < 2 weeks	1825	1949	2026	1994
		Total number waiting	1957	2092	2112	2139
		%	**93.3%**	**93.2%**	**95.9%**	**93.2%**

E.B.7			Quarter 1	Quarter 2	Quarter 3	Quarter 4
Cancer - Two week wait for breast symptoms (where cancer not initially suspected)	2013-14	Number waiting < 2 weeks	250	249	294	309
		Total number waiting	259	266	304	327
		%	**96.5%**	**93.6%**	**96.7%**	**94.5%**
	2014-15	Number waiting < 2 weeks	322	288	-	-
		Total number waiting	337	303	-	-
		%	**95.5%**	**95.0%**	-	-
	2015/16 Plan	Number waiting < 2 weeks	358	320	301	381
		Total number waiting	376	338	318	407
		%	**95.2%**	**94.7%**	**94.7%**	**93.6%**

E.B.12			Quarter 1	Quarter 2	Quarter 3	Quarter 4
Cancer - All cancer 62 day urgent referral to first treatment wait	2013-14	Number waiting < 62 days	115	154	113	136
		Total number waiting	134	165	130	157
		%	**85.8%**	**93.3%**	**86.9%**	**86.6%**
	2014-15	Number waiting < 62 days	113	117	-	-
		Total number waiting	134	138	-	-
		%	**84.3%**	**84.8%**	-	-
	2015/16 Plan	Number waiting < 62 days	109	113	108	123
		Total number waiting	128	132	127	144
		%	**85.2%**	**85.6%**	**85.0%**	**85.4%**

E.B.13			Quarter 1	Quarter 2	Quarter 3	Quarter 4
Cancer - 62 day wait for first treatment following referral from an NHS cancer screening service	2013-14	Number waiting < 62 days	34	19	31	18
		Total number waiting	34	20	32	18
		%	**100.0%**	**95.0%**	**96.9%**	**100.0%**
	2014-15	Number waiting < 62 days	37	20	-	-
		Total number waiting	38	20	-	-
		%	**97.4%**	**100.0%**	-	-
	2015/16 Plan	Number waiting < 62 days	39	20	31	19
		Total number waiting	39	20	31	19
		%	**100.0%**	**100.0%**	**100.0%**	**100.0%**

E.B.14			Quarter 1	Quarter 2	Quarter 3	Quarter 4
Cancer - 62 day wait for first treatmnet for cancer following a consultant's decision to upgrade the patients priority	2013-14	Number waiting < 62 days	23	21	25	14
		Total number waiting	28	23	30	14
		%	**82.1%**	**91.3%**	**83.3%**	**100.0%**
	2014-15	Number waiting < 62 days	20	29	-	-
		Total number waiting	25	32	-	-
		%	**80.0%**	**90.6%**	-	-
	2015/16 Plan	Number waiting < 62 days	19	27	13	14
		Total number waiting	23	30	15	15
		%	**82.6%**	**90.0%**	**86.7%**	**93.3%**

E.B.8			Quarter 1	Quarter 2	Quarter 3	Quarter 4
Cancer - Percentage of patients receiving first definitive treatment within 31 days of a cancer diagnosis.	2013-14	Number waiting < 31 days	317	340	321	310
		Total number waiting	322	340	330	313
		%	**98.4%**	**100.0%**	**97.3%**	**99.0%**
	2014-15	Number waiting < 31 days	332	308	-	-
		Total number waiting	335	312	-	-
		%	**99.1%**	**98.7%**	-	-
	2015/16 Plan	Number waiting < 31 days	319	296	288	286
		Total number waiting	321	299	291	288
		%	**99.4%**	**99.0%**	**99.0%**	**99.3%**

E.B.9			Quarter 1	Quarter 2	Quarter 3	Quarter 4
Cancer - 31 Day standard for subsequent cancer treatments - surgery	2013-14	Number waiting < 31 days	66	76	80	73
		Total number waiting	67	76	81	73
		%	**98.5%**	**100.0%**	**98.8%**	**100.0%**
	2014-15	Number waiting < 31 days	66	68	-	-
		Total number waiting	67	70	-	-
		%	**98.5%**	**97.1%**	-	-
	2015/16 Plan	Number waiting < 31 days	59	61	57	58
		Total number waiting	60	63	57	59
		%	**98.3%**	**96.8%**	**100.0%**	**98.3%**

E.B.10			Quarter 1	Quarter 2	Quarter 3	Quarter 4
Cancer - 31 Day standard for subsequent cancer treatments - anti cancer drug regimens	2013-14	Number waiting < 31 days	92	97	79	76
		Total number waiting	92	97	79	76
		%	**100.0%**	**100.0%**	**100.0%**	**100.0%**
	2014-15	Number waiting < 31 days	95	85	-	-
		Total number waiting	95	85	-	-
		%	**100.0%**	**100.0%**	-	-
	2015/16 Plan	Number waiting < 31 days	94	84	84	74
		Total number waiting	94	84	84	74
		%	**100.0%**	**100.0%**	**100.0%**	**100.0%**

E.B.11			Quarter 1	Quarter 2	Quarter 3	Quarter 4
Cancer - 31 Day standard for subsequent cancer treatments - radiotherapy	2013-14	Number waiting < 31 days	96	107	113	102
		Total number waiting	96	107	114	102
		%	**100.0%**	**100.0%**	**99.1%**	**100.0%**
	2014-15	Number waiting < 31 days	120	112	-	-
		Total number waiting	121	113	-	-
		%	**99.2%**	**99.1%**	-	-
	2015/16 Plan	Number waiting < 31 days	135	126	138	128
		Total number waiting	136	127	139	129
		%	**99.3%**	**99.2%**	**99.3%**	**99.2%**

CCG Name:	CCG Code:	Validation Passed?
NHS BARNSLEY CCG	02P	YES

Please read the definitions in The Forward View into action: Planning for 2015/16 - Technical Definitions for commissioners before completing this template.

E.B.5

A&E Waiting times - Total time in the A&E department

Note: Plans are to be submitted by lead commissioners of Type 1 Trusts. Plan submitted should be for all attendances to A&E.

				Quarter 1	Quarter 2	Quarter 3	Quarter 4
Provider 1	BARNSLEY HOSPITAL NHS FOUNDATION TRUST	2013-14	Number waiting > 4 hours	1378	970	1063	1287
			Total Attendances	20191	20215	19349	19444
			% < 4 hours	**93.2%**	**95.2%**	**94.5%**	**93.4%**
		2014-15	Number waiting > 4 hours	625	595	-	-
			Total Attendances	20386	19895	-	-
RFF			% < 4 hours	**96.9%**	**97.0%**	-	-
		2015/16 Plan	Number waiting > 4 hours	438	417	819	631
			Total Attendances	20521	20027	20000	19702
			% < 4 hours	**97.9%**	**97.9%**	**95.9%**	**96.8%**

Validation Passed?

CCG Name: **CCG Code:** YES

NHS BARNSLEY CCG **02P**

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E.A.S.5		APRIL	MAY	JUNE	JULY	AUGUST	SEPTEMBER	OCTOBER	NOVEMBER	DECEMBER	JANUARY	FEBRUARY	MARCH	Total	
HCAI measure (C.Difficile infections)	2013-14	5	9	6	6	8	10	5	8	3	5	5	2	72	
	2014-15	3	4	4	5	10	9	-	-	-	-	-	-	35	2015-16 Objective
	2015-16 Plan	3	4	4	5	9	9	9	5	5	4	3	3	63	63

E.A.S.1

Dementia - Estimated diagnosis rate	2015-16 Plan	Number of People diagnosed (65+)	1954	1954	1954	1954	1954	1954	1954	1954	1954	1954	1954	1954
		Estimated dementia prevalence (65+ Only (CFAS II))	2674	2674	2674	2674	2674	2674	2674	2674	2674	2674	2674	2674
		%	**73.07%**	**73.07%**	**73.07%**	**73.07%**	**73.07%**	**73.07%**	**73.07%**	**73.07%**	**73.07%**	**73.07%**	**73.07%**	**73.07%**

E.A.3			Quarter 1	Quarter 2	Quarter 3	Quarter 4
IAPT Access - Roll Out	2013-14	The number of people who receive psychological therapies	0	8	862	985
		The number of people who have depression and/or anxiety disorders (local estimate based on Adult Psychiatric Morbidity Survey 2000).	26316	26316	26316	26316
		% per quarter (e.g. 3.75%)	0.00%	0.03%	3.28%	3.74%
	2014-15	The number of people who receive psychological therapies	885	-	-	-
		The number of people who have depression and/or anxiety disorders (local estimate based on Adult Psychiatric Morbidity Survey 2000).	26316	-	-	-
		% per quarter (e.g. 3.75%)	3.36%	-	-	-
	2015-16 Previous plan (from year 2 of 14/15 to 18/19 planning round)	The number of people who receive psychological therapies	3948			
		The number of people who have depression and/or anxiety disorders (local estimate based on Adult Psychiatric Morbidity Survey 2000).	26316			
		% annual	15.00%			
	2015-16 Plan	The number of people who receive psychological therapies	987	987	987	987
		The number of people who have depression and/or anxiety disorders (local estimate based on Adult Psychiatric Morbidity Survey 2000).	26316	26316	26316	26316
		% per quarter (e.g. 3.75%)	**3.75%**	**3.75%**	**3.75%**	**3.75%**

E.A.S.2			Quarter 1	Quarter 2	Quarter 3	Quarter 4
IAPT Recovery Rate	2013-14	The number of people who have completed treatement having attended at least two treatment contacts and are moving to recovery (those who at initial assessment achieved 'caseness' and at final session did not)	-	Incomplete Data	103	180
		The number of people who finish treatement having attended at least two treatment contacts and coded as discharged) minus (The number of people who finish treatment not at clinical caseness at initial assessment)	-	Incomplete Data	218	405
		%			47.2%	44.4%
	2014-15	The number of people who have completed treatement having attended at least two treatment contacts and are moving to recovery (those who at initial assessment achieved 'caseness' and at final session did not)	170	-	-	-
		The number of people who finish treatement having attended at least two treatment contacts and coded as discharged) minus (The number of people who finish treatment not at clinical caseness at initial assessment)	355	-	-	-
		%	47.9%	-	-	-
	2015-16 Previous plan (from year 2 of 14/15 to 18/19 planning round)	The number of people who finish treatement having attended at least two treatment contacts and are moving to recovery (those who at initial assessment achieved 'caseness' and at final session did not)	1250			
		The number of people who finish treatement having attended at least two treatment contacts and coded as discharged) minus (The number of people who finish treatment not at clinical caseness at initial assessment)	2499			
		%	50.0%			
	2015-16 Plan	The number of people who finish treatement having attended at least two treatment contacts and are moving to recovery (those who at initial assessment achieved 'caseness' and at final session did not)	313	313	313	313
		The number of people who finish treatement having attended at least two treatment contacts and coded as discharged) minus (The number of people who finish treatment not at clinical caseness at initial assessment)	625	625	625	625
		%	**50.1%**	**50.1%**	**50.1%**	**50.1%**

Mental Health Access

E.H.1 - A1			Quarter 1	Quarter 2	Quarter 3	Quarter 4
The proportion of people that wait 6 weeks or less from referral to entering a course of IAPT treatment against the number of people who finish a course of treatment in the reporting period.	2015-16 Plan	The number of ended referrals that finish a course of treatment in the reporting period who received their first treatment appointment within 6 weeks of referral	430	430	430	430
		The number of ended referrals that finish a course of treatment in the reporting period.[1]	573	573	573	573
		%	**75.0%**	**75.0%**	**75.0%**	**75.0%**

E.H.2 - A2			Quarter 1	Quarter 2	Quarter 3	Quarter 4
The proportion of people that		The number of ended referrals that finish a course of treatment in the reporting period who received their first treatment appointment within 18 weeks of referral	545	545	545	545

wait 18 weeks or less from referral to entering a course of IAPT treatment against the number of people who finish a course of treatment in the reporting period.	2015-16 Plan	The number of ended referrals who finish a course of treatment in the reporting period.[1]	573	573	573	573
		%	**95.1%**	**95.1%**	**95.1%**	**95.1%**

CCG Name:	CCG Code:	Validation Passed?
NHS BARNSLEY CCG	02P	YES

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CCGs applying for full delegated commissioning responsibility or joint commissioning arrangements are asked to submit E.D.1, E.D.2 and E.D.3. Details of the first CCGs given responsibility can be found at http://www.england.nhs.uk/2015/02/18/commissioning-of-gp/

Primary Care
Medical

E.D.1			Satisfaction with the quality of consultation at GP practices This is a score out of 500
The aggregated percentage of patients who gave positive answers to five selected questions in the GP survey about the quality of appointments at the GP practice		2015/16	436.6

E.D.2			Satisfaction with the overall care received at the surgery
The percentage of patients who gave positive answers to the GP survey question 'Overall, how would you describe your experience of your GP surgery?'	2015/16	Numerator - The number of patients who answered 'very good' or 'fairly good' to the question, 'Overall, how would you describe your experience of your GP surgery?'	3470
		Denominator - The number of patients responding to the question 'Overall, how would you describe your experience of your GP surgery?'	4075
		%	85.2%

E.D.3			Satisifcation with access to primary care
The percentage of patients who gave positive answers to the GP survey question 'Overall, how would you describe your experience of making an appointment?'	2015/16	Numerator - The number of patients answering ''Very good' or 'Fairly Good' to the question 'Overall, how would you describe your experience of making an appointment?'	2895
		Denominator - The number of patients responding to the question 'Overall, how would you describe your experience of making an appointment?	3997
		%	72.4%

Barnsley Clinical Commissioning Group

Putting Barnsley People First

BARNSLEY CLINICAL COMMISSIONING GROUP GOVERNING BODY

12 March 2015

Summary of 2014/15 Cancer Programme Board

1.	**PURPOSE OF THE REPORT**
	The purpose of this report is to define the work completed by the Cancer Programme Board in 2014/15 and identify the priorities for 2015/16. The outline will be used to form the basis for Programme Boards key activities and the overall timeframes of individual projects.
2.	**EXECUTIVE SUMMARY**
	The summary provides the overall vision and objectives of the Cancer Programme Board and gives an overview of the key projects delivered in 2014-15 to achieve these. In 2015-16 the Service Development Team will continue to deliver the on-going projects along with the work plan of new projects to facilitate the development and improvement of Cancer services for the patients of Barnsley. The plans for 2015-16 will be confirmed during the CCG prioritisation process.
3.	**THE COMMITTEE IS ASKED TO:** • Read and note the contents in the Summary.

Agenda time allocation for report:	10 minutes
Report of:	Dr John Harban
Designation:	Chair of the Cancer Board
Report Prepared by:	Amy Turner/James Barker
Designation:	Service Development Support Officer/ Lead Service Development Manager

1.	**SUPPORTING INFORMATION**	
1.1	**Links to the Assurance Framework**	
	This Report links to Assurance Framework, risk references 1.1 and 1.4	
1.2	**Links to Objectives**	
	To have the highest quality of governance and processes to support its business	X
	To commission high quality health care that meets the needs of individuals and groups	X
	Wherever it makes safe clinical sense to bring care closer to home	X
	To support a safe and sustainable local hospital, supporting them to transform the way they provide services so that they are as efficient and effective as possible for the people of Barnsley	X
	To develop services through real partnerships with mutual accountability and strong governance that improve health and health care and effectively use the Barnsley £. These partnerships will be with: Patients, the public, Practices, Providers, the Local Authority, the local voluntary sector and other stakeholders as required	X
1.3	**Links to NHS Constitution**	
	The NHS provides a comprehensive service available to all.	X
	Access to NHS Services is based on clinical need, not an individual's ability to pay.	X
	The NHS aspires to the highest standards of excellence and professionalism	X
	The NHS services must reflect the needs and preferences of patients their families and their carers.	X
	The NHS works across organisational boundaries and in partnership with other organisations in the interest of patients, local communities and the wider population	X
	The NHS is committed to providing best value for taxpayers' money and the most effective, fair and sustainable use of finite resources	X
	The NHS is accountable to the public, communities and patients that it serves.	X
1.4	**Equality and Diversity**	
	This section should seek to check that an Equality Impact Assessment has taken place. If completed, please add as Appendix.	Not Applicable

NHS
Barnsley Clinical Commissioning Group
Putting Barnsley People First

Summary of 2014/15
Cancer Programme Board
March 2015

1.	**Purpose**
1.1	The purpose of the summary is to celebrate and recognise the work completed in 2014/15 measuring the impact of success for each project. The document identifies how the project will develop into 2015/16. This document is designed to accomplish the following: a) Summarise the year 2014/15 b) The current status of ongoing projects c) Highlight the projects that will continue into 2015/16 d) Identify key tasks and milestones for each project e) The impact projects have made to services in Barnsley
2.	**The Vision and Objectives of the Cancer Programme Board**
2.1	To facilitate the development and improvement of cancer services for the patients of Barnsley. This will be achieved by: • increasing the use of cancer provision to reduce the demand and use of unplanned care services • shifting provision of services from secondary care to primary care settings, where clinically appropriate • involving patients in decisions about their own care, furthering the use of technology to help people manage their conditions, providing coordinated care for people who are using multiple services
3.	**Cancer Projects 2014-15**
3.1	**Prevention & Early Detection** **Project Lead: Nicola Johnson** • **Campaigns Overview:** To work collaboratively with Public Health and the CSU Communications Team or other marketing organisation to deliver localised campaigns focussing on tumour sites identified as priorities for the CCG. These are breast, colorectal, lung and prostate. Going forward 2 week wait conversion data will be collected and analysed to monitor the effect of the campaigns on activity at BHNFT. • **Website Overview:** The cancer website content is available and ready to be uploaded. Following the tender process and evaluation, a provider has been chosen. A kick off meeting was held on 23 February 2015 in

preparation for the go live date of 1 April 2015.

- **Go live dates:** Campaigns – On-going 2014/15
  Website – April 2015

- **Project Status:** A Head & Neck campaign was held in June/July 2014 by the CCG and BHNFT along with national campaigns for lung and ovarian cancer. Public Health held a cervical campaign in August 2014 and a bowel campaign in September 2014. The CSU Comms Team have delivered campaigns alongside the national campaigns through social media.

Evaluation of Campaigns: Both the Testicular/prostate and Cervical campaign have made an impact on Barnsley residents. As well as the information provided in the evaluation documents, statistics from BHNFT show the following:

Prostate Cancer 2ww average monthly referrals:
Aug-Oct (Pre-campaign): 11.3
November (During campaign): 15
Dec-Feb (Post-campaign): 15

Prostate Cancer diagnosis:
Aug-Oct (Pre-campaign): 5.3 diagnosed
November (During Campaign): 9 diagnosed
Dec – Feb (Post-campaign): 6 diagnosed

The above data shows there was an increase in referral activity and diagnosis of prostate cancer during the month of the campaign and following 3 months. This suggests the campaign has had a positive effect on people's awareness of the symptoms of prostate cancer and the need to contact their GP if they have any symptoms.

Cervical Screening referrals recalled suspicious of cervical cancer:
Dec – Feb (Pre-campaign): 54.3
March (During Campaign): 47
Apr – June (Post Campaign): 65

Cervical Screening recalls diagnosed with cancer:
Dec – Feb (Pre-campaign): 5
March (During Campaign): 1
Apr – June (Post Campaign): 2

The above data shows that although the number of recalls decreased during the month of the campaign, they increased in the following 3 months. It could be suggested (although not proven due to lack of data) that the number of cervical screens carried out in the Barnsley borough has increased following the campaign, which then results in an increase of recalls. However, the number of diagnoses has not increased. The evaluation of the campaigns has been circulated to the Programme Board.

	Jo's Cervical Cancer Trust, and the Fear or Smear cervical screening awareness campaign (2014) is a joint winner (along with a project from Newcastle) of the 2014 Cervical Screening Award. The awards "aim to find the best local cervical screening campaigns", and according to Jo's Cervical Cancer Trust, they were very impressed with the quality of the campaign, the targeting of the population group, and the collaboration between Public Health and other organisations and retailers in order to deliver the campaign. <u>Bowel Cancer:</u> Barnsley Public Health cannot access any data to examine whether bowel screens have increased or not. However, given that the project followed a published report which evidenced the effectiveness of encouragement from a patient's GP to participate in the screen, we would like to assume there has been an increase.
3.2	**Cancer Education for GPs** • **Project Lead: Nicola Johnson** • **Overview:** To produce a bi-monthly newsletter to be distributed to all GPs. This will give an overview of Programme Board initiatives, top tips on a particular tumour site in each edition and any relevant topical information in the media. This will be subject to review in March 2015. • The importance of 2WW appointments will continue to be stressed to GPs and the leaflets to give to patients were printed in various languages and distributed in October 2014. • Risk Assessment Tools for lung and colorectal cancer are in the final stages of development and will act as prompts/easy reference materials for GPs to ensure they are referring all possible cancer patients in to secondary care. • BEST events to be utilised effectively by the Cancer Board. Initially there will be a meeting in January 2015 to introduce the 'shared care' initiative which will initially be rolled out for prostate and colorectal cancer patients. This will enable non-metastatic patients with no further medical complications to be followed-up in primary rather than secondary care. • **Go Live Dates:** Newsletter - Throughout 2014/15 2WW - Throughout 2014/15 RAT tools - February 2015 • **Project Status:** Three editions of the newsletter have now been distributed, the success of this will be assessed at the end of March and alternatives discussed if necessary.

	• 2 week waits will be analysed to see whether the appointments are being used effectively. • Once reviewed by Dr Leese and Georgia Thompson, the RAT tools will be distributed to all GPs. **Evaluation of the Project:** The Cancer Board has a dedicated method of communication with GPs to share best practice and ensure patients receive timely treatment for suspected cancers. As part of the GP e-Newsletter evaluation a survey monkey questionnaire has been sent out to all Practice Managers to find out the preferred route for distributing information to GP's. Dr Leese presented the Shared Care proposal at the Men's Health BEST Event. A Business Case is currently being developed as part of the Shared Care Project. The Risk Assessment Tools are due to be delivered to practices in early 2015.
3.3	**Treatment Pathways** • **Project Lead: James Barker** • **Overview:** To hold breast, colorectal, lung and prostate workshops during 2014/15 to identify whether there are any gaps in the services and assess how best to address these. Clinical Nurse Specialists, Service Managers, Consultants and GPs will be invited to offer their thoughts and views and enable decisions to be made on how to improve the services going forward. • **Go live dates:** Colorectal – July 2014 Lung - September 2014 Breast – November 2014 Prostate – February 2015 • **Project Status:** As a result of the colorectal event BHNFT developed a Business Case for the CCG to purchase Cardio pulmonary exercise test (CPEX) equipment which would allow patients' fitness levels to be assessed prior to surgery. This was approved by the Cancer Programme Board in September 2014. • The lung and breast cancer action plans went to the Cancer Board in January 2015 and were approved. It was suggested that lung cancer screening, particularly in the east of Barnsley where the disease is more prevalent should be looked in to with BHNFT possibly working in collaboration with Mexborough Montague Hospital to provide this offering ease of access to patients.

	• The breast workshop again highlighted the shortage of Radiologists as an issue meaning that clinics are only available on a Tuesday which may not always be convenient for patients. • The prostate workshop highlighted the shortage of Urology Consultants within the trust. The CSU are populating the action plan and this will be circulated to the Programme Board to approve. **Evaluation of the Workshops:** The CPEX equipment has now been purchased and will help estimate risk for patients undergoing surgery to improve patient outcomes Each workshop has produced a robust action plan of the work required to support the ongoing improvement of cancer care in Barnsley. The action plans from the workshops will be utilised to inform a systematic review of Service Specifications in 2015-16. Any actions which are not addressed through this review will be looked at by the Service Development Team.
3.4	**End of Life Care** • **Project Lead: James Barker** • **Overview:** To develop a strategy which will bring together the End of Life (EoL) services available in Barnsley and offer recommendations on how to proceed with the development of EoL registers. As a result of this the need for additional palliative care provision will be determined. A website is also in the final stages of development and is designed to signpost patients and carers to the services available to them in the Barnsley area. • **Go live date:** Strategy and Website April 2015 • **Project Status:** Within this project there are three key elements: o The compilation and implementation of the Barnsley End of Life strategy o The development of the End of Life register o The design and launch of the website. • Project timelines for each of these elements are April 2015 for the strategy and website and the register will form part of the Barnsley Quality Outcomes Framework which will be implemented throughout 2015/16. **Evaluation of the Project:** Barnsley CCG will have a robust strategy for the ongoing development of End of Life Care. The Strategy will highlight key recommendations that will form the basis on an ongoing work plan to ensure the services in Barnsley are supporting people as they approach last days of life. The strategy will be completed by 1st April 2015.

3.5	**Survivorship** • **Project Lead:** James Barker • **Overview:** Following the success of the launch event on the 10th November 2014, three further meetings have been booked to scope out the project and develop a Business Case which will identify the improvements required and how they will be implemented. • **Go live dates: 2015-16** • **Project Status:** Two out of the three meetings have been held with the third meeting due to take place in March 2015. **Evaluation of the Project:** The Business Case will form a work plan to commence in 2015/16.
3.6	**Shared Care Pathway** • **Project Lead:** Nicola Johnson **Overview:** A Business Case is being developed to outline the approach of moving care closer to home by moving the follow up care of prostate and colorectal cancer patients from secondary care to primary care, after two years of the condition being stable without complications. Shared Care has been included in phase 3 of the Barnsley Quality Framework subject to approval. • **Go live dates: 2015-16** • **Project Status:** The Business Case will be completed by the end of March 2015 ready for implementation from April 2015.
4.	**Cancer Projects 2015-16**

4.1 Prevention & Early Detection

- **Project Lead:** Nicola Johnson
- **Plan for 2015/16:** To continue to enhance national campaigns through the Cancer Website and monitor the effects of these and the national campaigns.
- **Project timeline and key actions**

Key Action	Start date	End Date
1) Lessons learnt - review data	March 2015	April 2015
2) Launch cancer website	April 2015	Review – 2015/16
3) Identify the best method of measuring the success of campaigns	April 2015	June 2015
4) Monitor effect of campaigns	2015/16	2015/16

4.2 Cancer Education for GPs

- **Project Lead:** Nicola Johnson
- **Plan for 2015/16:** To review the GP newsletter and organise distribution of the Risk Assessment Tools and to link to the Cancer Website.
- **Project timeline and key actions**

Key Action	Start date	End Date
1) Review of newsletter and engagement	July 2015	July 2015
2) Monitor 2WW attendances by practice	August 2015	October 2015
3) Collaboration with Dr Atcha to support GP education at BEST events	April 2015	April 2015
4) Distribute RAT tools	April 2015	April 2015

4.3 Treatment Pathways

- **Project Lead:** Louise Bond
- **Plan for 2015/16:** To implement the action plans from the workshops through the development of revised service specifications for all elements of Barnsley's cancer services and develop revised SLAs between BHNFT and STH.
- **Project timeline and key actions**

Key Action	Start date	End Date
Review of all action plans to identify common trends	April 2015	May 2015
Engage with key stakeholders	May 2015	may 2015

	required to support specification development		
	Redraft service specifications	May 2015	October 2015

4.4 End of Life Care

- **Project Lead:** James Barker
- **Plan for 2015/16:** To begin to roll out the recommendations from the strategy.
- **Project timeline and key actions**

Key Action	Start date	End Date
Finalise the EoL strategy	March 2015	March 2015
Confirm action plan resulting from the strategy, including approval.	April 2015	April 2015
Develop work plan for implementation of key recommendations including engagement with key stakeholders	May 2015	May 2015
Manage the implementation of key recommendations	May 2015	March 2016

4.5 Survivorship

- **Project Lead:** Nicola Johnson
- **Plan for 2015/16:** To implement the project plan developed in the survivorship meetings.
- **Project timeline and key actions**

Key Action	Start date	End Date
Develop Business Case for Survivorship project	January 2015	March 2015
Business Case delivered for approval	April 2015	May 2015
Develop and deliver improvements in line with the approved Business Case and project plan	July 2015	September 2015

4.6 Shared Care

- **Project Lead:** Nicola Johnson
- **Plan for 2015/16:** To implement the pathway changes required to move colorectal and prostate follow ups from acute care to primary care.
- **Project timeline and key actions**

Key Action	Start date	End Date

		Develop Business Case	March 2015	March 2015
		Business Case delivered for approval	April 2015	April 2015
		Develop and deliver pathway changes	July 2015	September 2015

Barnsley Clinical Commissioning Group

Putting Barnsley People First

BARNSLEY CLINICAL COMMISSIONING GROUP GOVERNING BODY

12 March 2015

Summary of 2014/15 Planned Care Programme Board

1.	**PURPOSE OF THE REPORT**
	The purpose of this report is to define the work completed by the Planned Care Programme Board in 2014/15 and identify the priorities for 2015/16. The outline will be used to form the basis for Programme Boards key activities and the overall timeframes of individual projects.
2.	**EXECUTIVE SUMMARY**
	The summary provides the overall vision and objectives of the Planned Care Programme Board and gives an overview of the key projects delivered in 2014-15 to achieve these. In 2015-16 the Service Development Team will continue to deliver the on-going projects along with the work plan of new projects to facilitate the development and improvement of Planned Care services for the patients of Barnsley. The plans for 2015-16 will be confirmed during the CCG prioritisation process.
3.	**THE COMMITTEE IS ASKED TO:** • Read and note the contents in the Summary.

Agenda time allocation for report:	10 minutes
Report of:	James Barker
Designation:	Lead Service Development Manager
Report Prepared by:	Amy Turner/James Barker
Designation:	Service Development Support Officer/ Lead Service Development Manager

1.	**SUPPORTING INFORMATION**	
1.1	**Links to the Assurance Framework**	
	This Report link to Assurance Framework, risk references 1.1 and 1.4.	
1.2	**Links to Objectives**	
	To have the highest quality of governance and processes to support its business	X
	To commission high quality health care that meets the needs of individuals and groups	X
	Wherever it makes safe clinical sense to bring care closer to home	X
	To support a safe and sustainable local hospital, supporting them to transform the way they provide services so that they are as efficient and effective as possible for the people of Barnsley	X
	To develop services through real partnerships with mutual accountability and strong governance that improve health and health care and effectively use the Barnsley £. These partnerships will be with: Patients, the public, Practices, Providers, the Local Authority, the local voluntary sector and other stakeholders as required	X
1.3	**Links to NHS Constitution**	
	The NHS provides a comprehensive service available to all.	X
	Access to NHS Services is based on clinical need, not an individual's ability to pay.	X
	The NHS aspires to the highest standards of excellence and professionalism	X
	The NHS services must reflect the needs and preferences of patients their families and their carers.	X
	The NHS works across organisational boundaries and in partnership with other organisations in the interest of patients, local communities and the wider population	X
	The NHS is committed to providing best value for taxpayers' money and the most effective, fair and sustainable use of finite resources	X
	The NHS is accountable to the public, communities and patients that it serves.	X
1.4	**Equality and Diversity**	
	This section should seek to check that an Equality Impact Assessment has taken place. If completed, please add as Appendix.	Not Applicable

NHS
Barnsley Clinical Commissioning Group
Putting Barnsley People First

Summary of 2014/15
Planned Care Programme Board
March 2015

1.	**Purpose**
1.1	The purpose of the summary is to celebrate and recognise the work completed in 2014/15 measuring the impact of success for each project. The document identifies how the project will develop into 2015/16. This document is designed to accomplish the following: a) Summarise the year 2014/15 b) The current status of ongoing projects c) Highlight the projects that will continue into 2015/16 d) Identify key tasks and milestones for each project e) The impact projects have made to services in Barnsley
2.	**The Vision and Objectives of the Planned Care Programme Board**
2.1	To facilitate the development and improvement of planned care services for the patients of Barnsley. This will be achieved by: • Increasing the use of planned care provision to reduce the demand and use of unplanned care services • Shifting provision of services from secondary care to primary care settings, where clinically appropriate • Involving patients in decisions about their own care, furthering the use of technology to help people manage their conditions, providing coordinated care for people who are using multiple services.
3.	**Planned Care Projects 2014-15**
3.1	**Teledermatology** **Project Lead: Ann Lightowler** • **Overview:** To implement a Teledermatology service at Barnsley Hospital NHS FT to provide timely access to a consultant for patients with skin conditions that can be photographed and reviewed remotely. Each patient will be provided with an individual care plan or referral to secondary care for continued treatment. • **Go live date:** 5th January 2015 • **Project Status:** The Phase 1 project is progressing in line with the agreed

	timescales and the first 9 GP practices can now begin to refer patients to the service with CCG support being provided to practices as they start to use the service. • Phases 2 and 3 of this project will continue into 2015/16. A request for practices for Phase 2 has been sent out.
3.2	**Procurement of Diagnostic Equipment for Primary Care** **Project Lead: Ann Lightowler** • **Overview:** To procure on behalf of all GP practices in Barnsley diagnostic equipment to reduce referrals into secondary care and allow for the effective manage of conditions and diagnose in Primary Care. The following equipment will be provided: Blood Pressure Monitors and ECG machines. • **Go Live Dates:** ECG Machines – 1st April 2015 • **Project Status:** The Blood pressure monitors have been provided and installed at GP Practices. The tender for the ECG machines has been awarded to Seca and the equipment will be ordered during March and April 2015. • Training on the machines will be provided throughout April 2015.
3.3	**Sound Doctor** **Project Lead: Ann Lightowler** • **Overview:** To implement and pilot a web based service to support the self-management of long term conditions, specifically COPD and Diabetes. The service will be made available to all the health community across Barnsley along with the support to use the service and promote the benefits to patients. • **Go live date:** November 2014 • **Project Status:** The service is being actively promoted across GP practices and services specialising in COPD and Diabetes.
3.4	**Optimising Care Pathways** **Project Lead:** Ann Lightowler • **Overview:** To implement a clinical pathway system for use in general practice that will support and refine patient pathways and methods of referral. • **Go live date:** April 2015

	• **Project Status:** Within this project there are four key elements:
	  ○ The implementation of the Map of Medicine (MoM) software package across all GP practices in Barnsley
	  ○ The development of localised referrals software, implemented across interested practices
	  ○ The development of localised pathways within the MoM software package
	  ○ An ongoing engagement and communication strategy with all GP practices in Barnsley to ensure maximum usage of the software and its benefits.
	
	Project timelines for each of these elements are being drafted with early stakeholder engagement scheduled from January 2015. A kick off meeting will be scheduled for early 2015-16.

3.5	**Optimising the Management of Patients with CVD** **Project Lead:** Nicola Johnson • **Overview:** To develop effective risk evaluation and reporting tools that the will enable GPs to understand those patients with and at risk of CVD. This will be supported further by the recruitment of a CVD Nurse who will provide training and support to GP practices across Barnsley. • **Go live dates:** Identification of 'at risk' patients reporting – April 2015 CVD Nurse Recruitment – May 2015 • **Project Status:** The Risk reporting tool is currently being trialled at the Huddersfield Road Surgery in preparation for a phased roll out across Barnsley in 2015. • An appointment has been made to the CVD Nurse vacancy and it is expected they will be in post by the end of April 2015.

3.6	**Community Based Ophthalmology**
	
	Project Lead: Nicola Johnson
	
	• **Overview:** To introduce four local optical care services across high Street opticians. The new services will reduce inappropriate referrals to secondary care. The four schemes are:
	
	  ○ Primary Eyecare Assessment and Referral Service (PEARS)
	  ○ Cataract Referral scheme
	  ○ Intra Ocular Pressure refinement
	  ○ Paediatric referral scheme
	
	• **Go live date:** 19th January 2015

- **Project Status:** 18 Barnsley based Opticians have joined the scheme and are now offering services patients across the town.

Evaluation of Project to date:

The service is being offered from 22 Optician branches across Barnsley. The activity received for January 2015 is detailed below for each of the services:

Service	Number of Referrals
Primary Eyecare Assessment and Referral Service	31
Cataract Referral Scheme	7
Intra Ocular Pressure refinement	8
Paediatric Referral Scheme	0

3.7 **Review of Respiratory Services in Barnsley**

Project Lead: Gail Lett

- **Overview:** A comprehensive review to understand the quality and scope of current respiratory service in Barnsley compared to national guidelines and best practice. The report will contain recommendations on potential service improvements to be delivered in 2015/16.

- **Review completion date:** March 2015

- **Project Status:** The review is on target to be completed by March 2015. A summary of the review and key recommendations will be presented to the Programme Board in April 2015. This will form the work plan going forward in 2015-16.

3.8 **Review and Development of Diabetes Services in Barnsley**

Project Lead: James Barker

- **Overview:** To map the current provision of services available to diabetics across Barnsley and to map a revised pathway based on national guidelines and best practice. Alongside the mapping exercise the development of a comprehensive business case setting out the need for change and its impact on patients and local health services.

- **Review completion date:** March 2015

- **Project Status:** The review is on target to be completed by March 2015. The Business Case setting out the proposed changes and their implications will inform the work plan for 2015-16.

3.9 **Exercise Class for patients with Parkinson's Disease**

The Board funded a community exercise class for people with Parkinson's.

This incorporates elements of a falls prevention programme and is supported by a health led assessment clinic, social support from community services and the voluntary sector. The benefits of the this group:

- Peer support
- Decrease social isolation
- Individuals taking responsibility for their own health and social wellbeing
- Individuals having access to health, social and voluntary services.

4. Planned Care Projects 2015-16

4.1 Teledermatology

Project Lead: Ann Lightowler

- **Plan for 2015/16:** To deliver the roll out of phase 2 and 3 of the project, ensuring all GP practices in Barnsley have the required equipment and training to utilise the service.

- **Project timeline and key actions**

Key Action	Start date	End Date
Phase 1 lessons learnt review	March 2015	March 2015
Identify Phase 2 Practices	February 2015	March 2015
Training and engagement with Phase 2 practices	April 2015	April 2015
Go live for Phase 2 practices	May 2015	June 2015
Phase 2 lessons learnt review	August 2015	August 2015
Identify Phase 3 Practices	July 2015	August 2015
Training and engagement with Phase 3 practices	September 2015	September 2015
Go live for Phase 3 practices	October 2015	November 2015
Phase 3 and Project Benefit Review	January 2016	January 2016

4.2 Sound Doctor

Project Lead: Ann Lightowler

- **Plan for 2015/16:** To continue the roll out and engagement of the Sound Doctor Service

- **Project timeline and key actions**

Key Action	Start date	End Date
Continued engagement with health care providers and patients (ongoing)	January 2015	March 2016
Hoyland Self-Management Event	January 2015	January 2015
Continued review of service use and uptake	April 2015	March 2016

4.4 Optimising Care Pathways

Project Lead: Ann Lightowler

- **Plan for 2015/16:** To continue the implementation a clinical pathway system for use in general practice that will support and refine patient pathways and methods of referral.

- **Project timeline and key actions**

Key Action	Start date	End Date
Pre-launch engagement with GP's demonstrating the benefits of the programme and identifying GP Practices that are interested in developing the referrals and pathways.	January 2015	March 2015
Understand and develop KPIs and methods to determine the success of the project.	January 2015	March 2015
Recruit and appoint a Project Manager	January 2015	March 2015
Commence the development localised pathways with interested GPs and other stakeholder e.g. BHNFT	February 2015	March 2015
Launch the 'free' elements of MoM across Barnsley GPs. Start monitoring of MoM impact.	April 2015	April 2015
Commence the development localised referral work	May 2015	May 2015
Pilot the local pathways across Barnsley GPs	May 2015	March 2016
Pilot the local referrals across Barnsley GPs	September 2015	March 2016

4.5 Optimising the management of patients with CVD

Project Lead: Nicola Johnson

- **Plan for 2015/16:** To continue the implementation of risk reporting tools and completion of CVD nurse recruitment and roll out of CVD training for GP practices.

- **Project timeline and key actions**

Key Action	Start date	End Date
CVD Nurse Recruitment	January 2015	April 2015
Targeted practice engagement	February 2015	June 2015
Agree training programme and roll out for GP Practices	March 2015	April 2015
CVD Nurse training and GP practice	May 2015	April 2016

	development		
	Finalise the content of the 'at risk' reporting tool	January 2015	February 2015
	Agree roll out of the 'at risk' reporting tool	February 2015	March 2015
	Roll out of reporting tool to all GP practices	May 2015	March 2016

4.6 Review of Respiratory Services in Barnsley

Project Lead: James Barker

- **Plan for 2015/16:** To confirm the recommendations presented in the review and to develop a comprehensive programme of service improvements across respiratory services.

- **Project timeline and key actions**

Key Action	Start date	End Date
Receive the completed respiratory review	March 2015	March 2015
Confirm the recommendations and agree the implementation approach	April 2015	April 2015
Implementation of key recommendations from the report	May 2015	March 2016

4.7 Review and Development of Diabetes Services in Barnsley

Project Lead: James Barker

- **Plan for 2015/16:** To implement the pathway changes identified with the Diabetes Business Case and service mapping review.

- **Project timeline and key actions**

Key Action	Start date	End Date
Submission of Business Case and pathway maps for Governing Body approval	March 2015	March 2015
Confirm the recommendations and agree the implementation approach	April 2015	April 2015
Implementation of the pathway changes	May 2015	March 2016

Barnsley Clinical Commissioning Group
Putting Barnsley People First

GOVERNING BODY

Thursday 12 March 2015

CQUIN Proposals for 2015/16

1.	**PURPOSE OF THE REPORT**
	To inform the Governing Body of the locally agreed CQUINs for 2015/16 for BHNFT and SWYPFT.
2.	**EXECUTIVE SUMMARY**
	It is proposed that there are four locally agreed schemes for BHNFT and four locally agreed schemes for SWPFT.
3.	**THE GOVERNING BODY IS ASKED TO**: Receive the attached briefing paper for information.

Agenda time allocation for report: 10 minutes.

Report of: Brigid Reid

Designation: Chief Nurse

Report Prepared by: Dianne Swiers - Interim Safeguarding Lead Adults
Karen Martin - Deputy Chief Nurse

1.	**SUPPORTING INFORMATION**	
1.1	**Links to the Assurance Framework**	
	This report provides assurance in respect of risks 1.1 and 1.4 on the Governing Body Assurance Framework.	
1.2	**Links to Objectives**	
	To have the highest quality of governance and processes to support its business	✓
	To commission high quality health care that meets the needs of individuals and groups	✓
	Wherever it makes safe clinical sense to bring care closer to home	x
	To support a safe and sustainable local hospital, supporting them to transform the way they provide services so that they are as efficient and effective as possible for the people of Barnsley	✓
	To develop services through real partnerships with mutual accountability and strong governance that improve health and health care and effectively use the Barnsley £.	✓
1.3	**Governance Arrangements Checklist**	✓
	Financial Implications	
	Contracting Implications	Discussed with contracting team
	Quality	Prepared by Quality Team
	Consultation / Engagement	Discussed with service providers
	Equality and Diversity	NA
	Information Governance	NA
	Environmental Sustainability	NA
	Human Resources	NA

2.	**BACKGROUND INFORMATION**
	Commissioning for Quality and Innovation (CQUIN) is a payment framework which is designed to incentivise providers into achieving goals in quality domains such as effectiveness, safety, innovation and experience. At the time of writing this paper, the national CQUIN schemes for 2015/16 have not yet been published. It is anticipated that they will include 4 national indicators, with an even balance between physical and mental health, these will include: • Limited updating of 2 of the 2014/15 schemes concerning Dementia and delirium care and improving the physical health of people with mental health conditions. • Two new CQUINs, one on the care of patients with acute kidney injury and the other on the identification and early treatment of sepsis. In addition there will be a new national CQUIN theme on improving emergency care across local communities. Commissioners will be expected to select indicators from a menu of options. An internal audit report 'CQUIN Benchmarking, 360 Degree Assurance' (January 2015) analysed the 2014/15 CQUIN schedules across the East Midlands and Yorkshire and the Humber. The report is very critical of many schemes and suggests that the following questions should be asked: 1. Are there opportunities for area based indicators? 2. Does the descriptor give enough detail to enable focused measurement of success to be determined? 3. Does the numerator and denominator give clear detail about how success against the CQUIN measure will be determined? 4. Has the source of data underpinning the measurement of the indicator been established? 5. How do you demonstrate the reliability of data supporting achievement against the CQUIN measure? 6. How does your organisation capture risk associated with the CQUIN? These questions have been considered when preparing the CQUIN for 2015/16. In addition, it would be useful to review the process for agreeing CQUIN schemes for 2016/17. The review should include: • Who needs to be involved in drafting CQUIN and at what stage? (A timeline with roles and responsibilities would help). • What data is needed to determine which CQUINs would be worked up? (What are others doing? What is our intelligence showing is needed?). • What likely value is attributable to each CQUIN? (Do providers know how much they will achieve if successful and therefore what would be reasonable to deliver?).

	• At what stage does the long list become the shortlist? (i.e. staff are clear when to stop working up a CQUIN that will not be agreed but concentrate on producing robust CQUINs that are likely to be agreed). • How can joint CQUINs be considered? (e.g. hospital and community CQUIN on End of Life care). • How are clinical staff kept in the loop once the draft goes to contracting? (There have been many comments during this round regarding staff not knowing what happens next, CQUINs changing and staff who drafted the CQUIN not understanding the implications, and clinical staff not knowing if they are being delivered or not). This would ensure that CQUIN targets identify need and it will be clear how improvements will be measured, with staff fully engaged in the process.
3.	**DISCUSSION**
	Commissioners must offer each provider the opportunity to earn up to 2.5% of its annual contract value by successfully delivering CQUIN schemes. CQUIN schemes are either nationally mandated or locally agreed. As the national CQUIN for 2015/16 are likely to be more onerous, it was agreed with providers that locally agreed CQUINs would be limited in number. This year's CQUIN proposes to reflect the providers' views on their key areas for improvement. In the case of SWYPFT, one of the proposed schemes forms part of the CQUIN agreed with West Yorkshire CCG, which will give some consistency of approach across the Trust. The schemes for 2014/15 which will not be continued as a CQUIN are: **Barnsley Hospital NHS Foundation Trust (BHNFT):** • Clinical Communications – work is ongoing to achieve this CQUIN and will be transferred into the Quality schedule for next year. • Seven Day Working - this CQUIN is due to report in Quarter 4. **South and West Yorkshire Partnership Foundation Trust (SWYPFT):** • Pressure Ulcers - there have been some issues meeting the targets agreed largely due to the small numbers of cases, eg only 2 patients had deteriorating pressure ulcers in Quarter 2. However a key indicator "*the number of patients deemed at risk who do not develop a pressure ulcer*" has exceeded target (92% Quarter 3). The narrative submission shows good review of RCAs and lessons learned. • Antimicrobial Stewardship - systems for data collection have been established, improvement targets will be reported in Quarter 4. • Dementia - the number of patients seen within 15 working days has been better than target which was set at 70% (78% in Quarter 3). Number of patients seen diagnosed within 12 weeks has exceeded target (76% in Quarter 3). An audit showing information supplied to patient at diagnosis will be reported in Quarter 4.

4.	**IMPLICATIONS**
	The schemes proposed for 2015/16 are listed below and are shown in Appendix 1 and 2. Details of each scheme can be found as appendices to this report. **BHNFT (Appendix 1):** • 4.1 Antimicrobials - this is a stretch of the scheme for 2014/15 and will require improvements in antimicrobial prescribing, such as antimicrobials will have a stop date. Each prescription will have a specified indication. The overall intention is to reduce the number of healthcare associated infections. • 4.2 Learning Disability (LD) - this is a scheme to introduce trained learning Disability Champions across the Trust who will provide information to the LD Nurse to ensure that reasonable adjustments are made for patients with LD. The overall intention is to improve the care experience and outcomes for patients with a learning disability in the acute care setting. • 4.3 Pressure Sores - this is an expansion for the 2014/15 scheme and is designed to continue to drive improvements in the prevention of pressure sores and to prevent deterioration of existing sores. • 4.4 Do Not Attempt Resuscitation (DNAR) - compliance with the Trust's policy on DNAR will be audited. A Training Needs analysis for frontline staff involved in DNAR decisions will be undertaken, appropriate training will be delivered and evaluated. **SWYPFT (Appendix 2):** • 4.5 High Performing Teams - this is an expansion of the 2014/15 scheme and now includes the analysis of serious incidents to identify Clinical Human Factors. The overall intention is to improve working relationships between team members in order to provide effective services to patients. A specific aim is to introduce a system where Clinical Human Factors are identified within incident investigation. This is likely to be a national CQUIN requirement in future years. • 4.6 Learning Disability Cancer Screening - this is an expansion of the 2014/15 scheme. Further stretch targets are agreed for cancer screening in this client group. The overall intention is to ensure that patients with LD access cancer screening at or above the level of the population as a whole. • 4.7 Barnsley Care Navigation/Telehealth - this is designed to increase the numbers of patients who are using this service. The overall intention is to facilitate a positive behaviour change that will impact on overall health and well-being. • 4.8 Mental Health Clusters - this is designed to ensure that clients are accurately assessed (and reassessed) and allocated an appropriate cluster. This forms the basis for payment, but can be expanded to support clinical practice.

5.	**RISKS TO THE CLINICAL COMMISSIONING GROUP**
	The schemes are designed to minimise risk to the CCG by ensuring that systems and processes are in place within provider organisations, to improve standards of care.
6.	**CONSULTATION**
	CQUIN meetings have been held within provider organisations and between the CCG and providers throughout the year. In addition, comments and suggestions have been sought from clinical experts and CQUIN leads within the organisations.
7.	**APPENDICES TO THE REPORT**
	Appendix 1: BHNFT Appendix 2: SWYPFT
8.	**CONCLUSION**
	The Governing Body are asked to receive the 8 CQUIN schemes proposed for 2015/16 for information.

BHNFT Local CQUIN Schemes 2015/16

Financial Breakdown

Goal	Goal Weighting (%)	Indicators	Indicator Weighting (%)
1	25%	A B C D E	35% 10% 10% 10% 35%
2	25%	A B	50% 50%
3	25%	A B	50% 30%
4	25%	A B C D	10% 30% 30% 30%

The Schemes

Goal	1
Name of Goal	Antimicrobial Stewardship
Number of Indicators	5
% weighting of applicable CQUIN funding	25%
Data Source	Submission of implementation plan with quarterly progress updates.
Additional Data Source	Not Applicable
Reports due	Quarterly 15 working days following period being reported
Report due (exceptions)	Clinical areas in which electronic prescribing is introduced may be excluded from audits should comparable data not readily be available. Topical preparations are excluded as are the following clinical areas; ITU, Paediatrics, Haematology and Outpatients.

Indicator	1A
Name/Description of Indicator	Embedding of revised local prescription documentation/implementation of electronic prescribing
Indicator Weighting	35%
Rationale for inclusion	Criterion 9 of The Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance outlines the guidance for compliance for registered organisations to provide evidence of prudent prescribing and antimicrobial stewardship. It states: "Procedures should be in place to ensure prudent prescribing and antimicrobial stewardship. There should be an ongoing programme of audit, revision and update. In healthcare this is usually monitored by the antimicrobial management team or local prescribing advisors". Current evidence clearly demonstrates that the inappropriate use of broad-spectrum antibiotics is associated with the selection of antibiotic-resistant bacteria such as Extended-Spectrum Beta-Lactamase (ESBL)-producing Gram-negative bacteria as well as the specific acquisition of MRSA, the induction of Clostridium difficile infection (CDI) and can cause long-lasting harmful changes to the body's protective microbial flora. Broad-spectrum antibiotics (including cephalosporins, quinolones and clindamycin) have been most associated with CDI, but all antibiotics should be avoided unless there are clear clinical indications for their use. Antibiotics should be used for the shortest duration possible that gives an appropriate clinical outcome and be managed within a multifactorial programme (including hand hygiene and infection prevention and control precautions) aimed at reducing HCAI and improving antimicrobial use. An Antimicrobial Stewardship programme is seen as a key component in the reduction of HCAI infections in a healthcare setting. However, a National Audit Office report, published in 2009, suggested that one-third of trusts in England did not have a robust strategy to review antimicrobial prescriptions automatically within a defined period. This CQUIN will ensure appropriate antimicrobial stewardship is in place in order to help reduce healthcare associated infections (HCAI) and contribute to slowing the development of antimicrobial resistance. This also links to Domain 5 from the Outcomes Framework: Treating and caring for people in a safe environment; and protecting them from avoidable harm.
Numerator	Not Applicable
Denominator	Not Applicable
Baseline	Project plan outlining progress of implementation against plan and timescales.
Target payment threshold	**Quarter 1** – Submission of a time bound project plan providing a breakdown to embed the use of revised local prescription documentation across BHNFT. **Quarter 2** –Project summary outlining progress of implementation against milestones and timescales. **Quarter 3** - Project summary outlining progress of implementation against milestones and timescales. **Quarter 4** – Fully embedded the use of the revised local prescription documentation/implementation of electronic prescribing according to baseline action plan
Additional Payment Based Reports	Not Applicable

Indicator	1B
Name/Description of Indicator	Proportion of antimicrobial prescriptions with a specified review or stop date
Indicator Weighting	10%
Rationale for inclusion	Criterion 9 of The Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance outlines the guidance for compliance for registered organisations to provide evidence of prudent prescribing and antimicrobial stewardship. It states: "Procedures should be in place to ensure prudent prescribing and antimicrobial stewardship. There should be an ongoing programme of audit, revision and update. In healthcare this is usually monitored by the antimicrobial management team or local prescribing advisors". Current evidence clearly demonstrates that the inappropriate use of broad-spectrum antibiotics is associated with the selection of antibiotic-resistant bacteria such as Extended-Spectrum Beta-Lactamase (ESBL)-producing Gram-negative bacteria as well as the specific acquisition of MRSA, the induction of Clostridium difficile infection (CDI) and can cause long-lasting harmful changes to the body's protective microbial flora. Broad-spectrum antibiotics (including cephalosporins, quinolones and clindamycin) have been most associated with CDI, but all antibiotics should be avoided unless there are clear clinical indications for their use. Antibiotics should be used for the shortest duration possible that gives an appropriate clinical outcome and be managed within a multifactorial programme (including hand hygiene and infection prevention and control precautions) aimed at reducing HCAI and improving antimicrobial use. An Antimicrobial Stewardship programme is seen as a key component in the reduction of HCAI infections in a healthcare setting. However, a National Audit Office report, published in 2009, suggested that one-third of trusts in England did not have a robust strategy to review antimicrobial prescriptions automatically within a defined period. This CQUIN will ensure appropriate antimicrobial stewardship is in place in order to help reduce healthcare associated infections (HCAI) and contribute to slowing the development of antimicrobial resistance. This also links to Domain 5 from the Outcomes Framework: Treating and caring for people in a safe environment; and protecting them from avoidable harm.
Numerator	Number of antimicrobial prescriptions with a specified review or stop date.
Denominator	Number of antimicrobial prescriptions.
Baseline	Quarter 4 2014/15 audit results.
Target payment threshold	**Quarters 1** – Submission of quarterly audit report that outlines achievement levels above Quarter 4 2014/15 achieved or trajectory outcome, whichever is the highest. **Quarter 2** - Submission of quarterly audit report that outlines achievement levels above Quarter 4 2014/15 achieved or trajectory outcome, whichever is the highest. **Quarter 3** - Submission of quarterly audit report that outlines achievement levels above Quarter 4 2014/15 achieved or trajectory outcome, whichever is the highest. **Quarter 4** - Submission of quarterly audit report that outlines achievement levels above Quarter 4 2014/15 achieved or trajectory outcome, whichever is the highest.
Additional Payment Based Reports	Not Applicable

Indicator	1C
Name/Description of Indicator	Proportion of antimicrobial prescriptions with a specified indication
Indicator Weighting	10%
Rationale for inclusion	Criterion 9 of The Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance outlines the guidance for compliance for registered organisations to provide evidence of prudent prescribing and antimicrobial stewardship. It states: "Procedures should be in place to ensure prudent prescribing and antimicrobial stewardship. There should be an ongoing programme of audit, revision and update. In healthcare this is usually monitored by the antimicrobial management team or local prescribing advisors". Current evidence clearly demonstrates that the inappropriate use of broad-spectrum antibiotics is associated with the selection of antibiotic-resistant bacteria such as Extended-Spectrum Beta-Lactamase (ESBL)-producing Gram-negative bacteria as well as the specific acquisition of MRSA, the induction of Clostridium difficile infection (CDI) and can cause long-lasting harmful changes to the body's protective microbial flora. Broad-spectrum antibiotics (including cephalosporins, quinolones and clindamycin) have been most associated with CDI, but all antibiotics should be avoided unless there are clear clinical indications for their use. Antibiotics should be used for the shortest duration possible that gives an appropriate clinical outcome and be managed within a multifactorial programme (including hand hygiene and infection prevention and control precautions) aimed at reducing HCAI and improving antimicrobial use. An Antimicrobial Stewardship programme is seen as a key component in the reduction of HCAI infections in a healthcare setting. However, a National Audit Office report, published in 2009, suggested that one-third of trusts in England did not have a robust strategy to review antimicrobial prescriptions automatically within a defined period. This CQUIN will ensure appropriate antimicrobial stewardship is in place in order to help reduce healthcare associated infections (HCAI) and contribute to slowing the development of antimicrobial resistance. This also links to Domain 5 from the Outcomes Framework: Treating and caring for people in a safe environment; and protecting them from avoidable harm.
Numerator	Number of antimicrobial prescriptions with a specified indication.
Denominator	Number of antimicrobial prescriptions.
Baseline	Quarter 4 2014/15 audit results.
Target payment threshold	**Quarters 1** – Submission of quarterly audit report that outlines achievement levels above Quarter 4 2014/15 achieved or trajectory outcome, whichever is the highest. **Quarter 2** - Submission of quarterly audit report that outlines achievement levels above Quarter 4 2014/15 achieved or trajectory outcome, whichever is the highest. **Quarter 3** - Submission of quarterly audit report that outlines achievement levels above Quarter 4 2014/15 achieved or trajectory outcome, whichever is the highest. **Quarter 4** - Submission of quarterly audit report that outlines achievement levels above Quarter 4 2014/15 achieved or trajectory outcome, whichever is the highest.
Additional Payment Based Reports	Not Applicable.

Indicator	1D
Name/Description of Indicator	Antimicrobials used for an appropriate duration
Indicator Weighting	10%
Rationale for inclusion	Criterion 9 of The Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance outlines the guidance for compliance for registered organisations to provide evidence of prudent prescribing and antimicrobial stewardship. It states: "Procedures should be in place to ensure prudent prescribing and antimicrobial stewardship. There should be an ongoing programme of audit, revision and update. In healthcare this is usually monitored by the antimicrobial management team or local prescribing advisors". Current evidence clearly demonstrates that the inappropriate use of broad-spectrum antibiotics is associated with the selection of antibiotic-resistant bacteria such as Extended-Spectrum Beta-Lactamase (ESBL)-producing Gram-negative bacteria as well as the specific acquisition of MRSA, the induction of Clostridium difficile infection (CDI) and can cause long-lasting harmful changes to the body's protective microbial flora. Broad-spectrum antibiotics (including cephalosporins, quinolones and clindamycin) have been most associated with CDI, but all antibiotics should be avoided unless there are clear clinical indications for their use. Antibiotics should be used for the shortest duration possible that gives an appropriate clinical outcome and be managed within a multifactorial programme (including hand hygiene and infection prevention and control precautions) aimed at reducing HCAI and improving antimicrobial use. An Antimicrobial Stewardship programme is seen as a key component in the reduction of HCAI infections in a healthcare setting. However, a National Audit Office report, published in 2009, suggested that one-third of trusts in England did not have a robust strategy to review antimicrobial prescriptions automatically within a defined period. This CQUIN will ensure appropriate antimicrobial stewardship is in place in order to help reduce healthcare associated infections (HCAI) and contribute to slowing the development of antimicrobial resistance. This also links to Domain 5 from the Outcomes Framework: Treating and caring for people in a safe environment; and protecting them from avoidable harm.
Numerator	Number of antimicrobial prescriptions used for an appropriate duration. (All antibiotics that are clearly not required should be stopped.)
Denominator	Number of antimicrobial prescriptions.
Baseline	Quarter 4 2014/15 audit results.
Target payment threshold	**Quarters 1** – Submission of quarterly audit report that outlines achievement levels above Quarter 4 2014/15 achieved or trajectory outcome, whichever is the highest. **Quarter 2** - Submission of quarterly audit report that outlines achievement levels above Quarter 4 2014/15 achieved or trajectory outcome, whichever is the highest. **Quarter 3** - Submission of quarterly audit report that outlines achievement levels above Quarter 4 2014/15 achieved or trajectory outcome, whichever is the highest. **Quarter 4** - Submission of quarterly audit report that outlines achievement levels above Quarter 4 2014/15 achieved or trajectory outcome, whichever is the highest.
Additional Payment Based Reports	Not Applicable.

Indicator	1E
Name/Description of Indicator	Proportion of antimicrobial prescriptions issued in accordance with prescribing guidelines or provided with a documented reason for use.
Indicator Weighting	35%
Rationale for inclusion	Criterion 9 of The Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance outlines the guidance for compliance for registered organisations to provide evidence of prudent prescribing and antimicrobial stewardship. It states: "Procedures should be in place to ensure prudent prescribing and antimicrobial stewardship. There should be an ongoing programme of audit, revision and update. In healthcare this is usually monitored by the antimicrobial management team or local prescribing advisors". Current evidence clearly demonstrates that the inappropriate use of broad-spectrum antibiotics is associated with the selection of antibiotic-resistant bacteria such as Extended-Spectrum Beta-Lactamase (ESBL)-producing Gram-negative bacteria as well as the specific acquisition of MRSA, the induction of Clostridium difficile infection (CDI) and can cause long-lasting harmful changes to the body's protective microbial flora. Broad-spectrum antibiotics (including cephalosporins, quinolones and clindamycin) have been most associated with CDI, but all antibiotics should be avoided unless there are clear clinical indications for their use. Antibiotics should be used for the shortest duration possible that gives an appropriate clinical outcome and be managed within a multifactorial programme (including hand hygiene and infection prevention and control precautions) aimed at reducing HCAI and improving antimicrobial use. An Antimicrobial Stewardship programme is seen as a key component in the reduction of HCAI infections in a healthcare setting. However, a National Audit Office report, published in 2009, suggested that one-third of trusts in England did not have a robust strategy to review antimicrobial prescriptions automatically within a defined period. This CQUIN will ensure appropriate antimicrobial stewardship is in place in order to help reduce healthcare associated infections (HCAI) and contribute to slowing the development of antimicrobial resistance. This also links to Domain 5 from the Outcomes Framework: Treating and caring for people in a safe environment; and protecting them from avoidable harm.
Numerator	Number of antimicrobial prescriptions issued in accordance with prescribing guidelines or provided with a documented reason for use.
Denominator	Number of antimicrobial prescriptions.
Baseline	Quarter 4 2014/15 point prevalence survey.
Target payment threshold	**Quarter 1** – Submission of point prevalence survey results from which an improvement trajectory may be agreed. **Quarter 2** – Submission of point prevalence survey results which demonstrate improvement in line or above agreed trajectory. **Quarter 3** – Submission of point prevalence survey results which demonstrate improvement in line or above agreed trajectory. **Quarter 4** - Submission of point prevalence survey results which demonstrate improvement in line or above agreed trajectory.
Additional Payment Based Reports	Not Applicable.

Goal	2
Name of Goal	Pressure Ulcers
Number of Indicators	3
% weighting of applicable CQUIN funding	25%
Data Source	BHNFT internal systems
Additional Data Source	Not Applicable
Reports due	Quarterly 15 working days following period being reported
Report due (exceptions)	Not Applicable

Indicator	2A
Name/Description of Indicator	Educational plan for front line staff
Indicator Weighting	40%
Rationale for inclusion	The CQUIN for 2014/15 was designed to establish systems for data collection, set improvement trajectories and achieve targets from baseline. As a result of this work, tissue viability link nurses are now in place on all ward areas, feedback systems are in place to enable front line staff to be made aware of lessons learned and develop reflective learning. Pressure ulcer guidelines have been developed depicting which equipment should be utilised for at risk patients. All patients with Grade 3 and 4 pressure ulcers are reported via Datix (Hospital acquired Grade 3 and Grade 4 have a root cause analysis and are reported as serious incidents to the CCG). To further develop this work the Trust will introduce an education plan for 15/16 to ensure that front line nursing staff are compliant with the current requirements for the prevention of pressure ulcers, with particular focus on the high risk areas. The Trust will begin to monitor the numbers of grade 2 pressure ulcers and will undertake a Root Cause Analysis on all hospital acquired Grade 2 and 3 Pressure Ulcers that are hospital acquired. Key themes from all RCAs will be identified and an action plan to address the issues raised will be produced and implemented.
Numerator	Not Applicable.
Denominator	Not Applicable.
Baseline	Not Applicable.
Target payment threshold	**Quarter 1** – Submission of an educational plan to deliver sessions to front line nursing staff in in-patient areas and ED. The sessions will cover new developments in pressure area care and lessons learned from Root Cause Analysis. The sessions will be part of essential training for nursing and support staff from Quarter 2 onwards. **Quarter 2** – Number and percentage of staff who have attended training. **Quarter 3** – Number and percentage of staff who have attended training. **Quarter 4** – Number and percentage of staff who have attended training.
Additional Payment Based Reports	Not Applicable

Indicator	2B
Name of Indicator	Hospital Acquired Pressure Ulcer monitoring
Indicator Weighting	40%
Description of indicator	i) Recording of hospital acquired Grade 2 pressure ulcers ii) RCA of all hospital acquired Grade 2 and 3 ulcers iii) Identification of key themes and actions taken for hospital acquired Grades 2-4 pressure ulcers.
Rationale for inclusion	The CQUIN for 2014/15 was designed to establish systems for data collection, set improvement trajectories and achieve targets from baseline. As a result of this work, tissue viability link nurses are now in place on all ward areas, feedback systems are in place to enable front line staff to be made aware of lessons learned and develop reflective learning. Pressure ulcer guidelines have been developed depicting which equipment should be utilised for at risk patients. All patients with hospital acquired Grade 3 and 4 pressure ulcers are reported via Datix (hospital acquired Grade 3 and 4 have a root cause analysis and are reported as serious incidents to the CCG). To further develop this work the Trust will introduce an education plan for 15/16 to ensure that staff are compliant with the current requirements for the prevention of pressure ulcers, with particular focus on the high risk areas. The Trust will begin to monitor the numbers of grade 2 pressure ulcers and will undertake a Root Cause Analysis on all Grade 3 and 2 Pressure Ulcers that are hospital acquired. Key themes from all RCAs will be identified and an action plan to address the issues raised will be produced and implemented.
Numerator	Not Applicable.
Denominator	Not Applicable.
Baseline	Not Applicable.
Target payment threshold	**Part i)** – Quarterly report of the number of patients admitted for more than 72 hours acquiring a Grade 2 pressure ulcer.. (40% weighting) **Part ii)** – Quarterly report of all Root Cause Analyses undertaken by the Trust for hospital acquired Grade 2 and 3 pressure ulcers attributable to the Trust split by clinical area. (40% weighting). **Part iii)** – Quarter 3 submission of a report showing the key themes from Root Cause Analyses (Grades 2-4), undertaken 1 April 2015 to 30 Sept 2015, that also identifies the actions taken/systems implemented to prevent future pressure ulcers. (20% weighting) including whether appropriate equipment (in compliance with the Trust policy) is in place to prevent pressure ulcers, and whether there was any delay in providing the equipment.
Additional Payment Based Reports	Not Applicable

Goal	3
Name of Goal	Do Not Attempt Cardiopulmonary Resuscitation (DNA CPR)
Number of Indicators	3
% weighting of applicable CQUIN funding	25%
Data Source	BHNFT Internal Systems
Additional Data Source	Not Applicable
Reports due	Quarterly 15 working days following period being reported
Report due (exceptions)	Not Applicable.

Indicator	3A
Name/Description of Indicator	Compliance with current DNA CPR policy
Indicator Weighting	50%
Rationale for inclusion	The importance of making the right decisions about CPR as an integral part of good clinical practice. Every anticipatory decision about CPR must be based on assessment of the person's individual circumstances at that time. Patients (or their representatives if they are unable to make decisions for themselves) should be involved in the decision-making process. This will often involve a person making a shared decision with their healthcare professionals, but where CPR has no realistic chance of success it may involve informing people of the decision and explaining the basis for it. When CPR has no realistic chance of success it is important to make decisions when they are needed, and not to delay a decision because a person is not well enough to have it explained to them or because their family or other representatives are not available. A clear plan should be made to explain and discuss the decision with the person and/or their representatives at the earliest practicable opportunity. Whenever possible, anticipatory decisions about CPR are best made well in advance, when people are well enough and have enough time to consider them carefully and discuss them fully with anyone that they wish to, including their family and members of their healthcare team. There should be an emphasis on the importance of careful documentation and effective discussion and communication of anticipatory decisions about CPR.
Numerator	Not Applicable
Denominator	Not Applicable
Baseline	Not Applicable
Target payment threshold	**Quarter 1** – BHNFT to develop an audit tool to assess the compliance with the DNA CPR policy. **Quarter 2** – Submission of an audit report to identify non-compliance with DNA CPR policy. **Quarter 2** – Plans to be produced to identify specific actions that will be undertake to prevent future non-compliance. **Quarter 3** – Updated action plans to be submitted. **Quarter 4** – Repeat of Quarter 2 audit to identify non-compliance with DNA CPR policy.
Additional Payment Based Reports	Not Applicable

Indicator	3B
Name/Description of Indicator	Staff Training Needs Analysis
Indicator Weighting	30%
Rationale for inclusion	The importance of making the right decisions about CPR as an integral part of good clinical practice. Every anticipatory decision about CPR must be based on assessment of the person's individual circumstances at that time. Patients (or their representatives if they are unable to make decisions for themselves) should be involved in the decision-making process. This will often involve a person making a shared decision with their healthcare professionals, but where CPR has no realistic chance of success it may involve informing people of the decision and explaining the basis for it. When CPR has no realistic chance of success, it is important to make decisions when they are needed and not to delay a decision because a person is not well enough to have it explained to them or because their family or other representatives are not available. A clear plan should be made to explain and discuss the decision with the person and/or their representatives at the earliest practicable opportunity. Whenever possible, anticipatory decisions about CPR are best made well in advance, when people are well enough and have enough time to consider them carefully and discuss them fully with anyone that they wish to, including their family and members of their healthcare team. There should be an emphasis on the importance of careful documentation and effective discussion and communication of anticipatory decisions about CPR.
Numerator	Not Applicable
Denominator	Not Applicable
Baseline	Not Applicable
Target payment threshold	**Quarter 1** – Submission of a comprehensive training needs analysis which identifies front line clinicians' development needs in respect of implementing DNA CPR. **Quarter 2** – Roll out of appropriate training and development to deliver identified needs of front line clinicians. BHNFT to report the number of sessions and number of staff trained during the quarter. **Quarter 3** – Roll out of appropriate training and development to deliver identified needs of front line clinicians. BHNFT to report the number of sessions and number of staff trained during the quarter. **Quarter 4** – Results from a qualitative survey should be submitted that shows the level of clinician satisfaction with training and development and their ongoing needs in respect of DNAR CPR.
Additional Payment Based Reports	Not Applicable

Goal	4
Name of Goal	Reduction in Health Inequalities for LD patients
Number of Indicators	4
% weighting of applicable CQUIN funding	25%
Data Source	BHNFT Internal Systems
Additional Data Source	Not Applicable
Reports due	Quarterly 15 working days following period being reported
Report due (exceptions)	Not Applicable.

Indicator	4A
Name of Indicator	LD Champions
Indicator Weighting	10%
Description of indicator	A minimum of one LD Champion will be identified in every clinical area
Rationale for inclusion	The Confidential Enquiry into Premature Deaths of People with Learning Disability (2013) demonstrates that men with LD die on average 13 years earlier and women with LD on average 20 years earlier. The most common underlying causes of death were cardio vascular disorders and cancer. 42% of the deaths investigated by the confidential enquiry were premature with the most common reasons being delay in diagnosis and treatment, problems identifying needs and providing care in response to changing needs The Department of Health estimates that 2.5% of the population have a learning disability. BHNFT would therefore expect to see 1,524 in patients, 6,700 out patients and 1,950 A/E attendees with LD per year. However the Learning Disability Health Self-assessment Framework for 2013/14 (NHS Barnsley CCG and Barnsley MBC) suggests the number of patients registered with a GP who have a learning disability is 1,389. It is acknowledged that many individuals who have a mild learning disability, do not consider themselves to have a disability. CQUIN for 2014/15 has resulted in improvements, but in order to further reduce health inequalities in this group, the numbers of LD clients for whom reasonable adjustments are made needs to increase. Examples of reasonable adjustments would include: • Larger print • Easier to understand words, pictures and symbols • Clear and easy to understand information and signs • More time to listen and explain • First or last appointment Some of these measures would benefit those patients who have a LD but who do not consider themselves to have a disability.
Numerator	Not Applicable
Denominator	Not Applicable
Baseline	Not Applicable
Target payment threshold	**Quarter 1** – The training and competency plan for the LD Champion will be defined together with a clear defined documented description of the role. S **Quarter 2** – Submit a list of LD Champions (all clinical areas will have access to a LD Champion.). **Quarter 3** – Updated list of LD Champions and confirmation of training. **Quarter 4** – Updated list of LD Champions and confirmation of training.
Additional Payment Based Reports	Not Applicable

Indicator	4B
Name of Indicator	LD Liaison Nurse
Indicator Weighting	30%
Description of indicator	Recording of LD patients accessing acute services (inpatients, outpatients and Emergency Care)
Rationale for inclusion	The Confidential Enquiry into Premature Deaths of People with Learning Disability (2013) demonstrates that men with LD die on average 13 years earlier and women with LD on average 20 years earlier. The most common underlying causes of death were cardio vascular disorders and cancer. 42% of the deaths investigated by the confidential enquiry were premature with the most common reasons being delay in diagnosis and treatment, problems identifying needs and providing care in response to changing needs The Department of Health estimates that 2.5% of the population have a learning disability. BHFT would therefore expect to see 1,524 in patients, 6,700 out patients and 1,950 A/E attendees with LD per year. However the Learning Disability Health Self-assessment Framework for 2013/14 (NHS Barnsley CCG and Barnsley MBC) suggests the number of patients registered with a GP who have a learning disability is 1,389. It is acknowledged that many individuals who have a mild learning disability, do not consider themselves to have a disability. CQUIN for 2014/15 has resulted in improvements, but in order to further reduce health inequalities in this group, the numbers of LD clients for whom reasonable adjustments are made needs to increase. Examples of reasonable adjustments would include: • Larger print • Easier to understand words, pictures and symbols • Clear and easy to understand information and signs • More time to listen and explain • First or last appointment Some of these measures would benefit those patients who have a LD but who do not consider themselves to have a disability.
Numerator	Not Applicable
Denominator	Not Applicable
Baseline	Quarter 3 submission 2014/15
Target payment threshold	**Quarter 1** - Number of LD patients reported to LD Liaison Nurse during the quarter, split between Inpatients, Outpatients and Emergency Care. **Quarter 2** - Number of LD patients reported to LD Liaison Nurse during the quarter, split between Inpatients, Outpatients and Emergency Care. **Quarter 3** - Number of LD patients reported to LD Liaison Nurse during the quarter, split between Inpatients, Outpatients and Emergency Care. **Quarter 4** - Number of LD patients reported to LD Liaison Nurse during the quarter, split between Inpatients, Outpatients and Emergency Care.
Additional Payment Based Reports	Not Applicable

Indicator	4C
Name of Indicator	Record of assessment and reasonable adjustments
Indicator Weighting	30%
Description of indicator	The LD Champion will keep records of the assessment and any reasonable adjustments made.
Rationale for inclusion	The Confidential Enquiry into Premature Deaths of People with Learning Disability (2013) demonstrates that men with LD die on average 13 years earlier and women with LD on average 20 years earlier. The most common underlying causes of death were cardio vascular disorders and cancer. 42% of the deaths investigated by the confidential enquiry were premature with the most common reasons being delay in diagnosis and treatment, problems identifying needs and providing care in response to changing needs The Department of Health estimates that 2.5% of the population have a learning disability. BHFT would therefore expect to see 1,524 in patients, 6,700 out patients and 1,950 A/E attendees with LD per year. However the Learning Disability Health Self-assessment Framework for 2013/14 (NHS Barnsley CCG and Barnsley MBC) suggests the number of patients registered with a GP who have a learning disability is 1,389. It is acknowledged that many individuals who have a mild learning disability, do not consider themselves to have a disability. CQUIN for 2014/15 has resulted in improvements, but in order to further reduce health inequalities in this group, the numbers of LD clients for whom reasonable adjustments are made needs to increase. Examples of reasonable adjustments would include: • Larger print • Easier to understand words, pictures and symbols • Clear and easy to understand information and signs • More time to listen and explain • First or last appointment Some of these measures would benefit those patients who have a LD but who do not consider themselves to have a disability.
Numerator	The number of identified LD patients who have accessed planned care and have had an assessment of their need for adjustments made
Denominator	The number of identified LD patients accessing acute services
Baseline	Not Applicable
Target payment threshold	**Quarter 1** – 100% of all identified LD patients to have an assessment of their need for adjustments **Quarter 2** – 100% of all identified LD patients to have an assessment of their need for adjustments **Quarter 3** – 100% of all identified LD patients to have an assessment of their need for adjustments **Quarter 4** – 100% of all identified LD patients to have an assessment of their need for adjustments
Additional Payment Based Reports	Not Applicable

Indicator	4D
Name of Indicator	Patient satisfaction survey
Indicator Weighting	30%
Description of indicator	Survey of LD patients/carers to establish satisfaction levels with the assessment and any adjustments made
Rationale for inclusion	The Confidential Enquiry into Premature Deaths of People with Learning Disability (2013) demonstrates that men with LD die on average 13 years earlier and women with LD on average 20 years earlier. The most common underlying causes of death were cardio vascular disorders and cancer. 42% of the deaths investigated by the confidential enquiry were premature with the most common reasons being delay in diagnosis and treatment, problems identifying needs and providing care in response to changing needs The Department of Health estimates that 2.5% of the population have a learning disability. BHFT would therefore expect to see 1,524 in patients, 6,700 out patients and 1,950 A/E attendees with LD per year. However the Learning Disability Health Self-assessment Framework for 2013/14 (NHS Barnsley CCG and Barnsley MBC) suggests the number of patients registered with a GP who have a learning disability is 1,389. It is acknowledged that many individuals who have a mild learning disability, do not consider themselves to have a disability. CQUIN for 2014/15 has resulted in improvements, but in order to further reduce health inequalities in this group, the numbers of LD clients for whom reasonable adjustments are made needs to increase. Examples of reasonable adjustments would include: • Larger print • Easier to understand words, pictures and symbols • Clear and easy to understand information and signs • More time to listen and explain • First or last appointment Some of these measures would benefit those patients who have a LD but who do not consider themselves to have a disability.
Numerator	Not Applicable
Denominator	Not Applicable
Baseline	Not Applicable
Target payment threshold	**Quarter1** – Development of a patient satisfaction survey for LD patients/carers to establish levels of satisfaction with the assessment and any adjustments made. **Quarter 2** – Submission of patient satisfaction survey results. **Quarter 3** – Submission of patient satisfaction survey results. **Quarter 4** – Submission of patient satisfaction survey results.
Additional Payment Based Reports	Not Applicable

APPENDIX 2 – SWYPFT Local CQUIN Schemes 2015/16

Financial Breakdown

Goal	Goal Weighting (%)	Indicators	Indicator Weighting (%)
1	20%	A B C D	25% 25% 25% 25%
2	30%	A	Quarter 1= 35% Quarter 2 = 21.67% Quarter 2 = 21.67% Quarter 4 = 21.66%
3	30%	A	Quarter 1 report = 10%, Quarter 2, Quarter 3 & Quarter 4 = Achievement of trajectory = up to 30% per quarter (10%/Quarter achieved)
4	20%	A	25%/completed quarterly requirement

The Schemes

Goal	1
Name of Goal	Mental Health Clustering
Number of Indicators	4
% weighting of applicable CQUIN funding	20%
Data Source	SWYPFT - PbR DQ Dashboard
Additional Data Source	Indicator D Part 2 - Clinical Audit
Reports due	Quarterly 15 working days following period being reported
Report due (exceptions)	Indicator D Part 2 – Quarter 2 & Quarter 4 Only

Indicator	1A
Name of Indicator	Mental Health Currency – Clustering of initial referral assessments
Indicator Weighting	25%
Description of indicator	A cluster is completed within 2 months for 98% of 'eligible' initial referral assessments
Rationale for inclusion	To provide accurate information related to: • Service user numbers and flows within services • Service User needs (cluster profiles) • Service User outcomes This element of the CQUIN will build on the existing measure of cluster assignment and will ensure timeliness of cluster allocation following initial referral therefore improving reliability, validity and quality of the data.
Numerator	Number of eligible clients whose initial cluster date is within 8 weeks of the date of eligibility
Denominator	All eligible clients initially clustered in the reporting period.
Baseline	Proportion of in scope patients assigned to a cluster as at December 2014 = 93.97%
Target payment threshold	Proportion of in scope patients assigned to a cluster as at December 2014 = 98% within 8 weeks for eligible service users.
Additional Payment Based Reports	Exception reporting can allow the provider to reach 98% or above. I.e. external factors such as awaiting diagnostic tests causing a delay in the clustering process. In such cases a full exception report for each client this affects will be required for commissioner to consider.

Indicator	1B
Name of Indicator	Mental Health Currency – Review of service users and clusters
Indicator Weighting	25%
Description of indicator	Increasing the % of service users reviewed within frequency: 1. % of service users are reviewed within frequency (Quarter 1 = 77%, Quarter 2 = 78%, Quarter 3 = 80%, Quarter 4 = 80%) 2. 98% of service users have had the cluster reviewed within 18 months.
Rationale for inclusion	To provide accurate information related to: • Reassessment of service user need • Service user numbers and flows within services • Service User outcomes • Costing framework
Numerator	1. Count of all clients whose review is due within the reporting period who are clustered within the cluster frequency (to include reviews that occur within the month of due review) 2. Count of all clients, whose review is within the reporting period, occurs within 18 months of their preceding MHCT assessment
Denominator	All clients reviewed within the reporting period.
Baseline	Proportion of patients within Cluster Review Periods = 75.61%
Target payment threshold	Quarter 1 = 77% Quarter 2 = 78%, Quarter 3 = 80%, Quarter 4 = 80%
Additional Payment Based Reports	Not Applicable

Indicator	1C
Name of Indicator	MH Clustering - Adherence to Red Rules
Indicator Weighting	25%
Description of indicator	Improvement in adherence to the red rules
Rationale for inclusion	• The Clinician Rated Outcome Measure (CROM) based on MHCT/HoNOS is now recommended for use. Providers and commissioners need to assure themselves that MHCT data submitted for each cluster is accurate, complete and of high quality. • To incentivise data quality improvements related to clustering and outcomes measurement
Numerator	Count of clients, where their initial cluster adhere to the Red Rules
Denominator	All clients initially clustered within the reporting period.
Baseline	Proportion of initial cluster allocations adhering to red rules = 68.42% (Average of 72.68% for the period April – December 2014)
Target payment threshold	Quarter 1 = 75% Quarter 2 = 77% Quarter 3 = 78% Quarter 4 = 80%
Additional Payment Based Reports	Not Applicable

Indicator	1D
Name of Indicator	MH Clustering – Crisis Plan
Indicator Weighting	Part 1 = 12.5%, Part 2 = Quarter 2 = 6.25%, Quarter 4 = 6.25%
Description of indicator	The proportion of service users on (CPA) Care Plan Approach with a crisis plan in place and the quality of the crisis plan.
Rationale for inclusion	It is good practice to ensure there is a crisis plan in place for all patients in the event of a deterioration or breakdown of carer arrangements. A proactive crisis plan is an indicator of good practice. Understanding this by cluster allows organisations to consider targeted initiatives.
Numerator	1. The number of users recorded as on CPA at the end of the reporting period and who have been under the care of SWYPFT for at least 100 days who have a crisis plan. 2. The number of service users in the audit sample for whom a care plan exists meeting the required standards. (Audit at Quarter 2, Quarter 4)
Denominator	The number of users who are recorded as subject to the Care Programme Approach and who have been under the care of SWYPFT for at least 100 days.
Baseline	Part 1 - December 2014 = 74%
Target payment threshold	Part 1 = Quarter 1 = 80% Quarter 2 = 85% Quarter 3 = 90% Quarter 4 = 95% Part 2 = Quarter 2 = 70% Quarter 4 = 80%
Additional Payment Based Reports	**Part 2:** **Quarter 2** - Random audit of 30 clinical records. Provider to achieve 70% service users with a crisis plan meeting required standards. **Quarter 4** - Random audit of 30 clinical records. Provider to achieve 80% service users with a crisis plan meeting required standards. Required standards for Crisis Plan identified as: • early warning and relapse indicators • the person to whom the service user is most responsive • how to contact that person • the actions the service user themselves can take • previous strategies which have been successful in engaging the service user • a 24-hour Trust or local services contact number for the service user • action to be taken if the service user is non-compliant with the package of care • action to be taken by the GP in a crisis • Communication with relatives, etc. • any other information which may be helpful in the management of crisis

Goal	2
Name of Goal	Care Navigation/Telehealth
Number of Indicators	1
% weighting of applicable CQUIN funding	30%
Data Source	SWYPFT internal system
Additional Data Source	Not Applicable
Reports due	Quarterly 15 working days following period being reported
Report due (exceptions)	Not Applicable

Indicator	2A
Name of Indicator	Care Navigation/Telehealth
Indicator Weighting	Quarter 1 Report = 35% following CCG satisfaction against described criteria Quarter 2, Quarter 3 & Quarter 4 = 10%/Quarter Quarter 2, Quarter 3 & Quarter 4 Report = 11.67%/Quarter following CCG satisfaction against described criteria
Description of indicator	The CQUIN proposes enhancing community approaches to self managed and self directed care in the fields of COPD, Heart failure, Community Matrons and Care Navigation. As part of the single assessment process, all new patients will be assigned a self resilience score and aligned to an appropriate level of the Community Nursing Operating Framework (approximately 2,300 patients). This will lead to an increase in patients referred to the Barnsley Care Navigation/ Telehealth Service. Patients will receive appropriate information, advice, and support to facilitate a positive behaviour change that will impact on their overall health and well being.
Rationale for inclusion	The NHS Outcomes Framework identifies that to maintain high quality services in times of austerity providers need to change the focus on how care is delivered. Domain 2 enhancing the quality of life for people with long term conditions, suggests testing out new ways of working. The Health foundations work on patient centred care into practice, highlights outcomes that can be attributed to self managed care, these are: • Self efficacy- motivation and confidence in own ability • Patient engagement in healthy behaviours • Clinical and Quality of Care outcomes • Cost and resource benefits SWYPT provides a telephonic care navigation/ telehealth service, which provides patients with the means to access services they require to manage their health and well being. The service further supports patients to make positive health impacting behaviour changes by deploying motivational interviewing and behaviour change techniques. NHS England state that over a quarter of the population have a long term condition and advise that those with a LTC should be better equipped to manage their own health as this has been demonstrated to prevent deterioration and complications, including admissions to hospital and makes people feel in control of their own lives
Numerator	The total number of new referrals to the COPD, Heart Failure and Community Matrons.
Denominator	The number of patients assigned a self resilience score and referred to the appropriate service for patients with long term conditions i.e. Care Navigation Service or suitable equivalent.
Baseline	Established as part of Quarter 1 report
Target payment threshold	Quarter 2, Quarter 3 & Quarter 4 = 100% of new referrals into the service areas (COPD service, Heart Failure Service, Community Matrons) will be allocated a resilience score
Additional Payment Based Reports	**Quarter 1 Requirement** - the identification of an appropriate resilience assessment tool Narrative Report including: - Identification of an appropriate evidence based resilience assessment tool to be used in practice. - provide training to the workforce within COPD, Heart Failure, Community Matrons and Care Navigation. - Build IT systems to support the tool for data capture and clinical recording. **Quarter 2, Quarter 3 & Quarter 4 Requirement** - All those assessed as appropriate (using the resilience tool) will be referred to Barnsley Care Navigation / Telehealth Service - The resilience score will identify a cohort of patients that will benefit from the input of the Care Navigation / Telehealth Service. Where identified these patients will be referred to the Care Navigation / Telehealth Service. - Feedback will be received from patients regarding the service received and the patient's opinion on their ability to self- manage. Narrative report (Incl. Figures above) to be submitted to the CCG

Goal	3
Name of Goal	Learning Disability Cancer Screening
Number of Indicators	1
% weighting of applicable CQUIN funding	30%
Data Source	GP/SWYPFT Systems
Additional Data Source	Not Applicable
Reports due	Quarterly 15 working days following period being reported
Report due (exceptions)	There will be some occasions where the achievement of the indicator is out of the providers control (e.g. If a GP has not undertaken a best interest assessment despite requests to do so). In this circumstance the provider will provide evidence of their attempts to resolve the issue, including escalation where appropriate. Providing evidence of reasonable efforts to attempt to resolve the issue are provided, this will be considered sufficient to achieve payment

Indicator	3A
Name of Indicator	Learning Disability Cancer Screening
Indicator Weighting	30% = Quarter 1 report = 10%, Quarter 2, Quarter 3 & Quarter 4 = Achievement of trajectory = up to 30% per quarter (10%/Quarter achieved)
Description of indicator	This is a continuation and stretch of the 2014/15 CQUIN. Specialist LD Nurses support clients with LD and primary care to improve access to cancer screening programmes. There is a lower % of clients with LD accessing screening for breast, cervical and bowel screening that the general population. The CQUIN for 14/15 ensured that the systems were put in place for LD nurses to access screening information and begin to facilitate clients to have screening where clinically indicated The provider must provide appropriate assistance and make reasonable adjustments for Service Users, carers and Legal Guardians who do not speak, read or write English or who have communication difficulties (including hearing, oral and learning impairments) Improvements have not been universal and this has not therefore resulted in absolute parity for clients with LD. The CQUIN for 2015/16 requires improvements to ensure that access to cancer screening for clients with LD is at or within 5% of the level of the population as a whole
Rationale for inclusion	The previous CQUIN has resulted in an overall improvement in access, whilst Quarter 3 data is not yet published, the LD Health Self-Assessment framework report for 2013/14 shows a significant improvement in access to bowel cancer screening (Nov 2014), the figures in parentheses are the whole population: • Breast Cancer Screening 54.7% *(64.2%), an improvement from 51% in the previous year • Cervical Cancer screening (recorded or not indicated**) 48.7% (63.7%), an improvement from 43.7% in the previous year • Bowel Cancer screening 38.1% (44.6%) a significant increase from 17.1% the previous year *The physical attributes of some women with LD make it impossible to undertake mammography even if best interest and reasonable adjustments are made. **Cervical cancer risk factors may be lower for some women with LD than the population as a whole (eg a woman with profound disability who has never been sexually active "It is recognised that an assessment of mental capacity is undertaken by the health professional responsible. If the person has capacity to make the decision and decided to refuse OR if the person lacks mental capacity to make the decision a best interest decision is recorded as appropriate"
Numerator	The number of eligible people registered as having a Learning Disability in Barnsley who have accessed (or who have been exempted through an appropriate recorded risk assessment and/ or best interest decision) • Breast Cancer Screening • Cervical Cancer Screening • Bowel Cancer Screening
Denominator	The number of eligible people who are not registered as having a Learning Disability in Barnsley who have accessed • Breast Cancer Screening • Cervical Cancer Screening • Bowel Cancer Screening
Baseline	Quarter 1- Establish baseline based on Quarter 4 (14/15 results) Baseline to include outstanding work (e.g. best interest decisions, capacity assessments and also include an action plan that will address differences in access (e.g. better access figures from some GP surgeries/ LD specialist nurses) and differences in access to bowel cancer screening compared to other cancers
Target payment threshold	The plan will achieve delivery of the target to ensure that clients with LD access cancer screening to the same extent as the general population. Breast Cancer = 60% Cervical Cancer = 63% (* For Cervical Cancer an appropriate recorded risk assessment must be undertaken before a client is deemed to be exempt from screening) Bowel Cancer = 41%
Additional Payment Based Reports	Not Applicable

Goal	4
Name of Goal	High Performing Teams
Number of Indicators	1
% weighting of applicable CQUIN funding	20%
Data Source	SWYPFT Qualitative & Quantitative assessment and analysis
Additional Data Source	Not Applicable
Reports due	Quarterly 15 working days following period being reported
Report due (exceptions)	Not Applicable

Indicator	4A
Name of Indicator	High Performing Teams
Indicator Weighting	25%/completed quarterly requirement
Description of indicator	To improve the inert working relationships between SWYPFT and primary care
Rationale for inclusion	This was a CQUIN for 14/15. A survey of GPs (results to be reported in Quarter 3) will be re-visited in March 2015 following team building OD work Key messages from the public, patients and carers (National Voices Narrative 2013) demonstrates a need for single point of contact, quick responsive services and professionals that talk to each other. This CQUIN reflects these requirements Clinical Human Factors are likely to be included in national CQUIN requirements in the future. They are said to add value to productivity, efficiency, effectiveness and quality. This CQUIN contains elements of Clinical Human Factors and can be further developed in future years as required Incident reports are a key way in which human factors can be identified and resolved. Addressing Human Factors is likely to result in improvements to patient care
Numerator	Not Applicable
Denominator	Not Applicable
Baseline	Not Applicable
Target payment threshold	Not Applicable

Additional Payment Based Reports

Aim	**Reports Required for Payment**			
	Quarter 1	**Quarter 2**	**Quarter 3**	**Quarter 4**
Evaluate the ten question survey and produce a robust action plan taking account the evaluation and previous patient engagement events	All HPT members for each practice will have completed the survey.	The Action plan will seek to resolve the key issues identified within the survey, demonstrating how patients will benefit as a result	Report actions complete and findings/benefits	Report actions complete and findings/benefits
Establish clear links with the LA 'Pioneer project and have in place reciprocal working arrangements at all levels from strategic planning to local delivery	A report on links forged at each level will be made	A report on new working arrangements as result of these improved links will be given	A report on improvements to communication and resultant patient benefits will be produced	
Carry out evaluation of progress of HPT group		Group members will be asked to evaluate their perception of improvements to communication as a result of HPT. This can be by focus group, telephone interview or questionnaire		

Use outcomes of Incident investigations, complaints and concerns from staff to consider underlying human factor elements such as: Situational awareness, decision making, communication, team working, leadership, managing stress, coping with fatigue	Reports of SI investigations (redacted) will be made available to HPT members where there is suggestion that Human Factor elements may have played a part. HPT members will discuss the intelligence from these reports, share the lessons learned and consider how issues might be addressed collaboratively Quarterly report on lessons shared from SI's that have a Human Factor element and how they are being addressed. The report will demonstrate how patients will benefit from the improvements	Reports of SI investigations (redacted) will be made available to HPT members where there is suggestion that Human Factor elements may have played a part. HPT members will discuss the intelligence from these reports, share the lessons learned and consider how issues might be addressed collaboratively Quarterly report on lessons shared from SI's that have a Human Factor element and how they are being addressed. The report will demonstrate how patients will benefit from the improvements	Reports of SI investigations (redacted) will be made available to HPT members where there is suggestion that Human Factor elements may have played a part. HPT members will discuss the intelligence from these reports, share the lessons learned and consider how issues might be addressed collaboratively Quarterly report on lessons shared from SI's that have a Human Factor element and how they are being addressed. The report will demonstrate how patients will benefit from the improvements	Reports of SI investigations (redacted) will be made available to HPT members where there is suggestion that Human Factor elements may have played a part. HPT members will discuss the intelligence from these reports, share the lessons learned and consider how issues might be addressed collaboratively Quarterly report on lessons shared from SI's that have a Human Factor element and how they are being addressed. The report will demonstrate how patients will benefit from the improvements
High Performing Team members to share and use this intelligence to inform work streams	HPT members will make recommendations for future work streams to address issues that cannot be resolved by members themselves Quarterly report on	HPT members will make recommendations for future work streams to address issues that cannot be resolved by members themselves Quarterly report on issues identified from	HPT members will make recommendations for future work streams to address issues that cannot be resolved by members themselves Quarterly report on issues identified from SI's that cannot be addressed by	HPT members will make recommendations for future work streams to address issues that cannot be resolved by members themselves Quarterly report on issues identified from SI's that cannot be addressed by

			issues identified from SI's that cannot be addressed by HPT members	SI's that cannot be addressed by HPT members	HPT members	HPT members	

NHS
Barnsley Clinical Commissioning Group
Putting Barnsley People First

GOVERNING BODY

12 March 2015

Child Sexual Exploitation

1.	**PURPOSE OF THE REPORT**
	This report is to update the Governing Body with regard to Child Sexual Exploitation (CSE) in Barnsley since the report presented in December 2014.
2.	**EXECUTIVE SUMMARY**
	As identified to the Governing Body at its September meeting Barnsley is sadly not exempt from CSE activity and so, in the light of the tragic impact of historic inadequate action identified in Rotherham by the Jay report August 2014, the Barnsley Safeguarding Children Board (BSCB) prioritised a briefing about such activity to its September Board. As a result of that briefing the Governing Body requested that they receive monthly update reports.
3.	**THE GOVERNING BODY IS ASKED TO:**
	Note the information provided in the report and its implications for the CCG as a partner agency of the Barnsley Safeguarding Children Board.

Agenda time allocation for report: 10 minutes

Report of: Brigid Reid

Designation: Chief Nurse

Report Prepared by: Brigid Reid

Designation: Chief Nurse

1.	**SUPPORTING INFORMATION**	
1.1	**Links to Assurance Framework**	
	The report is relevant to risk 5.1 as this relates to the Safeguarding of vulnerable young people and children.	
1.2	**Links to Objectives**	
	To have the highest quality of governance and processes to support its business	√
	To commission high quality health care that meets the needs of individuals and groups	√
	Wherever it makes safe clinical sense to bring care closer to home	
	To support a safe and sustainable local hospital, supporting them to transform the way they provide services so that they are as efficient and effective as possible for the people of Barnsley	
	To develop services through real partnerships with mutual accountability and strong governance that improve health and health care and effectively use the Barnsley £.	√
1.3	**Governance Arrangements Checklist**	
	Financial Implications	Not relevant
	Contracting Implications	Not relevant
	Quality	Yes
	Consultation / Engagement	Yes
	Equality and Diversity	Yes
	Information Governance	Not relevant
	Environmental Sustainability	Not relevant
	Human Resources	Not relevant

2.	**INTRODUCTION**
	Following the publication of the independent enquiry into Child Sexual Exploitation (CSE) in Rotherham (Jay 2014) there has been concern across agencies in Barnsley that we may have a similar situation in the borough. There has been a further CSE report published in October 2014 "Real Voices, Child Sexual Exploitation in Greater Manchester" an independent report by Ann Coffey MP. This report focuses on the abuse that occurred in Rochdale and focuses on what young people have to say about what is happening to them. Barnsley Safeguarding Children Board (BSCB) received an update on the local arrangements for addressing CSE at the meeting held on 23 January 2015. This was reported to the Governing Body in February and as indicated then this month the updated CSE action plan is attached for the Governing Body's information.
3.	**DISCUSSION**
	Subsequent to the update shared with the Governing Body in February following a 2 week consultation the CSE & missing Panel user group the BSCB CSE action plan has been updated and is attached as Appendix A. At the March BSCB consideration of a 'true for us' review in relation to both the Casey report (shared with Governing Body members after the February meeting) and the recently published Serious Case Review into CSE in Oxfordshire will be requested. Whilst the latter (relating to the experiences of 6 victims over the period 2005-11) found no evidence of wilful professional neglect or misconduct by organisations, it commented that at times a worrying lack of curiosity and follow through, and that much work should have been considerably different and better. Of note to us is the reports view that 'There is little evidence that the local understanding of child sexual exploitation (CSE), or how to tackle it once identified, was significantly different from many parts of the country' . In addition to the local work through the BSCB, shadowing of practitioners working in geographical areas of vulnerability and intelligence identified 'hot spots' is being pursued. Governing Body members will also be aware of the Government's proposal for new criminal sanctions for those who fail to protect children from sexual exploitation announced on 3rd March. The government will consult on extending the new criminal offence of 'wilful neglect' of patients to children's social care, education and elected members. The plans include mechanisms to ensure local areas have long term practical plans - to uncover child sexual exploitation (CSE) and bring more offenders to justice - and are held to account for the effective delivery of these plans. There will also be a new national whistleblowing helpline for public sector workers to report bad practice and a new joint official health,

	police and education inspections plus a new Child Sexual Abuse Taskforce of professional troubleshooting experts in social work, law enforcement and health to support local areas at every level. In these plans the Government has indicated that child sexual abuse will now be prioritised as a national threat, like serious and organised crime which means police forces now have a duty to collaborate with each other across force boundaries to safeguard children including more efficient sharing of resources, intelligence and best practice, supported by specialist regional CSE police coordinators. Alongside these plans the Government has announced that an additional £7 million this year and in 2015 to 2016 will be given to organisations which support the victims of sexual abuse. The Department of Health has also published new guidance on the role of school nursing services in preventing CSE and the Department for Education will announce a new £3.8 million allocation from its Innovation Program. Sheffield and South Yorkshire councils have been allocated £1.2 million to develop a sub-regional delivery model for young people experiencing or at risk of child sexual exploitation. This will include recruitment, development and support of specialist foster carers to provide safe placements for young people across South Yorkshire. Clearly these national steps both support and challenge our local work to ensure that all that should be undertaken, from prevention to prosecution of CSE activity and inclusive of victim support, does happen and that key agencies are fully informed and supportive of the complex and integrated work required to do this.
4.	**IMPLICATIONS**
	As a partner agency of the BSCB the CCG has a role to ensure that we are part of the robust assurance process, through effective interagency challenge, to ensure that children and young people's safety and welfare is paramount and maximised in Barnsley. The April update to the Governing Body will reflect the further progress in relation to this from the March BSCB.
5.	**RISKS TO THE CLINICAL COMMISSIONING GROUP**
	The CCG are rightly concerned that any evidence of CSE activity in the Borough is appropriately managed. Through our membership of the BSCB, our scrutiny of providers and our support to Primary Care, our agency to maximise mitigation of risks is strong though clearly reliant upon open and transparent information shared by other agencies.

6.	**CONCLUSION**
	There is evidence of the work to progress the CSE action plan and this will be reviewed by the BSCB. Clearly there need to be mechanisms to test real time evidence of the effectiveness of this plan on practice and, most importantly, the experience of those who are victims and the culture in which the staff working with victims feel is prevalent. The BSCB will meet again on the 20th March 2015 where there will be an update on the Barnsley position regarding CSE and progress made.

Appendix A **BARNSLEY SAFEGUARDING CHILDREN BOARD**

CHILD SEXUAL EXPLOITATION ACTION PLAN January - December 2016

This Action Plan sits alongside the BSCB Strategy for CSE to prevent and protect children and young people from sexual exploitation to and to pursue perpetrators to prosecution, providing support and therapeutic help for all victims of CSE and their families.

This plan is led and progressed through the CSE Strategic Group of the BSCB which meets bi-monthly and has representation from all key statutory agencies and partners in Barnsley. Regular progress updates on this Action Plan are reported into the full BSC Board.

Definition of CSE
Barnsley Safeguarding Children Board adheres to the Department for Education definition as follows:

'Sexual exploitation of children and young people under 18 involves exploitative situations, contexts and relationships where young people (or a third person or persons) receive 'something' (e.g. food, accommodation, drugs, alcohol, cigarettes, affection, gifts, money) as a result of them performing, and/or another or others performing on them, sexual activities. Child sexual exploitation can occur through the use of technology without the child's immediate recognition; for example being persuaded to post sexual images on the Internet/mobile phones without immediate payment or gain. In all cases, those exploiting the child/young person have power over them by virtue of their age, gender, intellect, physical strength and/or economic or other resources. Violence, coercion and intimidation are common, involvement in exploitative relationships being characterised in the main by the child or young person's limited availability of choice resulting from their social/economic and/or emotional vulnerability.' 1

1. Ofsted, The sexual exploitation of children: it couldn't happen here, could it?, November 2014, https://www.gov.uk/government/publications/sexual-exploitation-of-children-ofsted-thematic-report

Updated: 20 January 2015

	Recommendation	Action Required	Lead Person	Timescale	Status RAG	Evidence of completion
1.	Agree one consistent definition of child sexual exploitation to be used and understood by all agencies and organisations in Barnsley	Definition to be determined by CSE Strategic Group at January 2015 meeting.	John Fitzgibbons	January 2015		Definition agreed and adopted. To be used on BSCB website and with all relevant CSE publications
	PREVENTION					
2.	Engage with children and young people and parents/carers to gain a better understanding of CSE and develop a programme of activities to be used in schools, youth settings, academies etc. which will raise awareness of the risks inherent to CSE and reduce risk taking.	Development of Training Material in consultation with the BSCB Multi Agency Trainer and voluntary agencies working on CSE, schools and community groups	DC in SYP - CSE Lead MACPT - BMBC BSARCS Children's Rights Officer	January – July 2015	In progress	YOT has linked up with BSARCS and offer a weekly drop in for young people at the Core. BSARCS have provided training and also materials for case workers to use on a 1-1 basis with young people who are at risk of or involved in CSE. YOT were additionally instrumental in introducing BSARCS CSE worker to schools through the Barnsley Challenge B and A network and subsequent groups have been run with

						identified young people.
3.	Raise awareness of CSE within Barnsley borough through a Borough wide awareness raising campaign so that front line practitioners and those in regular contact with young people are given information to help them recognise the signs and symptoms of CSE and to know when to report on concerns. Include targeted work with schools, private residential providers, hotels and bed and breakfast establishments, taxi drivers, limousine companies, licensed premises, Barnsley Interchange and other areas where young people may be particularly vulnerable.	Development of awareness raising material, Operation Make Safe (hotels, B&Bs) and delivery Discussion to be held with BMBC Licensing Officer re door supervisor arrangements/training Consideration to be given to poster campaign for hard to reach areas Training to taxi drivers revised and delivered on ongoing basis. Police to explore awareness raising at Interchange Training package developed for all Barnsley schools to ensure that key safeguarding staff are trained in CSE and all school staff undergo awareness training	DC SYP CSE Lead BMBC LADO BMBC Licensing Officer Police Safe@Last LSCB Trainer BSARCS Virtual Head	January – July 2015	In progress	Street Pastors notified Bespoke training offered to Street Pastors. Awareness event took place in July 2014 at the Barnsley Interchange to make contact with people passing through the building to provide information about available resources. **Update January 2015** BSCB trainer Karen Harrison and Virtual School lead Dave Benbow have devised an awareness training package for key staff in all secondary and primary schools in Barnsley to be delivered in conjunction with BSARCs trainer Katy Proudman in the Spring term 2015

4.	Core training to be devised and delivered to all professionals who come into contact with children and young people including information on warning signs, the impact of CSE to ensure greater victim identification.	To be included as part of BSCB Multi Agency Training Programme for 2013-14 and 2014-15.	MACPT and Workforce Management and Development Sub Committee of BSCB	January – December 2015	In progress	Revised BSCB Training programme in place Building on training delivered in 2014. **Update January 2015** *Karen Harrison updated CSE Strategic Group with detail of BSCB training programme plan re CSE*
5.	Ensure all agencies of the BSCB provide training for their front line staff within their single agency training programmes as well as encouraging staff to access BCSB training	CSE Training to be reviewed and monitored by the Workforce Development Sub Group of the BSCB and through Section 11 Safeguarding Audits Workforce Development subgroup to map training being delivered across different agencies and report into CSE Strategic Group	Chair of Workforce Development Sub Group Chair of Workforce Development Sub Group	April 2015	In progress	Training for primary care to be held on 18 February 2015. Designated nurses across South Yorkshire arranged and hosted a CSE Level 5 conference in September with over 250 delegates including many of the Barnsley health services Safeguarding Leads. **Update 17 October** Whole YOT CSE training was delivered by BSARCS 1ST and

						29th October 2014.
6.	Evaluate the effectiveness of CSE training with a focus on how it makes a difference to keeping children and young people safer (Ofsted recommendation 2014)	Workforce Development subgroup to map what training has been delivered to whom and assess the impact this has made via feedback/audit activity/evaluation	Chair of Workforce Development Subgroup	April 2015	In progress	
7.	Engage with providers of residential child care (LA and private, and including foster carers) to ensure that staff are sufficiently trained to recognise and respond to the signs of CSE. And to ensure that residential managers routinely report to the BMBC Safeguarding Unit when children are placed in their settings from other local authorities.	Review previous attendance at awareness-raising events and training, identifying members of CIC Team, residential unit staff and foster carers. Identify gaps in take up and provide additional awareness-raising/training sessions Give specific consideration to a joint event for CIC team members and BMBC residential staff. Specific consideration to be given to addressing IFA Quarterly meetings with all private residential providers in Barnsley Revision of Out of Authority Placements process for children placed within Barnsley to ensure better reporting and awareness of other LA looked after children.	Head of Safeguarding and Quality Assurance	December 2014 and ongoing quarterly (Quarterly meetings in 2015) March 2015	In progress	Meeting held with private residential providers held in November 2014 and January 2015 Further meetings arranged for March, June, September and December 2015 are diarised. (Stephanie Evans Service Manager co-ordinates) Out of Authority

						procedures under revision by Task and Finish group – in progress
8.	Review the function and role of the multi agency CSER Forum in order to develop more robust operational oversight of active CSE cases, to improve protection and reduce risk and to gather trends and themes to report to inform strategic developments	Terms of Reference for the CSER Forum (now CSE & Missing Panel) to be revised and a new panel process implemented which places the emphasis of intervention as child protection in all cases of high and medium risk.	Head of Safeguarding and Quality Assurance	February 2015	completed	New Draft Terms of Reference agreed by the BSC Board in November 2014 and new Panel operational by February 2015
9.	Develop mechanisms to gather local intelligence to identify offenders, potential victims and "hot spots."	Via the CSE & Missing Panel develop and implement the use of an Intelligence submission form for partner agencies to complete. To ensure effective use of the intelligence form by partner agencies and sharing of information	DC SYP PCC funded analyst	March 2015	In progress	Form revised and in use. Numbers to be shared by police at September strategic meeting. 3 hot spots identified. **Update 16 October – SYP** Five 'Intelligence reports' have been received since the last meeting all from Julie Riggs of Barnardos. **January 2015 update** Revised CSER Panel to address this information gathering

						and sharing more effectively
10.	Monitor the incidence of young people at risk of being involved with CSE. Analyse the data collected in an agreed data set for CSE and to develop plans to meet the needs of children and young people known to be at risk of CSE.	Use the analysis of this data with the CSE Strategic Group to inform service, practice and policy development. Data set for CSE to be part of regular performance monitoring within Children's Social care and reported as regularly to the BSC Board All active cases of CSE to be reported to the CSE& Missing Panel to ensure data is collated and concerns acted upon robustly.	Head of Safeguarding and Quality Assurance	March 2015	In progress	
	PROTECTION					
11.	All agencies to ensure that cases where CSE is suspected are identified with a flag on their information systems to support better information sharing of children at risk and data capture.	Agencies are asked to review their information systems to ensure that CSE concerns are recorded and flagged on cases.	Directors of: BMBC SYP SWYPFT BHNFT All schools Barnsley College	April 2015	In progress	
12.	Ensure that all cases of suspected CSE are referred to social care and /or the police and that a joint risk assessment is undertaken in line	Social Care operational procedures to be amended accordingly Guidance and training for social care	Service Director social care SYP	January 2015	In progress	**Update Jan2015** CSE operational procedures revised. Training event at

	with the agreed South Yorkshire CSE Risk Assessment Protocol	and multi-agency staff reinforces the need to refer cases for joint assessment that show indicators of CSE				Social Work Forum January 2015 (attended by all social work staff and managers)
13.	To review the commission for return home interviews for young people after episodes of Missing to ensure that all young people are seen, information is shared with relevant agencies and all protective steps are taken to reduce risk.	Missing children procedures are revised in line with the revised South Yorkshire protocol for Missing (when finalised) and include a critical review of the commission for return home interviews to ensure it is a robust service. Information obtained from interviews is centrally collated and used to inform and improve future operational and strategic activity Report to BSCB on revised Missing Procedures in March 2015	Head of Safeguarding & Quality Assurance	March 2015	In progress	**Update Jan 2015** Task and Finish Group for Missing children set up in 2015 and procedures revision due for completion March 2015 Re-commissioning of return interview service is underway and will be a regional service
14	Adopt a whole family approach to the assessment of young people involved with/at risk of sexual exploitation ensuring that standard child protection processes are always followed.	Ensure that Risk Assessment Model reflects the whole family approach to assessments. Revised CSE procedure to protect children is embedded Assessment and JiT procedure and fully understood by all social work staff. Ensure that social care managers oversee all individual cases of CSE	Head of Service Social Care Head of Service Social Care Head of Service	March 2015		**Update 17 October** YOT are currently revising the Quality Assurance and Case Planning format to detail various areas including CSE. This will formalise the process that is already used. **Update Jan 2015** Social care

		and sign off all assessments, plans and review arrangements to address the level of risk Strategy Meetings for CSE cases are to be embedded within the child protection process and Section 47 Strategy process (and not separated)	Social Care Head of Service Social Care			procedures for front line assessment work have been revised to take account of CSE team, joint CSE assessments and changed function of the CSE & Missing Panel Social Work Forum (all social work staff and managers) January 2015 focus on CSE and key message given this is child protection work.
15	Review the areas of policy/practice to ensure that they are effective in identifying the work required with families and young people to effectively protect young people who are at risk of involvement with CSE Ensure all procedures reflect CSE	Undertake a review of the following areas and identify any required changes to practice/policy and procedures • Use of CAF • CIN Procedures • Relationship with Stronger Families Teams when low level concerns and early intervention could be the most appropriate response • Section 47 Strategy meeting process to include relevant	DC SYP Heads of Service Service Managers	March 2015	In progress	CSE is featured as an area to consider in the assessment processes and clearer responses are developed Revisions ongoing See Action 10 Revisions to JIT Protocol See Action 10 Revisions to JIT

		agencies and family members • Use of the South Yorkshire Risk Assessment Tool • When a Care Plan is completed for a child or young person and concerns about CSE are raised, the plan must address the effective way to manage and minimise the assessed level of risk • Placements for young people (residential/care leavers) assessment to include consideration of locality placement and the support package required to reduce the level of vulnerability.				Protocol See Action 14 See Action 7 **Update 16 October - SYP** CSE SW now embedded in CSE team. Four CSC staff trained in new SYP risk assessment tool. JIT protocol being reviewed by CSC to include recent changes.
16	Therapeutic support Provide therapeutic support to young people affected by CSE	Commission a therapeutic support service with partner agencies for identified victims and survivors of CSE to sustain risk reduction and recovery. Identify funding, develop a commissioning brief for the voluntary	Lead - Service Director for Children's Social Care Directors of: BMBC	May 2015	In progress	**Position 20 October 2014** Consider commissioning from MST BSARCS

		sector	SYP SWYPFT BHNFT			
	LSCB to agree a communication and media strategy for lead agencies in the event of a high profile CSE case	Communication leads for each agency to agree a common media strategy to be used if required.	Chair of CSE Strategic Group	March 2015	In progress	
	PROSECUTION					
17	Training to include giving professionals an understanding of how to provide and record evidence which can be used to bring prosecutions against abusers	Review what training ahs already been delivered and plan top address where there are gaps. Training and Education to be developed and then delivered to care homes, foster care placements and CYPFS staff	MACPT Workforce Management and Development Sub Committee of BSCB Head of Children's Services (Org Development) Barnardos	April 2015	In progress	Information is added into training programmes **Update 16 June** Health addressing issue re recording. Multi-agency training Lunchtime seminar in May on Preserving forensic evidence. Achieving best evidence is a common feature in relevant multi-agency training.
18	Where offences are thought to have occurred or are suspected use disruption tactics to reduce risks as part of planned and	Agreed disruption tactics to be implemented as required. Risk of CSE activity to be assessed	SYP CSER Panel Head of	April 2015	In progress	Embedded into practice and response to disclosures **Update June 16 2014**

	proactive moves toward formal investigation and prosecution.	in all licensing activity of the Council, such as approving taxi drivers, food outlets, public houses etc	Licensing (?)			SY Police fortnightly bulletin refers to disruption tactics and action planned/taken to disrupt perpetrator activity.
19	Where specific locations are identified as "hot spots" a disruption plan is implemented to reduce risks and disperse suspected perpetrators	Agreed disruption tactics to be implemented as required by SY Police CSE & Missing Panel to review and map hot spot information to disseminate to children's workforce for protective action/targeted education programmes	SY Police CSE & Missing Panel	April 2015	In progress	Embedded into practice and response to disclosures
20	Appropriate support is provided to victims of CSE both where prosecutions are being pursued and where this cannot be achieved. To include short and long term support	Clarify available services and their provision Referral Pathway to be developed by CSE Strategic Group	SYP BSARC Health	May 2015	In progress	Identified young people referred to BSARCs and Barnardos for appropriate services.
21	All appropriate risk assessments and supervision plans prepared by Probation Trust staff will include specific consideration of CSE.	Where required, supervision plans will specify how work to address the risks will form part of offender management activity.	Director of Probation, Barnsley	May 2015	Amber	

NB. Rag Rating: **Green** - work is either in progress or completed and is within timescale

Amber - work is in progress but has exceeded timescale and requires completion

Red - work has not progressed and needs urgent attention/resolution

NHS
Barnsley Clinical Commissioning Group
Putting Barnsley People First

GOVERNING BODY

12 March 2015

YORKSHIRE AMBULANCE SERVICE (YAS) ACTION PLAN UPDATE

1.	**PURPOSE OF THE REPORT**
	To provide the Governing Body with: • A CCG action plan to assure the governing body and CCG that patient safety is not compromised by YAS performance not achieving R1 and R2 nationally set targets for Barnsley patients.
2.	**EXECUTIVE SUMMARY**
	This report outlines the progress to date regarding concerns of YAS performance and quantifying the impact on patient safety. Both the CCG and YAS have introduced additional measures and strategies to improve performance and provide specific data regarding the correlation with patient safety. In addition at a meeting with the YAS Executive Medical Director on 4th March an indication was given that their revised and additional operational strategies are anticipated to improve performance from May onwards with a 6 – 12 months ongoing improvement trajectory. Clearly this will be a focus for our meeting with the YAS Executive Team at the end of March.
3.	**THE BOARD IS ASKED TO:** • Note the contents of the action plan • Approve the implementation of the action plan • Be assured of the YAS and CCG strategies being implemented

Agenda time allocation for report: 10 minutes.

Report of: Brigid Reid

Designation: Chief Nurse

Report Prepared by: Amanda Lindley

Designation: Quality Manager

1.	**SUPPORTING INFORMATION**	
1.1	**Links to the Assurance Framework**	
	This report provides assurance to the Governing Body against risks 14/5a and 14/5b.	
1.2	**Links to Objectives**	
	To have the highest quality of governance and processes to support its business	✓
	To commission high quality health care that meets the needs of individuals and groups	✓
	Wherever it makes safe clinical sense to bring care closer to home	
	To support a safe and sustainable local hospital, supporting them to transform the way they provide services so that they are as efficient and effective as possible for the people of Barnsley	
	To develop services through real partnerships with mutual accountability and strong governance that improve health and health care and effectively use the Barnsley £.	✓
1.3	**Governance Arrangements Checklist**	**Has the area been considered**
	Financial Implications	Performance monitored by F&PC
	Contracting Implications	Performance monitored by F&PC
	Quality	Yes
	Consultation / Engagement	Discussions with YAS, Healthwatch advised to monitor
	Equality and Diversity	EIA not completed but equality of access a major consideration
	Information Governance	N/A
	Environmental Sustainability	N/A
	Human Resources	N/A

2.	**INTRODUCTION**
2.1	There have been a number of previous papers around YAS's persistent and deteriorating failure to reach nationally set targets for R1 and R2 responses in 8 minutes for Barnsley patients.
2.2	However recent data does demonstrate improvement in performance for the Barnsley patients. See Appendix A – CCG YAS Performance Analysis.
2.3	The Governing Body requested to further understand any correlation between failure to achieve the nation target response time and patient safety.
2.4	YAS representatives, including the YAS Executive Medical Director attended the CCG on 4/3/15 and provided comprehensive details of work undertaken since June 2014 to assess level of harm (actual and potential) in relation to delayed response times (see detail in Appendix B – letter for West Yorkshire Quality Surveillance Group and Appendix D – YAS Q3 Quarterly Incident Report) and incoming operational strategies to address their current performance. This detail was received by the CCG Medical Director, Chief Nurse and Chief Officer.
2.5	Key work they described was; • The Clinical Duty Manager role providing real time improved clinical monitoring safeguard function over 24 hour period (See Appendix C for details of CCG visit to Control Centre). • An analysis of 2 weeks of Delayed response data from June and July was reviewed to check all instances where harm occurred had been picked up; of the 1,200 cases reviewed only 2 incidents hadn't been reported however neither had resulted in harm. • Continued achievement of the 'A19' standard, which is 95% met for conveyancing a resource to a red call within 19 minutes. • National debate regarding national target of 8 minutes was shared noting that the only response time to have an evidence base is acute cardiac events. • Of the some 2,200 calls per day in Yorkshire approximately 100 - 200 are deemed immediately life threatening. • A new 'Red Module' approach has been introduced in the last week of February that identifies as the 1st question to callers what the clinical problem is not the caller's location. The aim being that the right staffed vehicles are promptly dispatched based on clinical need, not location, and reducing the resource over allocation that can occur until further detail is evident. Evidence thus far is that 75% of Red 1 need is identified in the first 20 seconds (total coding takes 100 seconds). In the first week of operation they estimated that in approximately 300 instances (across the patch) significant resources had not been allocated and tied up unnecessarily. • A complete re-modelling review of service provision and structure with a national ORH specialist team is underway to consider where resources are located (due mid-April) NB linked to the above point currently 'stand by' points are not being used as vehicles are often perpetually in operation.

	• The Workforce plan has been revised, enhancing the numbers of technicians to address current paramedic shortages. The plan had been to phase this role out but changes to paramedic education have meant that needed profiling to meet workforce need; the technician role will develop future paramedics. • Plans to locate additional resource to West and South Yorkshire to reduce out of area 'drift' impact. In addition they described Internal weekly performance monitoring with an overarching principle of 'prioritising safety over targets'.
2.6	The CCG representatives found the level and detail of the work described helpful and encouraging, particularly the insight that the YAS Medical Director who attended is also the national lead for their peers and much of what YAS have introduced re safety monitoring is now being replicated elsewhere. YAS attendees welcomed the opportunity to meet with the CCG, understand our concerns and share the narrative behind their plans.
2.7	As requested by the CCG Chair a plan (See Appendix E) has now been formulated to focus on actions with YAS utilising the framework of Safety, Performance and Sustainability.
3.	**DISCUSSION**
3.1	Whilst it can naturally be assumed poor performance equates to negative effects on patient safety and increased risks, the evidence shared at the meeting and Appendices A & C provides a more meaningful basis to review the evidence. Whilst risk can never be totally minimised and incidents in relation to delay do occur there is good evidence to demonstrate that there is • Real time safety surveillance • Learning from incident analysis • Work to address Human Factors • Operational remediation
3.2	Work identified in the action plan to improve the data reported to the CCG will assist continued insight and challenge to ensure that performance improvement is meaningfully achieved and safety remains paramount.
4.	**RISKS TO THE CLINICAL COMMISSIONING GROUP**
4.1	There are 2 risks recorded on the risk register in relation to this area, including mitigating actions and control measures. These have been updated with progress updates as required. Both risks are scored as residual risk score red – 'extreme risk'. (14/5a – score – 25 and 14/5b – 20). The aim will be as the action plan is implemented and its impact monitored re-consideration of 14/5a score can be undertaken. YAS have also confirmed that performance is red on their risk registers and being reviewed and acted on as a high priority.

5.	**APPENDICES TO THE REPORT**
	• Appendix A CCG YAS Performance Analysis • Appendix B YAS Jan 2015 Assurance letter • Appendix C YAS Call Centre CCG Visit report • Appendix D YAS Q3 Quarterly Incident Report • Appendix E CCG Action Plan
6.	**CONCLUSION**
6.1	Progress against YAS performance will continue to be driven and closely monitored noting any evidence of increasing risk to patients which will be escalated to NHS England.
6.2	The Governing Body is asked to note the content of the report and support the proposed CCG action plan.

Appendix A – CCG YAS Performance Analysis

YAS Performance Analysis –

Comparison of December and January 2013/14 against December and January 2014/15

	Jan 15	**Dec 14**	**Jan – Dec 14/15 % Variance**	**Jan 14**	**Dec 13**	**Jan - Dec 13/14 % Variance**	**Jan 15 to Jan 14 % Variance**	**Dec 14 to Dec 13 % Variance**
Demand								
Red R1 and R2	1239	1398	88.63	1118	1178	94.91	**111**	**119**
Red 1	90	105	85.71	89	78	114.10	101	135
Red 2	1149	1293	88.86	1029	1100	93.55	112	118
YTD R1 and R2 demand	11862			10545			**112**	

Analysis of Demand

There has been an increased demand for Red response of 1317 (**12%**) calls for the year to date to January when compared to the same period last year. Comparing months, there was an **11%** higher demand for Red response in January 15 against January 14. This variance was higher at December with a **19%** higher demand in December 14 against December 13.

Looking at R1 calls the demand in January 15 was similar to January 14, however in December 14, there was a **35%** higher demand than in December 2013. This is reflected in the response time performance, particularly in December 14.

Demand fell between December 14 and January 15 and this is reflected in improved response time's performance.

The previous year, whilst overall demand fell from December 13 to January 14, demand for Red 1 response increased and this is also reflected in performance for the same period.

	Jan 15 %	Dec 14 %	Jan - Dec % Points Variance	Jan 14 %	Dec 13 %	Jan - Dec % Points Variance	Jan 15 to Jan 14 % Points Variance	Dec 14 to Dec 13 % Points Variance
Performance								
Red R1 and R2	66.00	51.60	**+14.40**	70.50	67.50	3.00	**-4.50**	-**15.90**
Red 1	65.60	58.10	7.50	65.20	66.70	-1.50	0.40	-8.60
Red 2	66.00	51.00	15.00	70.90	67.50	3.40	-4.90	-16.50
Improvement between Dec 14 and Jan 15 - Comparison to South Yorkshire CCG's								
Doncaster R1 and R2	65.30	59.80	5.50					
Doncaster R1	71.40	58.20	13.20					
Doncaster R2	64.80	60.00	4.80					
Rotherham R1 and R2	61.40	51.30	10.10					
Rotherham R1	60.70	59.00	1.70					
Rotherham R2	61.50	50.70	10.80					
Sheffield R1 and R2	67.10	58.30	8.80					
Sheffield R1	72.60	65.30	7.30					
Sheffield R2	66.80	57.80	9.00					

Analysis of Performance
Performance against response times targets has increased between December 14 and January 15.

The rate of improvement overall is higher than in the other South Yorkshire CCG patches and is also higher for R1's and R2's individually with the exception of Doncaster which saw an higher rate of improvement for R1 responses.

Performance compared to the same period as last year is lower in Barnsley for both January and December, with performance 4.5% and 15.9% lower respectively.

	Jan 15	Dec 14	Jan 14	Dec 13				
Response Times - Time taken to respond to 75% of calls	<10 mins*	<12 mins*	8:50 mins	9:00 mins				
* Due to the way data is reported the actual time is not available for the latest 2 periods as it is only available in full numbers to the figures show that 75% of calls were responded to in less than the minutes shown.								

Response times to achieve 75% for R1

The time taken to respond to 75% of calls has increased since the same periods in 2013/14. Whilst performance for R1 8 minute calls is not meeting the 75% target, in Barnsley 75% of calls are responded to in less than 10 minutes in January 2015. This is an improvement on December 2014 when 75% of calls were responded to in less than 12 minutes.

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Appendix B

Jo Pollard
Chief of Service Delivery and Quality
NHS Wakefield Clinical Commissioning Group
White Rose House
West Parade
Wakefield
WF1 1LT

21 January 2015

Dear Jo,

Increased service demand and performance pressures – assurance on quality and safety

Further to your request that we provide an assurance update to CCGs in relation to safety and quality of care during December, I have summarised our current position below.

In 2014 the Trust experienced a significant rise in demand relating to the higher acuity Red calls and meeting Red performance targets has been a significant challenge. A Performance Improvement Plan was implemented and performance improved in the months to November 2014.

A further increase in Red demand of 10% above the 2013/14 level was experienced throughout December, in line with the experiences of other ambulance Trusts around the country, with high spikes of activity on specific days over the festive period. Hospital turnaround times also rose significantly in December, reflecting the pressures on the wider health system. These factors placed additional severe pressures on the Trust's ability to meet response performance targets in December.

The primary concern of the Trust throughout this prolonged period of pressure during 2014/15 has been to maintain a safe service for patients and a number of additional measures have been developed and implemented over recent months to support this and to provide the necessary assurance in relation to the safety and quality of care.

In June 2014, we provided a briefing for the Contract Management Board, which set out our position at the time and our approach to safety and quality. This included an update on our monitoring of incident and near miss reports including Serious Incidents relating to delayed response, a new process for statistical monitoring of delayed responses and clinical review of the safety

POSITIVE ABOUT DISABLED PEOPLE

and quality implications of delayed responses, to enable us to understand in greater detail the relationship between performance and safety. This analysis was also used to inform the A&E Operational Improvement Plan.

It is important to recognise that when the Trust is meeting the Red performance targets and safety is not a significant concern, up to 25% of patients do not receive a response within the target measure. Our work demonstrated that whilst there was a potentially increased risk to patient safety as a result of additional delays and there was likely to be an impact on patients' experiences of the service, the correlation between response target performance and patient outcome is weak and there is no obvious linear relationship between them. The reason for this is that even within the Red categories, there are a high proportion of patients for whom a response within 8 minutes is not clinically critical.

We monitor reported incidents, whether generated internally or through service to service concerns, on a continuous basis, with close oversight of potential Serious Incidents by myself and the Executive Medical Director. In addition, there is a full review every 2 weeks, of information received through all of our reporting streams, including incident reporting and complaints, in order to gain a rounded view of safety and quality issues a rising and to agree a management plan for any issues of serious concern.

Since completing our baseline analysis of delayed response issues in June, as reported in our update to CMB in November 2014, we have also had additional processes in place to continuously monitor safety and quality, and this information is reviewed by the Executive team on a weekly basis, as part of the wider A&E Operational Improvement Plan. Our weekly monitoring includes:

- SI reports
- Other incident and near miss reports – patients and staff
- Complaints
- Statistical monitoring of delays in relation to call categories, with comparison to a reference period when the Trust was meeting the performance targets
- Report from real-time monitoring in the Emergency Operations Centre. This process entails call handlers flagging delayed responses with potential for harm to Clinical Team Leaders, who assess the call and highlight any cases where actual harm may have occurred for full clinical review.

The Trust has developed these monitoring processes in-house, as they are not standardised across the ambulance sector and they have been shared with other Trusts as good practice through the national ambulance Medical Directors' group.

The charts below provide a summary of the monthly picture.

Chart 1 – Red 1 excessive responses

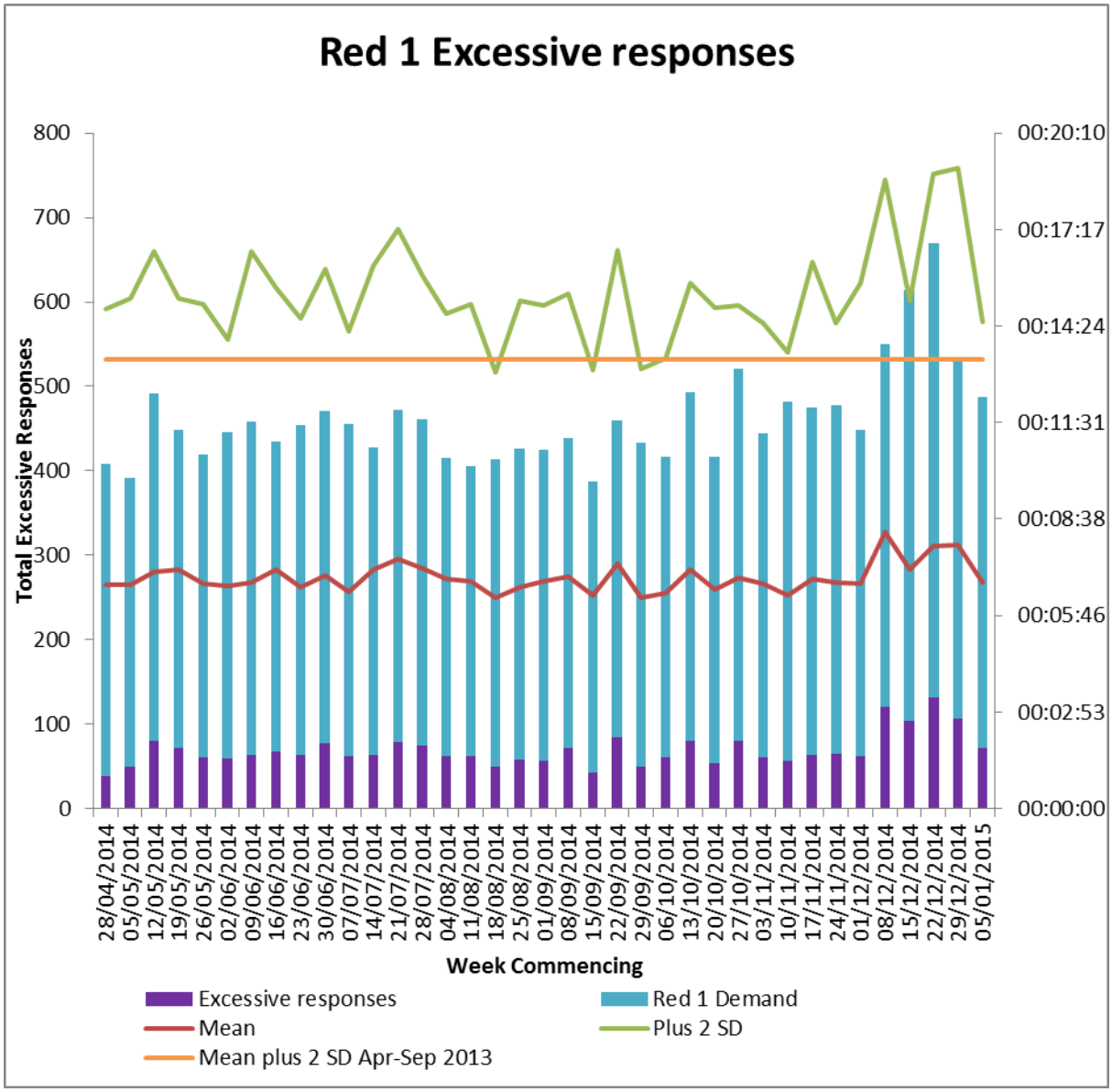
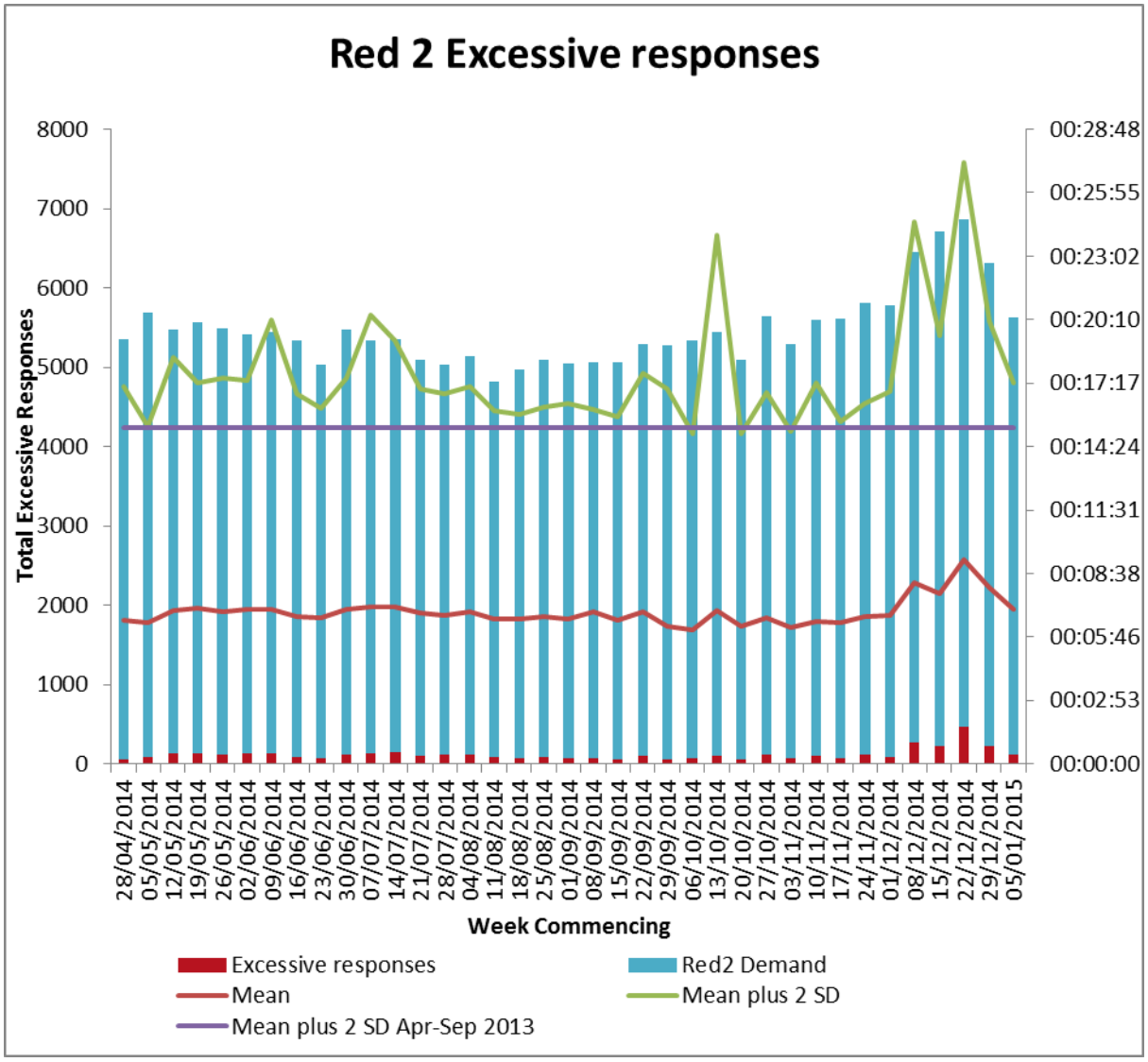
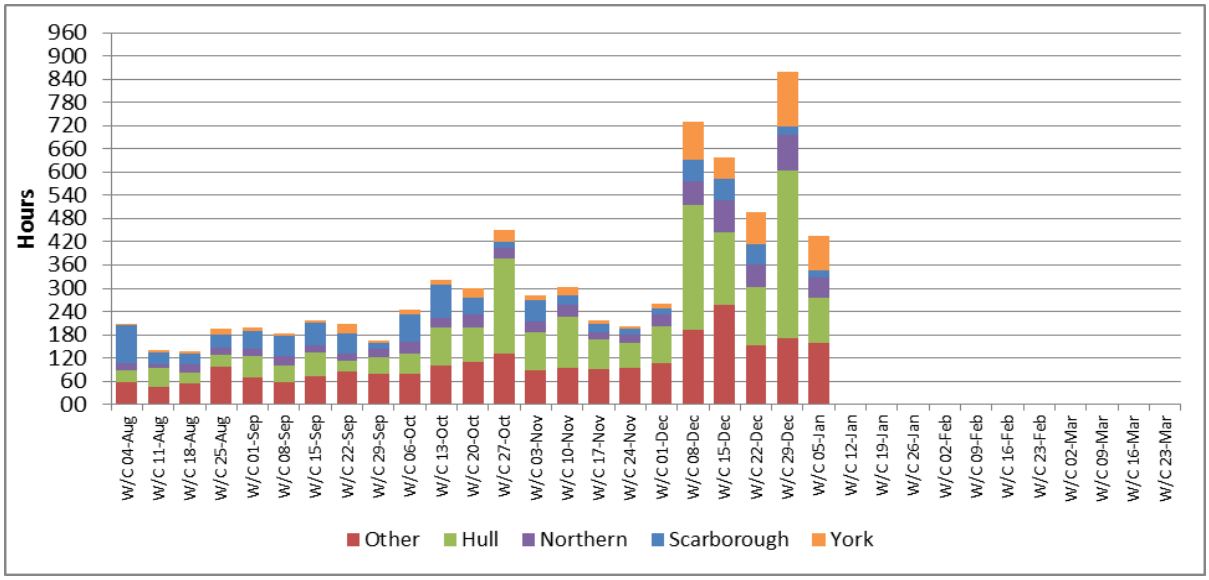


Chart 2 – Red 2 excessive responses



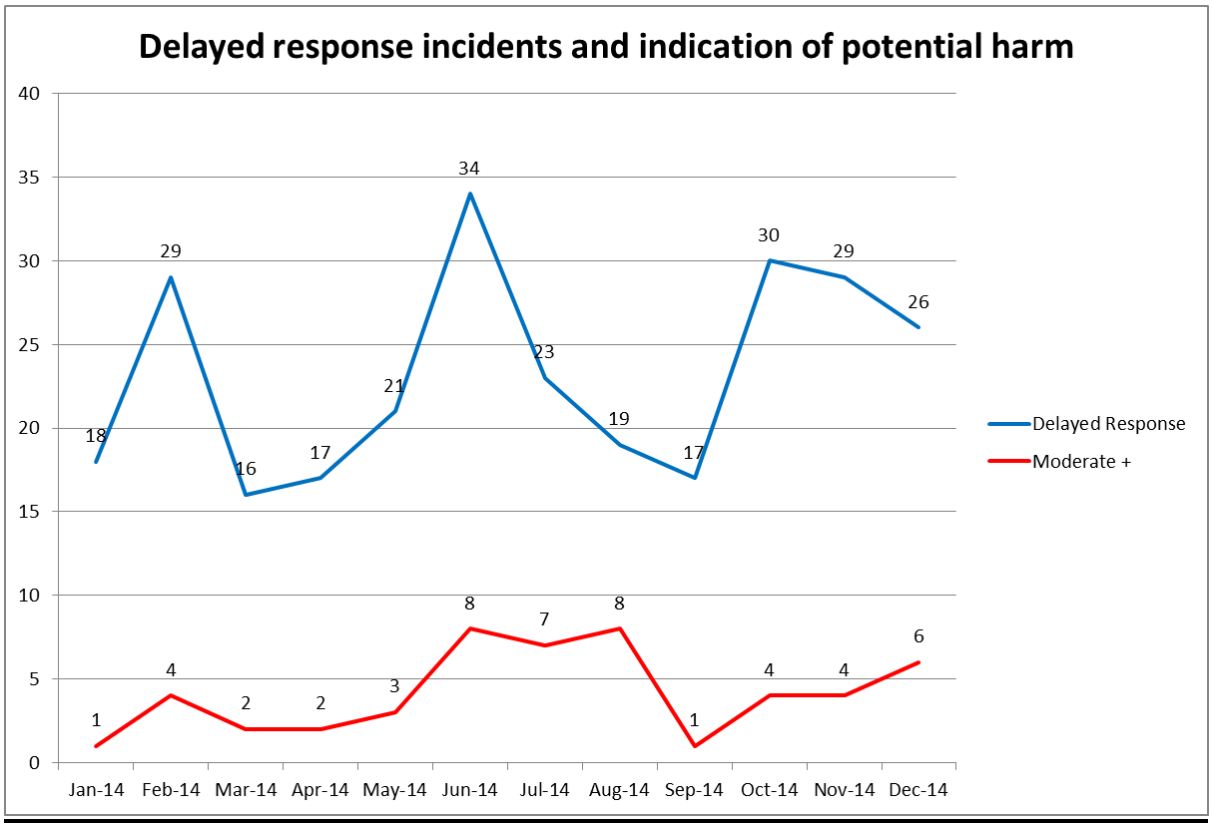
Charts 1 and 2 above show the monthly demand for Red 1 and 2, together with the number of delayed responses, mean response time, mean plus 2 standard deviations for our reference period and current mean plus 2 standard deviations. They illustrate the positive movement over recent months, in line with the A&E Improvement Plan and in spite of the 13% growth in demand year to date, but also clearly demonstrate the impact of the 10% additional demand above the anticipated level and wider system pressures including hospital turnaround delays during December (See Chart 3 below).

Chart 3 – hospital turnaround delays



To enable the Trust to respond to operational service pressures and maintain patient safety, the Resource Escalation Action Plan (REAP) process is used to establish predetermined medium term actions and response levels based on the level of risk in the system. In addition, on a real-time basis, the Trust operates a Demand Management Plan (DMP) which enables the Gold Commander and Medical Incident Commander (24/7 YAS Medical lead) to flex our response to patient care as peaks in demand are experienced, in order to prioritise the delivery of safe care to the higher acuity patients through targeted response and increased clinical triage. The addition of Mental Health Nurses and Midwives into the Clinical Hub during December also supported this process. In view of the extreme pressures in the system, the DMP was implemented to levels 4 or 5 – its highest levels on 10 days during December. We believe that these actions, together with our careful management of the wider system across our NHS 111 and 999 services were effective in minimising any additional harm to patients, in spite of the extreme performance challenges.

Chart 4 – Delayed response incidents



There is a good level of reporting from staff of incidents, near misses and concerns, supported by the web based Datix system and 24/7 incident reporting phone line. The level of moderate or above harm as reported by staff has been within the previously seen range, with a slight rise again during December, reflecting the additional pressures in the system.

Chart 5 – Serious Incidents

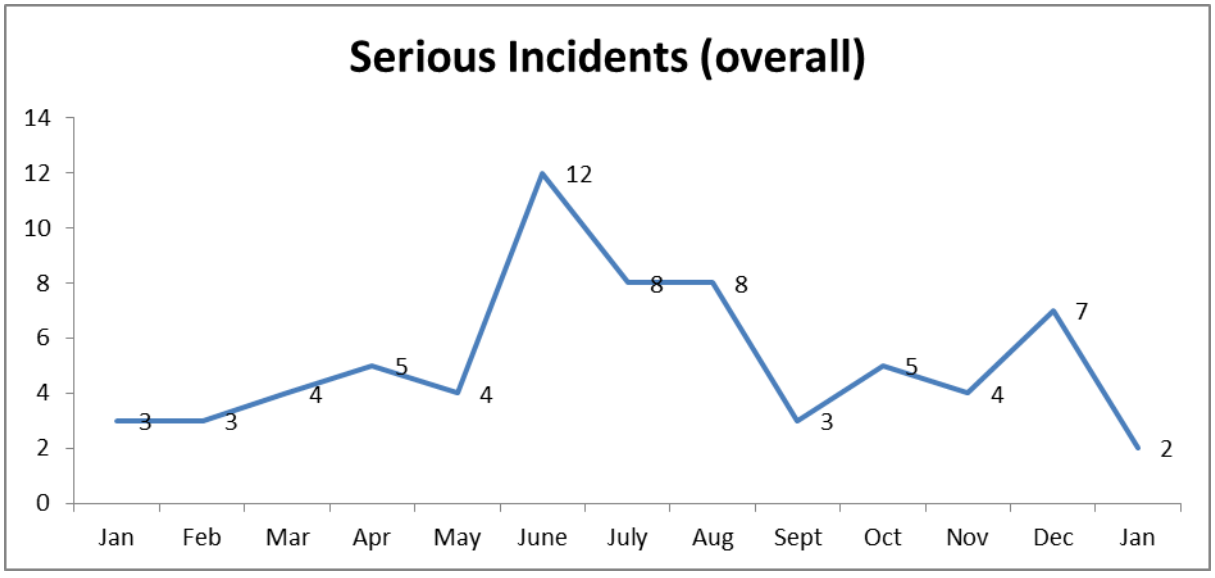
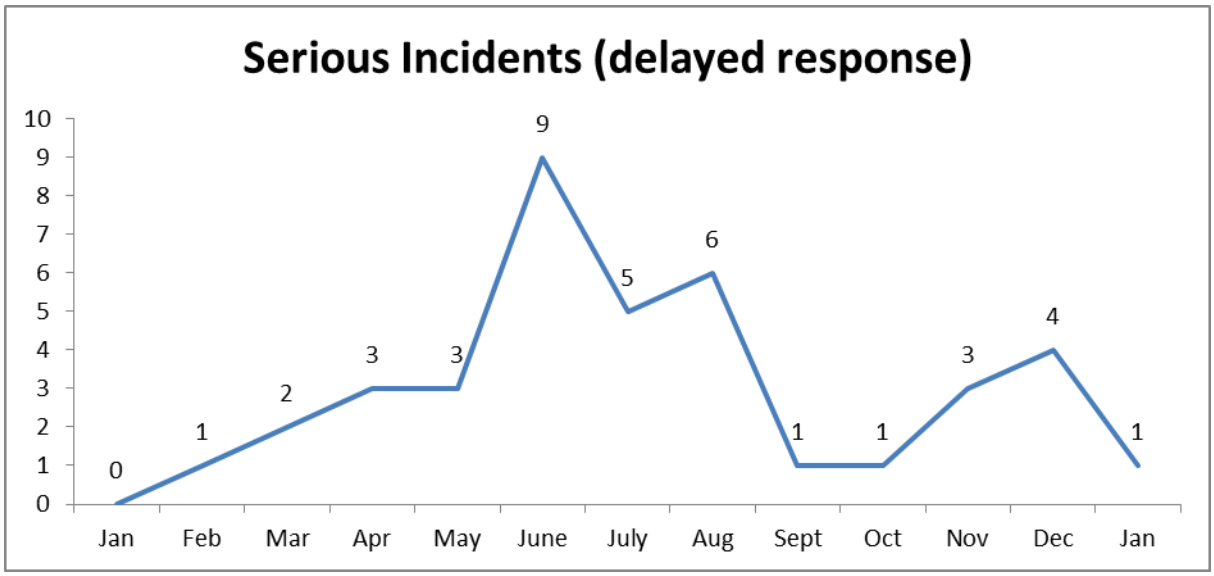


Chart 6 – Serious Incidents associated with delayed response



Charts 5 and 6 show the monthly number of reported Serious Incidents and the number of these related to delayed response. Overall, a higher number of Serious Incidents has been reported in 2014/15 than in previous years. This includes any incidents where death or severe injury is thought to be associated with a delayed response above the response time target level. The incident numbers therefore need to be interpreted with caution, as the impact of this delay on the patient's outcome is frequently not easy to determine and the association may be incidental rather than causative. We are carrying out a further analysis at present of closed SIs, to attempt to gain greater understanding of this relationship.

Following the peak in June-August, the number reported monthly was within the previously seen range. There was a rise in December although this is not proportionate to the level of increased demand and response performance. This reflects the additional measures implemented during December in line with our Demand Management Plan, to prioritise patient safety. The number of SIs reported to-date in January has fallen to within the previous monthly range.

In summary, the Trust Operational Improvement Plan has delivered gradual improvements in performance against a back-drop of increased red demand in the months to November 2014, but in December the Trust experienced significant further increases in red demand, combined with additional pressures from hospital turnaround delays, which severely affected our ability to meet performance targets.

Patient experience will have been affected during this period, and whilst the overall number of complaints is not increased, those related to delays rose to the highest level this year during December. We expect this to fall again to within the previous level during the remainder of quarter 4.

During this period, however, the Trust prioritised patient safety through its established escalation and demand management procedures and was successful in minimising the impact of the extreme demand pressures on patient outcome.

The pressures seen in December now appear to be easing and performance is beginning to recover. Further actions have been identified to support delivery of response time performance in quarter 4, to supplement the existing A&E Improvement Plan. We will continue to closely monitor the patient safety and quality indicators as previously, and to use this analysis to support the improvement plan and delivery of safe care.

I hope that this letter provides an appropriate level of assurance for commissioners in relation to safety and quality during this period of intense pressure. We are grateful to you for your support during this challenging period, and we look forward to the continued support of CCG colleagues in addressing some of the wider system pressures impacting on YAS responsiveness.

If I can be of any further assistance, please let me know.

Yours sincerely,

Steve Page
Executive Director of Standards and Compliance

NHS
Barnsley
Clinical Commissioning Group

Appendix C QPS/14/11/12 (i)

QUALITY & PATIENT SAFETY COMMITTEE

27 November 2014

Yorkshire Ambulance Service (YAS)
Control Centre Visit

1.	**PURPOSE OF THE REPORT**
	The aim of this report is to provide the Committee with a brief overview of the visit to the YAS Control Centre undertaken on Thursday 16 October 2014 by the Chief Nurse and Governing Body Member/Urgent Care Lead. Also attached is the Emergency & Urgent Ambulance Service Contract Monitoring report (October 2014) which was referenced at the previous meeting of the Committee, for further information.
2.	**EXECUTIVE SUMMARY**
	This report outlines the announced control centre visit.
3.	**THE COMMITTEE IS ASKED TO:** • Review and discuss the content of the report • Consider the need for additional Quality & Patient Safety Committee members to attend the Call Centre • Agree any further actions required to gain assurance from YAS • Highlight levels of assurance and any outstanding areas of concern to the Governing Body

Report of: Brigid Reid
Dr Sudhagar Krishnasamy

Designation: Chief Nurse
Governing Body Member/Urgent Care Lead

Report Prepared by: Rebecca Wixey

Designation: Quality Manager

1.	**SUPPORTING INFORMATION**	
1.1	**Links to the Assurance Framework**	
	This paper links to risk 'CCG 14/5a' from the CCG's corporate Risk Register.	
1.2	**Links to Objectives**	
	To have the highest quality of governance and processes to support its business	✓
	To commission high quality health care that meets the needs of individuals and groups	✓
	Wherever it makes safe clinical sense to bring care closer to home	
	To support a safe and sustainable local hospital, supporting them to transform the way they provide services so that they are as efficient and effective as possible for the people of Barnsley	
	To develop services through real partnerships with mutual accountability and strong governance that improve health and health care and effectively use the Barnsley £.	✓

1.3	**Governance Arrangements Checklist (Has the area been considered)**	**yes / no / not relevant?**
	Financial Implications	N/A
	Contracting Implications	N/A
	Quality	N/A
	Consultation / Engagement	N/A
	Equality and Diversity	N/A
	Information Governance	N/A
	Environmental Sustainability	N/A
	Human Resources	N/A

2.	**INTRODUCTION**
	The Committee has previously received various reports providing members with information on quality and safety issues relating to YAS performance and ambulance delays. To provide additional assurance, the Associate Medical Director made the offer to members of the Governing Body to attend the YAS Call Centre in Wakefield.
3.	**DISCUSSION**
	The Chief Nurse and Governing Body Member/Urgent Care Lead attended the Call Centre on Thursday 16 October 2014. The visit was facilitated by Ben Holdaway, Locality Director (EOC) and Dr Steven Dykes, Associate Medical Director. Following an overview of the Control Centre both the Chief Nurse and Governing Body Member were each able to spend 20 minutes with a call taker and 20 minutes at the Barnsley dispatch desk. For context, the Wakefield Control Centre where the visit took place is one of two for the whole of Yorkshire, the other one being York. Business resilience is through the 111 Centre in the Dearne (recently tested). **Call Taking** Calls are taken by dedicated staff using voice activated software which records them. The first bit of information required is the physical location of the caller. Whilst asking what is wrong with the patient could lead to more accurate coding earlier on, experience has shown that once clinical symptoms are requested it is very difficult to then get the caller to identify the location. As the call takers are not medically qualified the coding of the call is reliant upon the A&PDS system. Key words and phrases such as 'difficulty breathing', automatically trigger to an R1 code and this simultaneously appears on the relevant location's dispatch screen. Whilst in many instances this leads to the appropriate earliest possible dispatch of a paramedic response it can also mean that an R1 code is used when in fact it isn't necessary (as witnessed during the visit). This means that R1 dispatches are over inflated, and whilst codes can be changed up until the point of the first response at the scene, the significantly increased resources dispatched to an R1 call compounds the heavy demand, influencing the ability to meet the 8 minute target of first on scene. An example of this was witnessed by the Governing Body Member during his time with one of the call takers. Although the patient could be heard talking to the bystander who made the 999 call, the triage algorithm put the call as category R1 since the caller said the patient was not conscious. It would be helpful to know what percentage of these calls go to the clinical lead to re-triage to allocate them to the appropriate category. Clearly if medically qualified individuals were call-taking this could to a large extent be alleviated but the profile and cost of the service would be very different.

The work that the clinical duty managers are now undertaking to review "call stacks" is attempting to compensate for this and prioritise in real-time based on clinical need. Both the Locality Director (EOC) and the Associate Medical Director identified that for lesser response codes to be most effectively managed clear pathways to need to be in place, such as for falls. Otherwise attendance, even by urgent care practitioners, could be unnecessarily tied up whilst waiting for next steps to take place or resulting in inappropriate hospitalisation. Strong performance was noted against the 19 minute conveyance target (once stabilised) of 95% - YTD = 97%.

Call Dispatching

Call dispatching is a highly complex skill. Each dispatcher has three screens; one is the map with locations of currently dispatched RRVs (initial paramedic) and DCAs (ambulance with a crew of 2 who can convey the patient to hospital or other destination), and all those in standby positions. Another screen shows all calls coming in and their current status with the available crew to that location and their current activity at the bottom of the screen. The third is utilised to check other available location services should the resources of that location not be sufficient to meet demand. The dispatcher has to make frequent checks as the information on all screens changes rapidly.

At the point of viewing, Barnsley crews were tied up with work or not yet free from their mandatory breaks. The service operates a "take and tell" procedure whereby the dispatcher can utilise available crew from other locations if that is the best fit to meet the target response time (this is automatically displayed on the screen once the dispatcher makes that enquiry). It is this aspect that leads to geographical "drift" and evidence was seen of this happening both ways, i.e. in and out of the Barnsley area.

Even for a barn door R1, dispatched using a Barnsley crew as the call was being taken with a calculated ETA of 8 minutes, it cannot guarantee that happening as it is dependent upon factors on the road so in actual fact attendance was achieved in 8 minutes 30 seconds. The Chief Nurse & Governing Body Member also saw evidence that a crew attending a Road Traffic Accident with potential multiple casualties (a bus was involved) resulted in two individuals declining to be transferred to hospital. So whilst the right response was made to ensure safety at the scene, the utilisation of that resource made it unavailable to other patients during that time.

It would appear that only one ambulance service in the country (London) has an automatic dispatch system and when that had been trialled previously within Yorkshire it had been universally rejected. Nonetheless work is being undertaken to look to automate stand-down and stand-by activity to free dispatches up more to make the judgements required to dispatch best fit available at the time. What wasn’t seen occurring was either a dispatcher escalating a concern to a team leader or the clinical duty manager recoding or redirecting through stack checking. Whilst this isn't a criticism (there wasn't any evidence that such activity was required at that time), it would have been useful and informative in relation to a recent SI which identified that a dispatcher had not taken full opportunity to divert other ambulances to provide back up to the RRV on the scene.

	Consideration of other issues In addition the following issues were discussed:- • The need for as much cross-fertilisation between crews and control room to promote mutual understanding of roles and pressures (whilst paramedics attending a scene are clearly pressurised their focus is one single task whereas the control room dispatchers are continuously multitasking and reprioritising). • Barnsley has recently introduced an ambulance support vehicle (ASV) which although it looks like an ambulance is not manned by paramedics or available for urgent dispatch - rather frees up DCAs by transporting patients non-urgently. • Using the same vehicle to transfer 2 or more patients along the way to different hospitals to maximise the utilisation of limited resources as long as there is no infection risk. • The need for inter-hospital transfers (to specialist centres Leeds and Sheffield) and intra-trust transfers (e.g. Mid Yorks has 3 sites), particularly when nurse escorts are not provided, is affecting resource capacity. • In addition triage for inter-hospital patient transfer relies on the answers from the ward nurse, e.g an MAU nurse answered yes for a question whether the patient is from “critical care ward” even though the patient was coming from MAU. This changed the priority from P4 to P2 which could put strain on the limited crew. • Electronic care solution (access to care plans) has been piloted in Wakefield & an application has been made to the digital care fund to roll this out wider. (NB 111 calls do have access to electronic flags such as end-of-life and can liaise with out of hours services re this). • Work on the mental health Concordat is essential as significant resource tied up on a day-to-day basis in relation to patients with mental health needs. • In response to the Governing Body Member’s query re STEMI performance (as 7th out of 11 ambulance trusts in the country) it was clarified that the DCA despatching is only part of the reported data, also that MINAP is more reliable than SSNAP data. The response from YAS that the poor post-MI outcomes are due to the delay in hospital Rx and nothing to do with their R1 delays would require further triangulation of data to verify this. • Trial on cardiac arrest team leader role in Doncaster looking positive - though given the poor prognosis at point of unattended arrest it was noted that the biggest impact on improving cardiac arrest outcomes would be in dramatic increase in community-based skills (1100 children trained in 57 schools that day on 'start the heart').
4.	**IMPLICATIONS**
	As Committee members are aware the risk around YAS performance has now been on the CCG’s Risk Register for several months. The detail of the risk is as follows:

	If Yorkshire Ambulance Service (YAS) continues to under achieve against the Category A response standard of 75% within 8 minutes for Barnsley residents there is a risk that: (a) the quality and safety of patient care will be compromised (b) The reputation of the CCG with its stakeholders damaged. Responsible Committees need to continue to retain oversight of the issue until such time as it is deemed to have been resolved.
5.	**RISKS TO THE CLINICAL COMMISSIONING GROUP**
	The current report into the findings and discussions from the visit to the YAS Call Centre does not raise any specific risks however risks previously identified around YAS performance generally include: • Potential for the occurrence of Serious Incidents due to delays in responding to 999 calls • Insufficient scrutiny of related factors to ensure a comprehensive understanding of patient safety issues at the provider • Scrutiny of the CCG's commissioning by external sources • Reputational risk
6.	**APPENDICES TO THE REPORT**
	Appendix 1 - Emergency & Urgent Ambulance Service Contract Monitoring report (October 2014)
7.	**CONCLUSION**
	The Chief Nurse and Governing Body Member found the visit to the Call Centre to be extremely beneficial in furthering their understanding of the operational issues faced by the call centre staff and helped to put some of the things considered by the Committee into context. The Associate Medical Director has extended his offer of a visit to the Call Centre to other Governing Body Members/ Quality & Patient Safety Committee members should it be felt that this would be helpful.

Yorkshire Ambulance Service NHS
NHS Trust

An Aspirant Foundation Trust

Appendix D

MEETING TITLE Trust Management Group (TMG)		**MEETING DATE** 20/01/2015	
TITLE of PAPER	999 Quarterly Incident Report	**PAPER REF**	
STRATEGIC OBJECTIVE	To deliver clinically effective services which exceed regulatory and legislative standards To develop culture, systems and processes to support continuous improvement and innovation		
PURPOSE OF THE PAPER	To provide assurance to TMG that the contractual requirements of reporting to the Clinical Commissioning Groups (CCG) are being met. This report is shared with the CCGs and includes A&E, EOC and PTS. The contract requires a separate report for NHS 111 which accompanies this paper.		
For Approval	☐	**For Assurance**	☒
For Decision	☐	**Discussion/Information**	☒
AUTHOR / LEAD	Rebecca Mallinder (Risk Manager)	**ACCOUNTABLE DIRECTOR**	Executive Director of Standards & Compliance

DISCUSSED AT / INFORMED BY – include date(s) as appropriate *(free text – i.e. please provide an audit trail of the development(s)/proposal(s) subject of this paper)*:
Clinical Governance Group, Incident Review Group, Quality Committee

PREVIOUSLY AGREED AT:	**Committee/Group:** Senior Management Group	**Date:** 22/10/2014
RECOMMENDATION	It is recommended that TMG accept and approve the report and support the proposed recommendations.	

RISK ASSESSMENT	**Yes**	**No**
Corporate Risk Report and/or Board Assurance Framework	☐	☒
Resource Implications (Financial, Workforce, other - specify)	☐	☒
Legal implications/Regulatory requirements	☐	☒
Quality and Diversity Implications	☐	☒

ASSURANCE/COMPLIANCE	
Care Quality Commission Registration Outcome(s)	4: Care and welfare of people who use services 7: Safeguarding people who use services from abuse 16: Assessing and monitoring the quality of service provision
Monitor Governance Framework	All

Quarterly Incident Report
YAS
(A&E, EOC & PTS)
Q3 2014-15

1.0 INTRODUCTION

1.1 This report provides an overview of incident and Serious Incident (SI) analysis from Quarter 3 2014-15 (October 2014 – December 2014). It also highlights any lessons learned. The paper serves to provide assurance that the Trust is compliant with the contract requirements of the Yorkshire & Humber Commissioning Support. This report will cover YAS' Accident & Emergency (A&E) service, the Emergency Operations Centre (EOC) and the Patient Transport Service (PTS). The contract requires a separate report for NHS 111 and the two reports should be read in conjunction.

2.0 BACKGROUND / CONTEXT

2.1 The Incident Management Report Q3 2014-15 is the third quarterly report to be presented in this fiscal year.

2.2 **Part 1** of this report provides information on the following;

a) A breakdown of serious incidents (SIs).
b) Lessons learned and actions taken from serious incidents.

2.3 **Part 2** of this report provides information on the following:

a) A breakdown of the incidents reported during the previous 12 months and those during Quarter 3.
b) Lessons learned and actions taken

2.4 **Part 3**

a) Outline of proposed actions and next steps to be taken.

INCIDENT MANAGEMENT REPORT QUARTER 3, 2014/15

PART 1

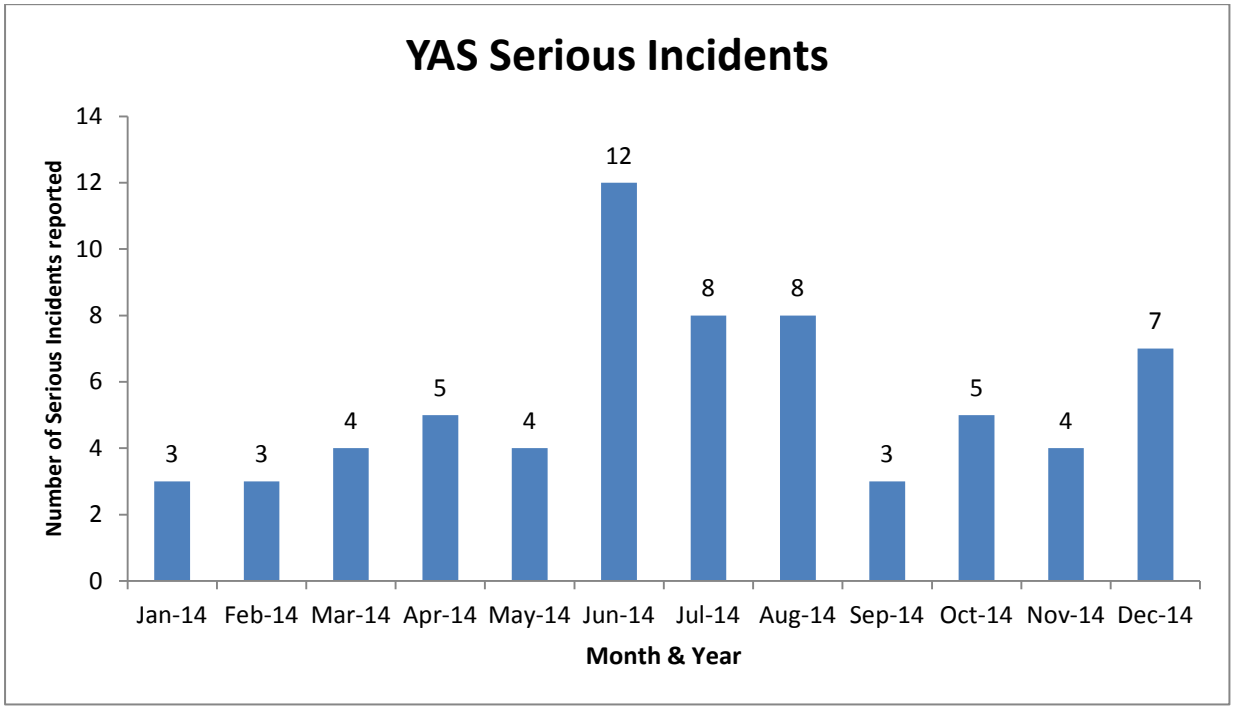
ANALYSIS OF SERIOUS INCIDENTS (SIs) REPORTED

This section contains the total number of 999 Serious Incidents (SIs) reported to Yorkshire & Humber Commissioning Support (via the STEIS electronic reporting system). These are generally incidents that have resulted in significant harm or death, or a serious 'near miss' that could have resulted in significant harm or death.

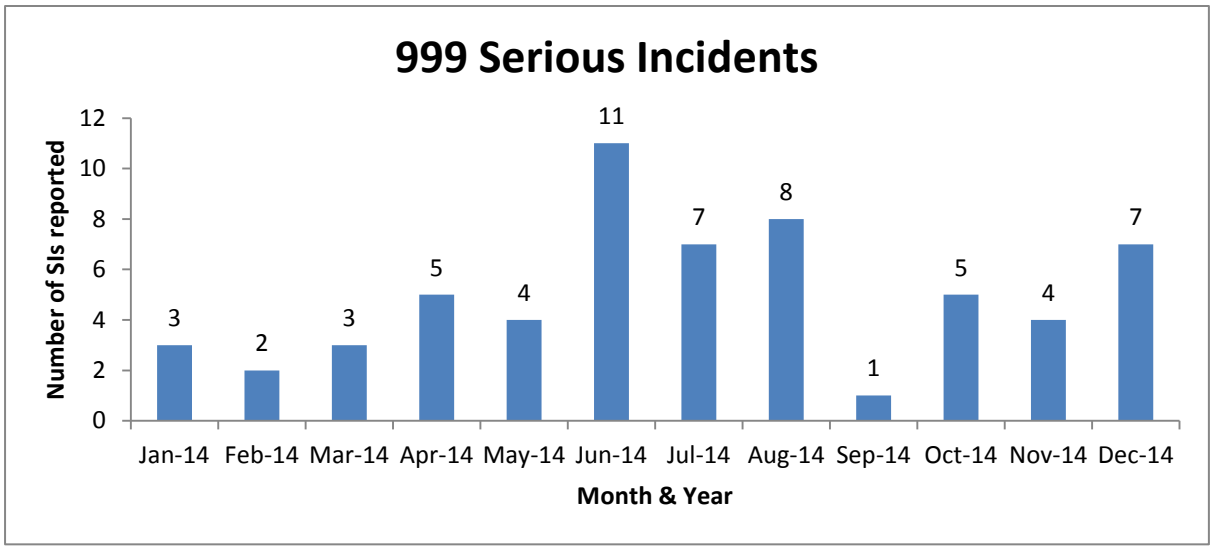
1.1 Number of Serious Incidents (SIs) and never events reported in each month for the 12 month period to the present

The Trust has not reported any Never Events throughout the last 12 months.

The bar chart below shows the total number of SIs reported across the Trust.



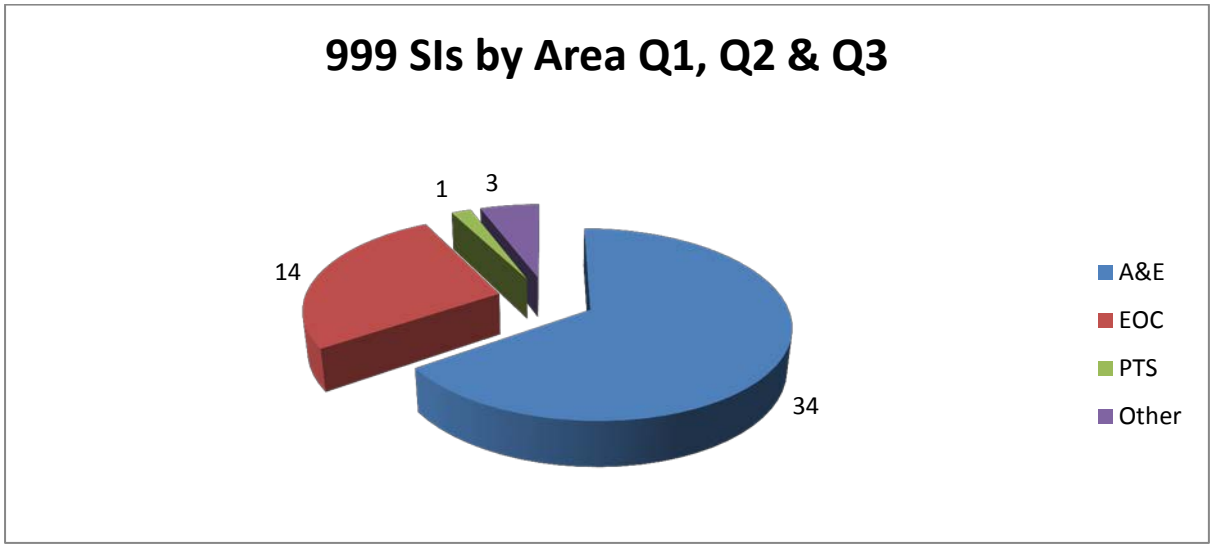
The bar chart below shows the SIs specific to A&E, EOC and PTS.



2014-15 has seen an increase in the number of Serious Incidents (SIs) reported in comparison to the previous 12 months. As highlighted in previous reports, there was an increase in SIs reported over the summer months and this was primarily a result of the increase in delayed responses (full analysis previously provided). Reported numbers during Q3 have returned back to within normal parameters with the exception of December where there was a spike. 4 of these incidents were delays in response, one related to a child death, one had issues around call coding and one related to clinical assessment and care.

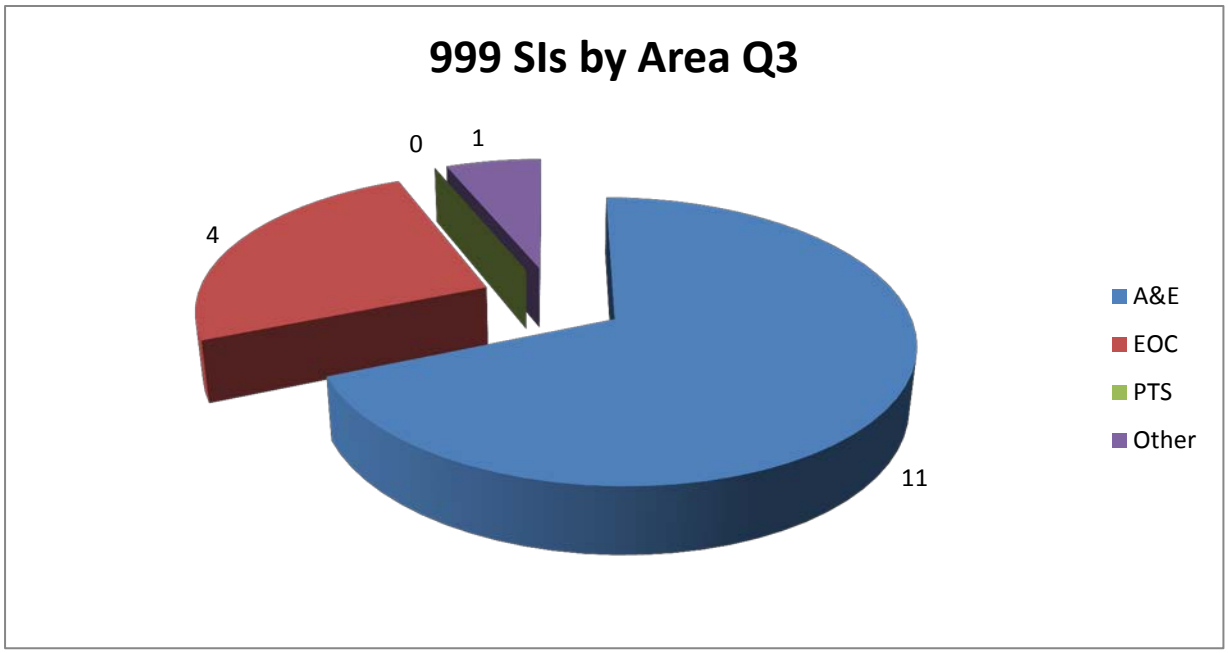
1.2. An overview of the category and severity of the serious incidents reported.

Overall for 14-15 to date, the breakdown of SIs is demonstrated below.

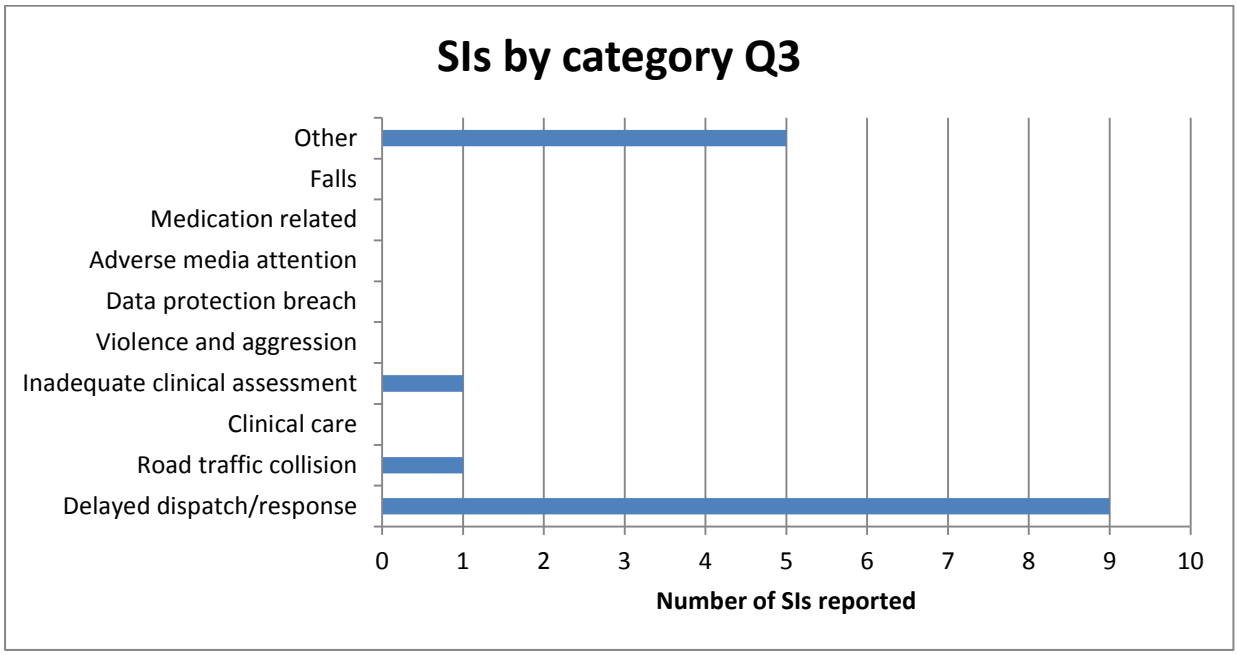


**The PTS SI has subsequently been de-logged due to the level of harm being lower than the threshold for SI criteria, which was only discovered during the investigation.*

For Quarter 3 specifically the breakdown is shown below.



The chart below shows the SIs by category in Q3.

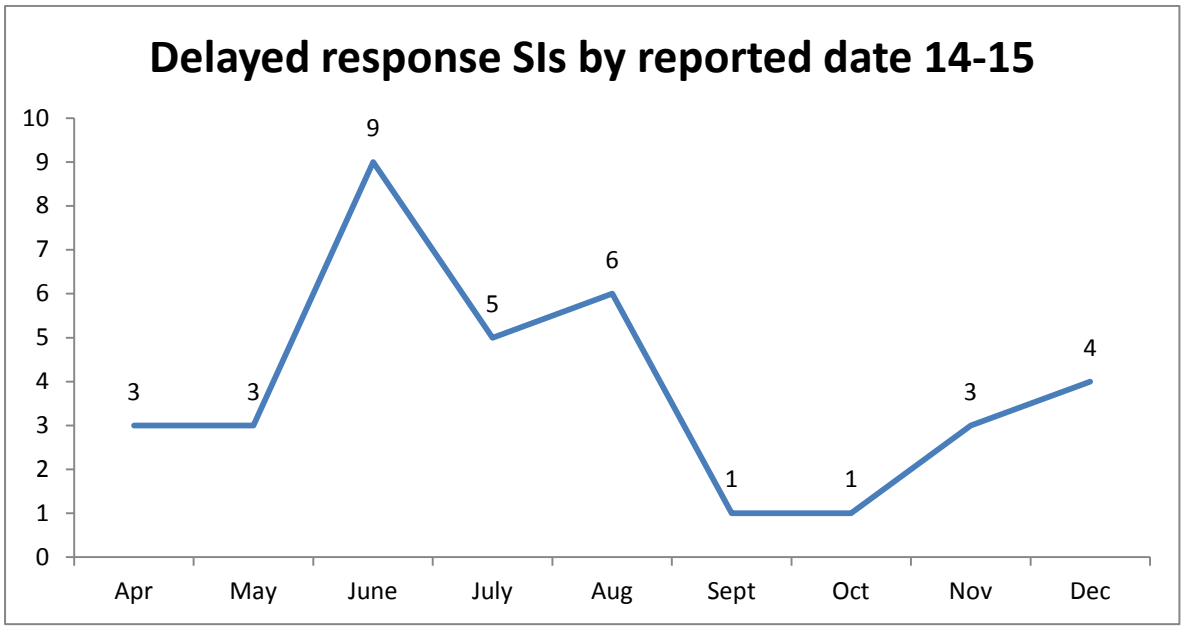


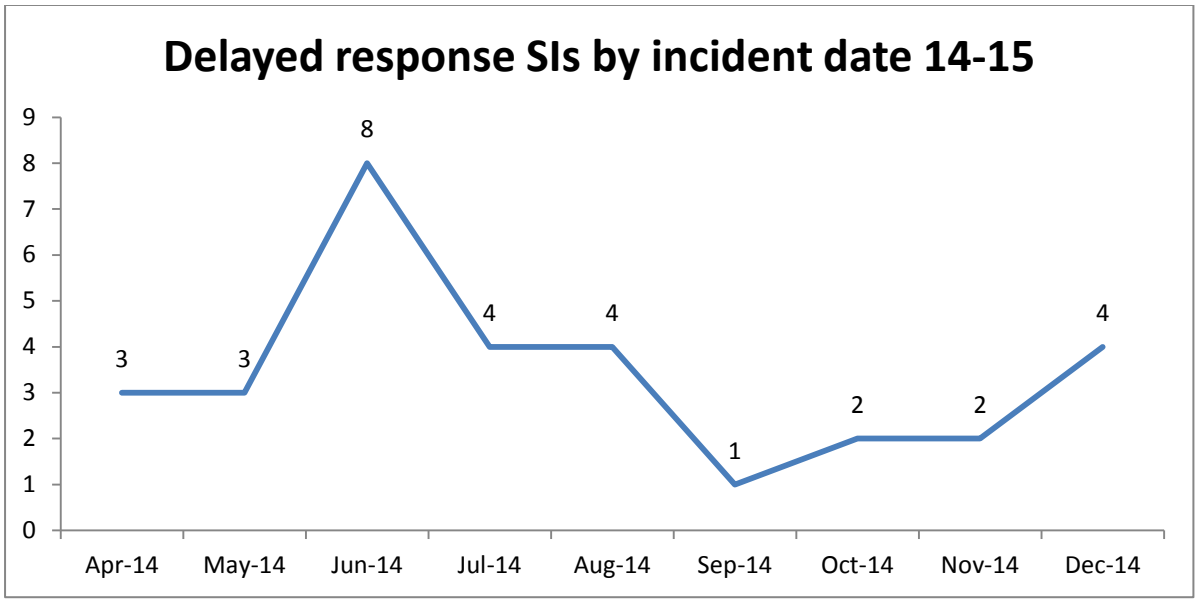
The 'other' incidents include lack of understanding in relation to a clinical pathway involving an acute hospital, a child death, management of a call from a third party and also including clinical care at a minor injuries unit, a system failure and a satellite navigation issue.

1.3 Identify themes and trends arising from the reported incidents with specific reference to the root cause and care and service delivery problems identified

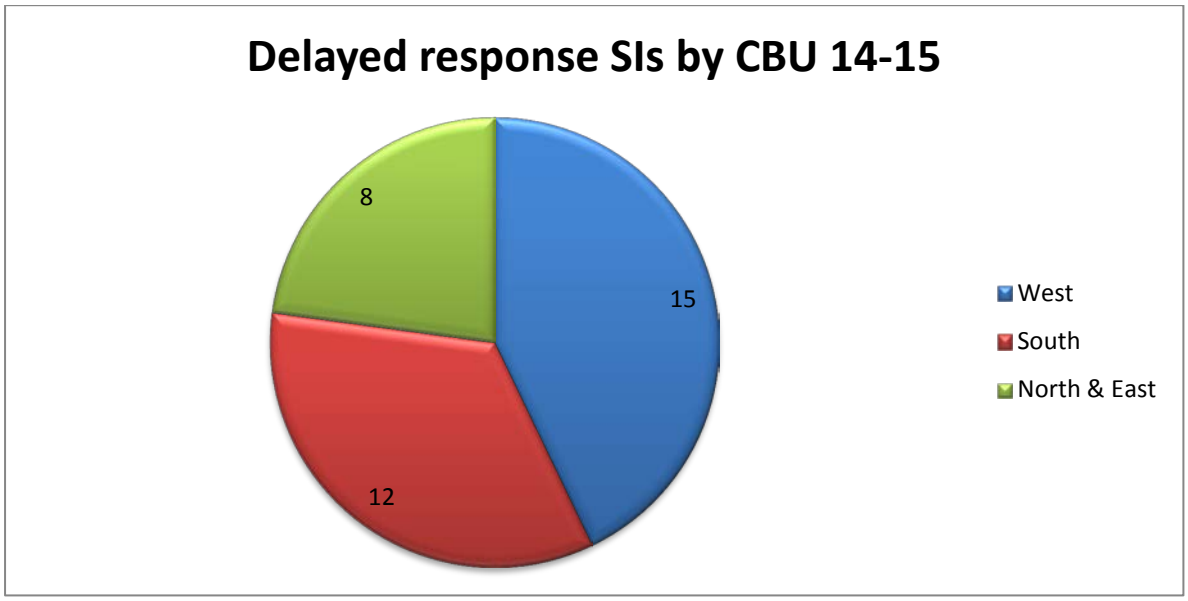
Similarly to Q2 the key theme arising from Q3 SIs relates to delays in response. Throughout this quarter analysis was undertaken on the delayed response SIs reported since April 2014 to identify the key themes and trends arising following investigation and to understand the true root causes.

Some of these SIs have involved delays involving coding errors & dispatch errors and some of these have been purely as a result of lack of available resource. The delayed response SIs are graphed below firstly by reported date and then by incident date.





The chart below shows the breakdown across the geographical area of the Trust.



The chart below shows the breakdown across the CCGs within Yorkshire.

Clinical Commissioning Group	Delayed response SIs
West	
Airedale, Wharfedale & Craven	2
Bradford City	1
Bradford Districts	4
Greater Huddersfield	2
Leeds North	1
Leeds West	1
North Kirklees	1
Wakefield	3
South	
Barnsley	1
Rotherham	2
Doncaster	4
Sheffield	5
North & East	
East Riding	3
Hull	3
Scarborough	1
Harrogate & Rural District	1

Of the 35 delayed response SIs reported during this period, as of 7 January, 7 of these are still under investigation therefore the following analysis is based on the 28 completed SI investigations.

The chart below identifies whether the SIs were delays in first response, delays in back up or both.

	Number of SIs
Delayed first response	22
Delayed back up	3
Delayed first response & back up	3

The following categories of root cause highlights the key issues arising from the investigations.

Root cause category	Number of SIs
Incorrect coding	5
Incorrect/inappropriate dispatch	4
Lack of available resource	17
Other	2

1.4 Compliance with the submission of investigation reports to the commissioner within specified timeframes and reasons for extensions

An inaugural meeting of the Commissioning CCG and CSU's agreed the principles of the National SI Reporting Framework, adopted from the original NPSA Framework by NHS England. This agreement is as follows:

- A 2 day notification to the CCG following declaration of an SI by YAS.
- A 45 day timeframe from notification of the SI to submission of the SI to the Commissioning CCG.

Of the 16 SIs reported during Q3, 9 of these were reported within 2 working days of YAS being made aware of the incident. The ones that were not reported within this timeframe either required further information to inform the SI decision or were highlighted to the Trust through other mechanisms i.e. safeguarding and did not immediately present themselves as possible SIs until further exploration had been undertaken.

Of the 29 open SIs (excluding NHS 111) at the end of December, one is beyond the 45 day report submission timescale. This is SI 2014.7701 which relates to potential abuse of controlled drug (CD) rights by an Emergency Care Practitioner (ECP). The police investigation was underway until mid-October 2014 where it concluded that there was no further action to be taken. YAS was then allowed to continue its investigation into this case and the report is expected to be submitted within the current extension, by the end of January 2015. Interventions were made following incident identification to strengthen YAS processes in relation to CDs as immediate actions taken.

At the time of report completion, YAS has 13 investigations underway, all expected to be completed within the required timescale (including the afore mentioned). YAS has 2 SIs to respond to review comments and therefore the remaining 14 SIs are with the CS and/or CCG for review or closure.

1.5 Confirm compliance with the Duty of Candour and detail any exceptions

Compliance with the Duty of Candour is currently being monitored via YAS Incident Review Group fortnightly. Any incidents reported on Datix and graded as having caused moderate or above harm to patients are considered under the Duty of Candour. For each SI reported the Being Open Policy is applied and where appropriate YAS contacts the patient and/or patient relative involved.

1.6 Specify the actions being taken aimed at improving practice to reduce the risk of recurrence and maintain the safety of patient care

The analysis provided in the sections above and in Part 2 of this report highlight the lessons learned that have been taken following incident and SI reporting in Q1 & Q2.

The table below provides information relating to the SI's reported in Q3 2014-2015 and where possible the root causes and lessons learned have been specified for the SIs in which the investigations have concluded. For those still under investigation, the root causes and lessons learned will be shared directly with commissioners as part of the SI review process and a summary of follow up to this learning will be provided in the Q3 report.

SI ref	Incident date	Description	Root Cause & Lessons Learned
2014/32079	01/10/2014	Delayed response to a 46 year old male with chest pains. Incorrect location entered which resulted in a 31 minute response to a RED 2.	R: Human error is the root cause of this incident. No additional changes to the system are recommended as the Yes / No prompt already exists and in most cases is an effective method of mitigating risk. L: To err is human, we need adequate barriers in place to safeguard against human error, in this case, the EOC have confirmed that system prompts are already present and are effective in the majority of cases.
2014/32200	02/10/2014	Whilst responding to an emergency call, a DCA was in collision with another vehicle which resulted in 3 patients being transported to hospital.	R: Whilst it has been found that the driver of the DCA acted appropriately in manoeuvring the traffic light controlled junction, this action involved an element of risk when proceeding through them whilst they were showing the red. The approaching car had travelled along a road that had a bend which meant there was less opportunity to see the ambulance any further in advance. L: Whilst it is not believed that the driver of the DCA acted inappropriately in approaching and negotiating the junction, collisions at traffic signals has been a regular occurrence across the Trust during the year. A poster campaign, video campaign and operational updates will be used to share the learning and key messages for staff.

2014/32250	01/10/2014	Delayed response to a 46 year old with chest pains. Satellite navigation system took vehicles to wrong location. Patient went into cardiac arrest	R: The automatic triangulation of co-ordinates had plotted the location of the incident to be pointing towards the back of the property, where there is no point of access. The satellite navigation system compounded this inaccuracy by not recognising that this point could not be accessed and providing an alternative route. A number of contributing factors have also been highlighted and will be addressed within the action plan. L: This investigation has highlighted the need for improved communication between EMD and attending responses as a general learning point. The knowledge management team need to be made aware of this inaccuracy in plotting the location.
2014/32349	04/10/2014	Delayed response to 34 year old male fitting	R: Lack of available resources to meet increased demand. L: EOC to be reminded about conducting the resource check as soon as possible. The Trust continues to monitor performance and make appropriate responses using the Operational Improvement Plan. This is reviewed on a weekly basis by the Executive Directors and learning cascaded accordingly.
2014/35009	13/10/2014	Several CAD outages during October with undiagnosed root cause.	R: At present it has not been possible for YAS or MIS to establish a root cause for the system failures. L: Ensure business continuity arrangements are in place and working effectively across all areas of the Trust to be able to manage system failures adequately ensuring patient safety.
2014/35811	31/10/2014	Delayed response to an 88 year old female.	Under investigation
2014/36035	03/11/2014	Delayed response to female stroke patient.	Under investigation
2014/36814	06/11/2014	Delayed back up to RRV.	Under investigation

2014/36864	08/11/2014	Delayed at hospital for a AAA transfer resulting in delayed treatment for critical patient.	Under investigation
2014/39425	06/11/2014	Child fitting was not administered drugs correct drugs prior to admission to hospital.	Under investigation
2014/40523	06/12/2014	Child Death - 4 year old drowning incident. Delay in response.	Under investigation
2014/40571	01/12/2014	Delay in response to a child who was suffering a severe allergic reaction.	Under investigation
2014/40578	05/12/2014	Delayed response to 10 year old fitting due to potential issues with coding on the AMPDS system.	Under investigation
2014/41038	13/12/2014	Call from a public place for 7 year old choking who was being taken to hospital. Investigation required into handling of calls, ambulance response and care delivered at MIU.	Under investigation
2014/41330	17/12/2014	Delayed response to 74 year old male cardiac arrest.	Under investigation
2014/41411	15/12/2014	Delayed response to 39 year old female.	Under investigation

1.7 Confirm that the action plans have been fully implemented in a timely fashion

All SI action plans are followed up internally by YAS' Risk & Safety team and evidence gathered to support the actions. These are done in accordance with the timescales specified within the investigation reports. An overview of the actions plans is submitted to the Quality Committee on a bi-monthly basis. The Trust presents evidence against completed actions at individual meetings with commissioners and an action plan tracker is monitored at the Patient Safety & Incident Sub Group.

1.8 Describe the effect of the actions implemented during the previous 12 months and further actions planned where required (where there is no reduction in cause, despite interventions being completed, further action plans will need to be developed)

Reported previously, YAS highlighted the success of a number of initiatives that have been implemented during the last 12 months, including the further development of the Patient Safety Thermometer and the reduction in falls across both the A&E and PTS service.

The Patient Safety Thermometer working group was expanded in September to be the Clinical Safety Improvement Group (CSIG) which takes key themes and trends identified via Incident Review Group (IRG) to develop work streams looking at improving patient safety. One of the work streams explored during Q3 was around analysing the care pathway related incidents to understand the real concerns. It was found that many of these were not actual care pathway incidents but had other elements involved and some was around staff understanding so work has been done to improve in this area.

The CSIG is also monitoring and managing the Sign up to Safety campaign that YAS is taking part in. The national pledges have been agreed to and YAS is currently developing a sepsis awareness programme as one of their specific pledges. This involves working with acute Trusts on pre-alerts and Early Warning Scores to ensure patients who are presenting with potential cases of sepsis, receive the quickest and most appropriate care intervention to help manage the condition.

The Sign up to Safety campaign is also developing key work streams in relation to improving incident reporting, lessons learned and enhancing a culture of being open and honest with staff and patients.

1.9 Specify the lessons learned and explain how they are shared within the organisation

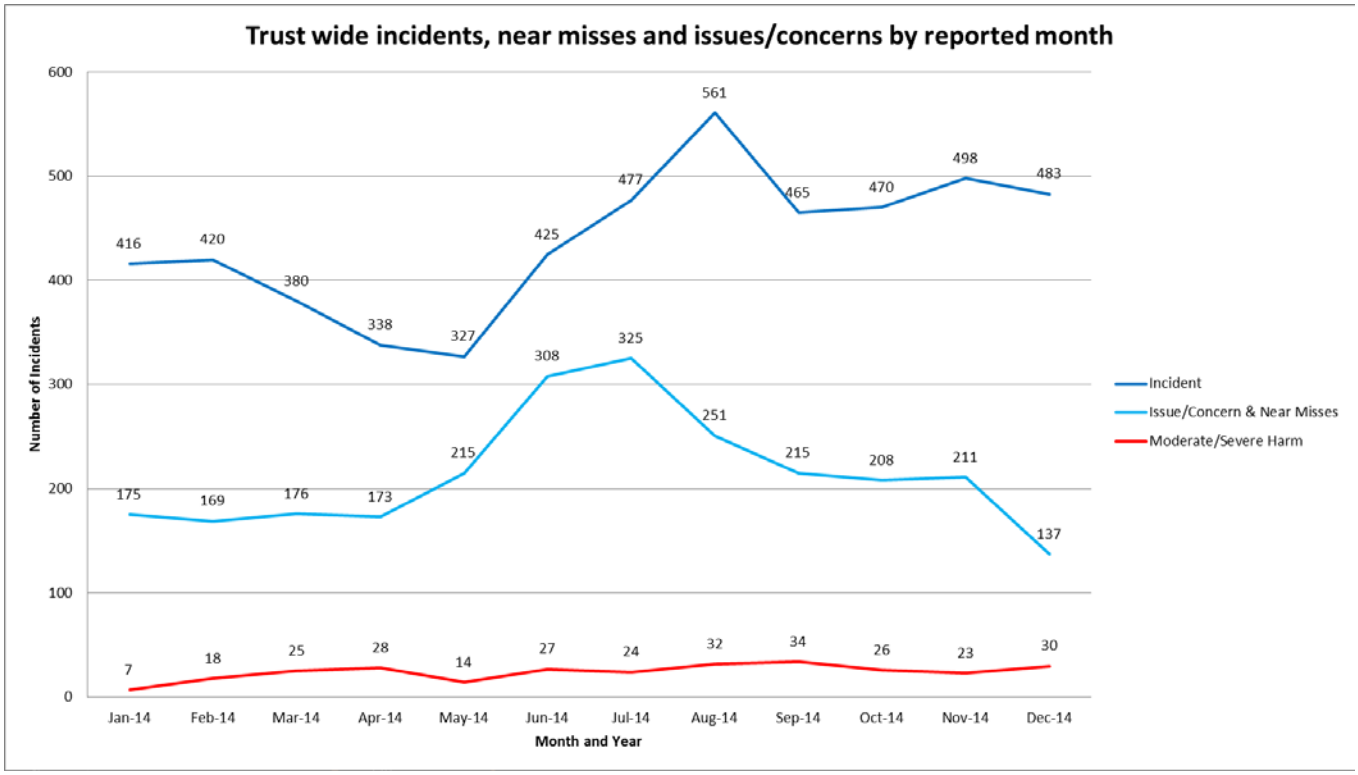
Key lessons arising from different themes and trends have been specified above. YAS ran a 'One week to make a difference' initiative during the first week of October which saw a large amount of resource focused on improving operational efficiency and quality of care. This included having a gold cell of staff responding immediately to any concerns raised by staff which was preventing efficient and high quality care.

This highlighted a number of key areas for the Trust to focus on over the coming months. One of the key issues was around fleet availability and this is now being progressed to ensure adequate resources are available across all geographic areas to help meet the demands upon the service.

PART 2

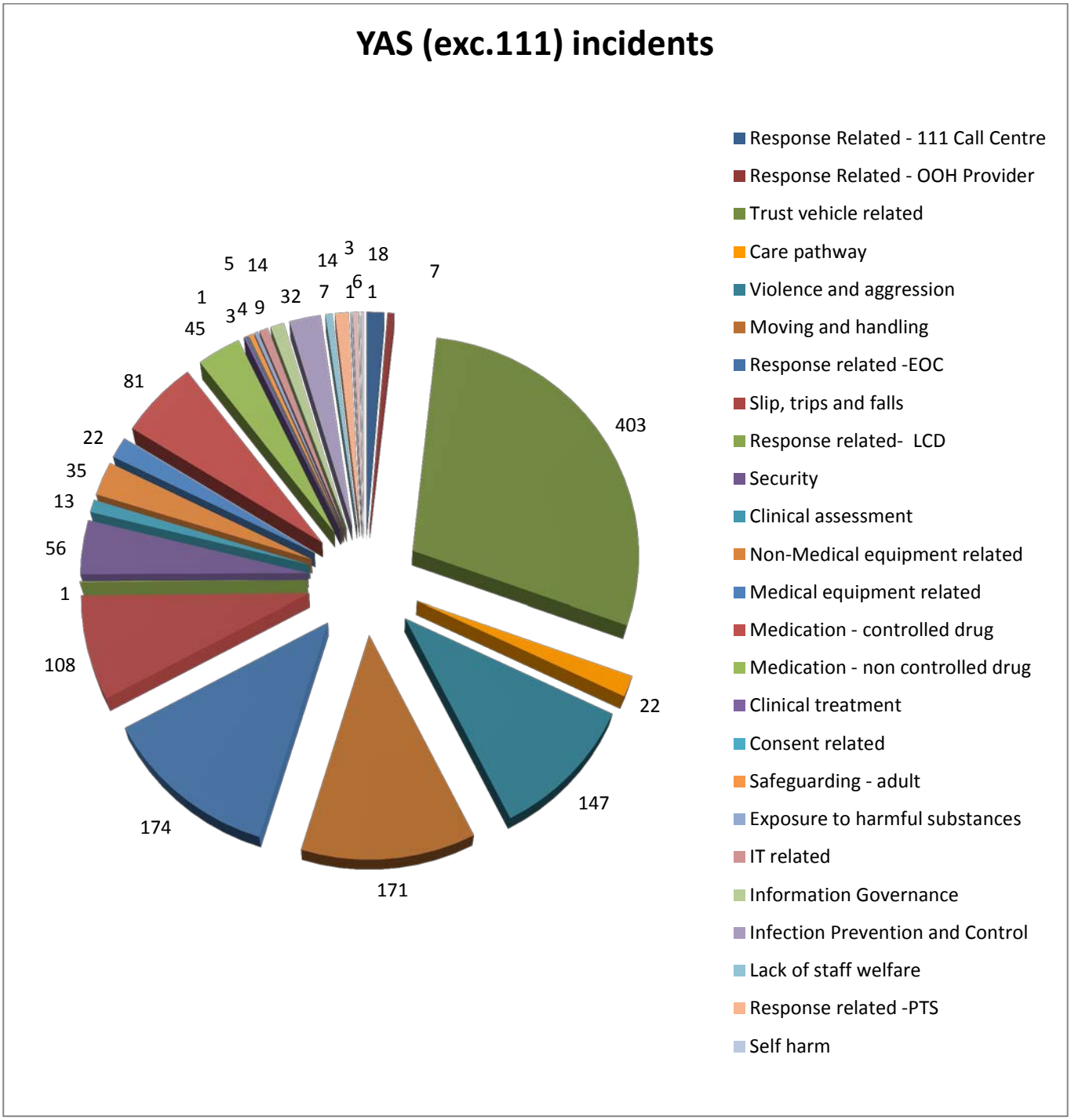
ANALYSIS OF PATIENT SAFETY INCIDENTS REPORT

2.1 Identify the numbers of incidents reported by month for the 12 month period to present

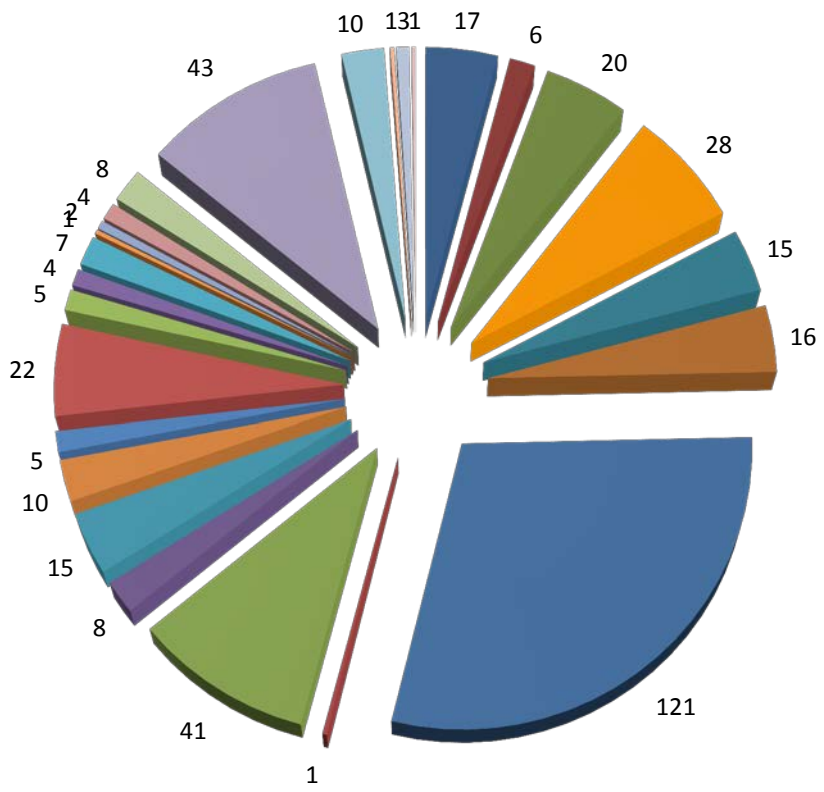


2.2 Include an overview of the category and severity of incidents reported, identifying the themes and trends arising from the reported incidents, with specific reference to the care and service delivery problems identified. Specify the key actions being taken aimed at improving practice to reduce risk and maintain the safety of patient care

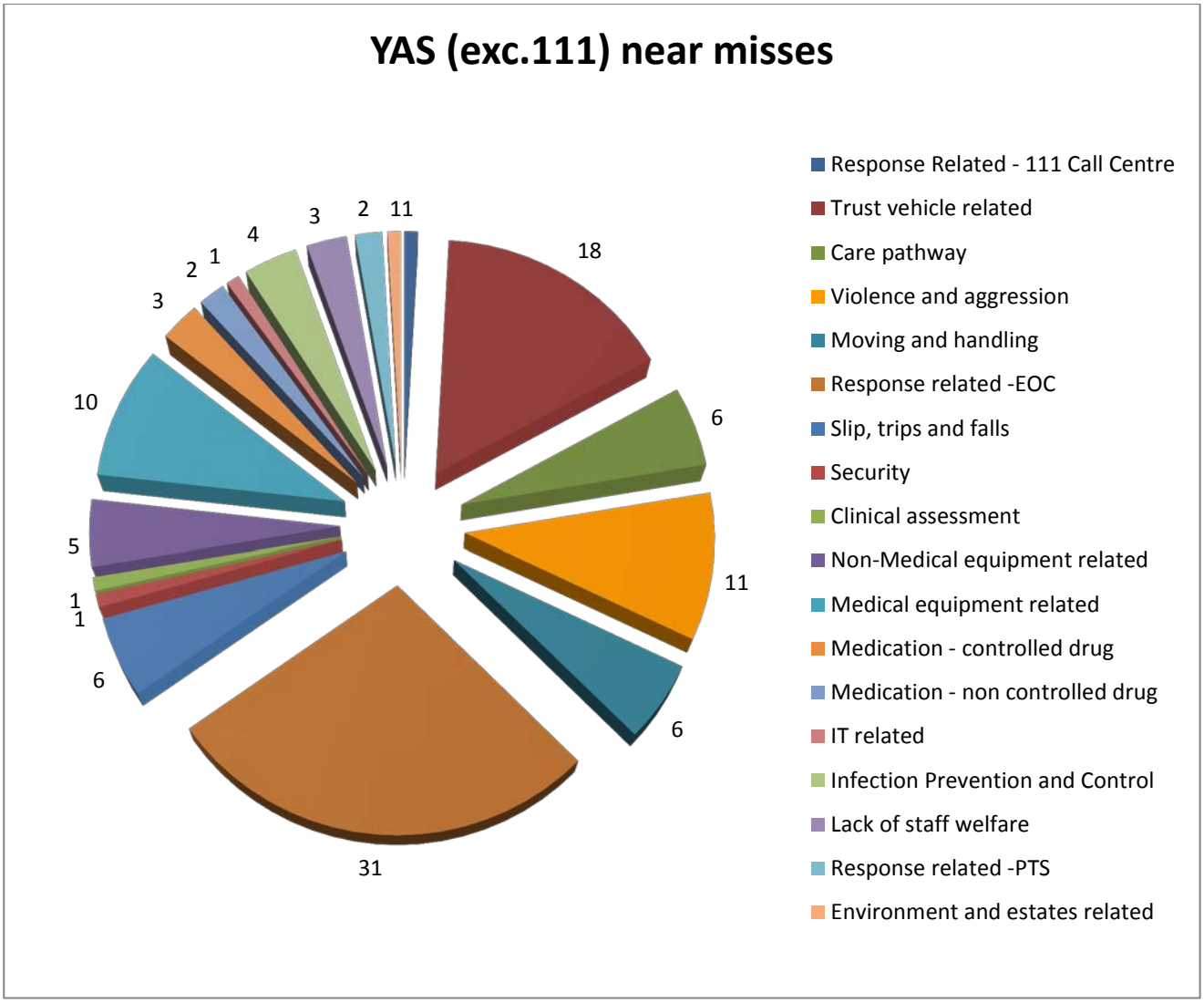
Incidents, Near Miss and Issues/Concerns reported Q3 for 14/15 - Top Categories



YAS (exc.111) issues/concerns



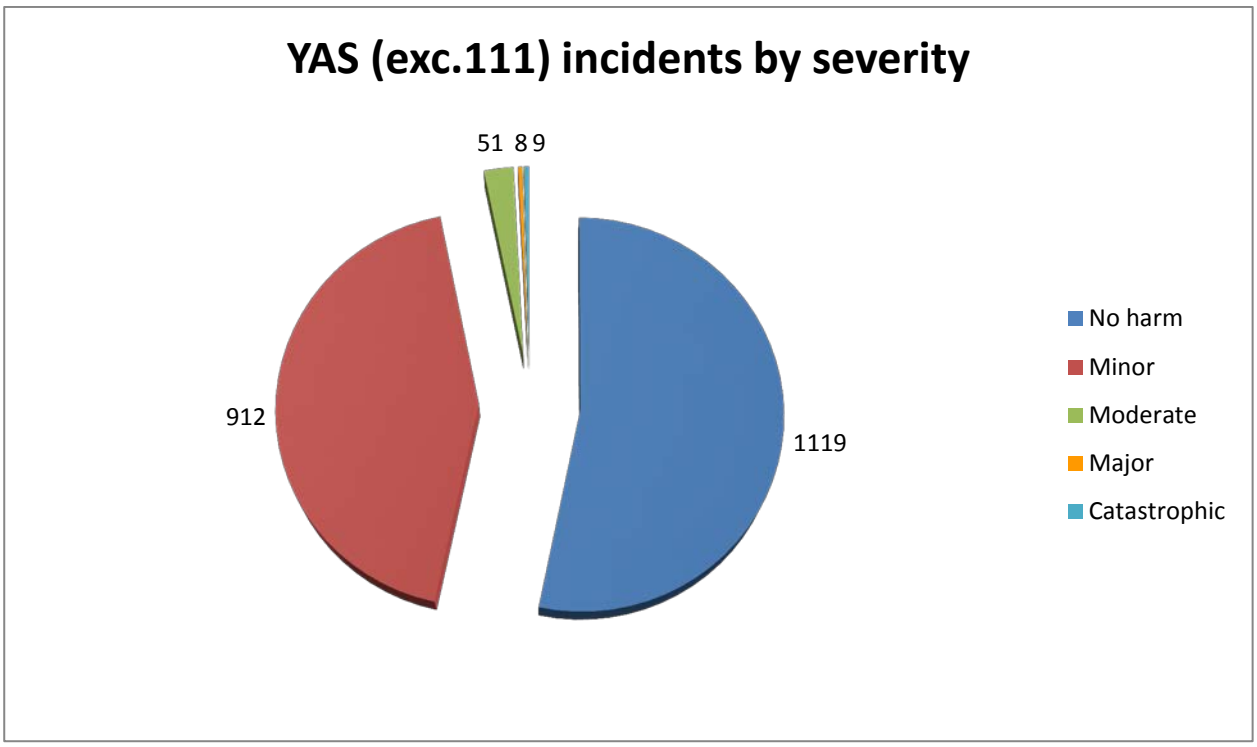
- Response Related - 111 Call Centre
- Response Related - OOH Provider
- Trust vehicle related
- Care pathway
- Violence and aggression
- Moving and handling
- Response related -EOC
- Response related- LCD
- Security
- Clinical assessment
- Non-Medical equipment related
- Medical equipment related
- Medication - controlled drug
- Medication - non controlled drug
- Clinical treatment
- Consent related
- Safeguarding - adult
- Safeguarding - children
- IT related
- Information Governance
- Infection Prevention and Control
- Lack of staff welfare
- Response related -PTS
- Self harm
- Environment and estates related



From the above analysis, the categories featuring prominently in incidents, near misses and issues/concerns are response related. Work is underway across the Trust to analyse the number of incidents passed from the 111 service to 999 and the impact this may have on the response and vice versa.

Trust vehicle related incidents remain a high category of reported incidents, as per previous quarters. Again, these are often minor bumps and collisions, not when staff are responding under emergency conditions. The Trust's Vehicle Accident Reduction Manager is working with the other ambulance trusts nationally on an awareness raising campaign. This will include a video highlighting the common themes and trends as well as the associated costs that these collisions have.

Incidents by severity



As the above chart demonstrates, the majority of incidents reported have resulted in no harm caused to patients and/or staff. Of the incidents which resulted in harm, many of these are coded as having caused minor harm. A small number (in comparision to overall incident figures) of incidents have resulted in moderate or above harm. These incidents are reviewed at the fortnightly Incident Review Group (IRG) chaired by the Executive Medical Director and the Executive Director of Standards & Compliance to review any potential SIs and to understand key actions that need to be taken.

2.3 The details of any reports or recommendations issued by a Coroner

None to be reported during Q3.

PART 3 PROPOSED ACTIONS AND NEXT STEPS

Continue to monitor risk systems through implementation of operational procedures and policies, Commissioning arrangements, and Internal Audit annual plan, and continue to address recommendations where required.

The Trust continues to be committed to providing a high quality and safe service to all patients across Yorkshire. Work will continue on a real-time basis to identify any harm caused to patients as a result of delays in response and/or delays in back up. Weekly and monthly monitoring of this also continues ensuring appropriate actions are put in place to rectify any issues identified. This information is being monitored on a Trust wide level as well as interrogation at a CCG level to inform any decision making.

Reports will continue to be presented to commissioners and updates on patient safety will be presented as normal via the quarterly CBU meetings, the bi-monthly Patient Safety & Incident Sub-Group and through the Contract Management Board.

Appendix E

Barnsley CCG Action Plan

	Theme	Action Required	Lead Person	Timescale	Evidence of completion
1	SAFETY	Seek evidence of impact of delayed responses on safety A) Systems B) Serious Incident Analysis	Chief Nurse & Medical Director	Before March Governing Body	Meeting on 4/3/15 shared with Governing Body
		Monitor on monthly basis and escalate any concerns to the Governing Body	Q & PS	Monthly	
		Regular review of Risk Register 14/5 a	Q & PS	Monthly	
		Ensure raised at South Yorkshire Quality Surveillance Group	Chief Nurse	April 15	
		Facilitate real time QA visits for GB members	Chief Nurse	Ongoing	
		Request Healthwatch maintain intelligence gathering	Chief Nurse	Ongoing	

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	Theme	Action Required	Lead Person	Timescale	Evidence of completion
2	PERFORMANCE	Meeting of Governing Body with YAS Executive Team to discuss performance remediation including Resource capacity Reduction of drift	Chair	26/3/15	Set up In progress
		Revise suite of YAS performance data to be made available to Finance & Performance committee	Head of Performance & Planning	April 15	
		Review CCG relationship with lead commissioner for South Yorkshire to ensure timely and effective communication to aid remediation	Chief Officer	April 15	

DRAFT

	Theme	Action Required	Lead Person	Timescale	Evidence of completion
3	SUSTAINABILITY	Seek assurances from YAS that measures to improve 1) & 2) are owned at all levels within YAS – particularly at middle management Through monitoring of 1) and 2) by QP&S and F&P the indications of sustainability or further risk is considered by the Governing Body and resulting actions taken to either escalate concerns with NHSE or proportionately reduce scrutiny	Chair through 26/3/15 meeting Governing Body	26/3/15 Ongoing	

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NHS
Barnsley Clinical Commissioning Group

Putting Barnsley People First

GOVERNING BODY

12 March 2015

RISK AND GOVERNANCE EXCEPTION REPORT

1.	**PURPOSE OF THE REPORT**
	To provide the Governing Body with the Risk and Governance Exception Report.
2.	**EXECUTIVE SUMMARY**
	The CCG's Assurance Framework and Risk Register provide the Governing Body with an overarching framework to manage all organisational risk: • the ***Governing Body Assurance Framework (GBAF)*** facilitates the Governing Body in assuring the delivery of the CCG's annual strategic objectives • the ***Risk Register*** is a mechanism to effectively manage the current risks to the organisation. **Governing Body Assurance Framework** The full GBAF is appended to this report. The three risks on the GBAF rated as red (extreme) are: • 1.1 If the CCG is unable effectively to manage the tension between BHNFT's roles as both a partner and a provider of services to the CCG, there is a risk that the CCG will fail to work effectively with BHNFT, resulting in failure to commission high quality health care that meets the needs of individuals and groups. • 3.1 If the CCG is not sufficiently clear on where it wants to be after 5 years, there is a risk that its operational business planning will not be appropriately integrated with or aligned to its long term objectives, resulting in a failure to support BHNFT in delivering safe and sustainable local hospital services, whilst transforming the way they provide services so that they are as efficient and effective as possible for the people of Barnsley. • 4.1 If the CCG is unable effectively to influence partners through the Health & Wellbeing Board, there is a risk that the Board will not articulate a clear 'sense of place' (strategy for Barnsley) or develop a strong sense of mutual accountability (eg for the Better Care Fund), which could result

in failure to deliver more joined up, higher quality, efficient and effective services for the people of Barnsley which address the priority areas in the JSNA.

The Governing Body should consider whether these risks continue to be managed and scored appropriately.

Corporate Risk Register

The full Risk Register is appended to this report. There are currently six extreme risks on the CCG's Risk Register which have been escalated to the Assurance Framework as gaps in assurance against risks on the Assurance Framework. The risks are:

- Ref CCG 13/1 (rated score 16 'extreme') – Non achievement of Health Care Acquired Infection Trajectory for C Difficile & MRSA

- Ref CCG 13/10 (rated score 16 'extreme') – The Hospital Standardised Mortality Ratio for the BHNFT is higher than expected

- Ref CCG 14/5a (rated score 25 'extreme') – Quality & patient safety risks relating to Yorkshire Ambulance Service (YAS) under achieving against the Category A response standard of 75% within 8 minutes), and also the hand over and turn around time standards

- Ref CCG 14/5b (rated score 20 'extreme') – Contractual and reputational risks relating to Yorkshire Ambulance Service (YAS) under achieving against the Category A response standard of 75% within 8 minutes), and also the hand over and turn around time standards

- Ref CCG 14/11 (rated score 15 'extreme') - BHNFT under performance in respect of people waiting > 6 weeks for diagnostic tests (eg due to lack of ultrasound capacity)

- Ref CCG 14/15 (rated score 16 'extreme') – Potential impact on quality & patient safety of incomplete D1 discharge letters.

Following discussion at the Finance & Performance Committee on 5 March 2015 two risks which were previously rated as extreme risks on the Risk Register have been de-escalated to high risk status and therefore removed from the GBAF. Those risks are:

- Ref CCG 13/3– Four Hour Operational Standard: score reduced from 16 (extreme) to 12 (high) due to improved performance across the year and removal of Monitor's licensing condition.

- Ref CCG 14/13 - Potential impact on the urgent care system in Barnsley as a result of the loss of 30 intermediate care beds from April 2015: score reduced from 20 (extreme) to 8 (high) as a result of the decision to fund the beds from the Better Care Fund.

One risk (ref CCG 13/35 - Impact of Local Authority actions around minimum

	council and social care reductions) has been removed from the Risk Register during February 2015 as it duplicates risk 14/13. The CCG's Committees continue to review and manage all the risks identified. **Information Governance Update** The CCG recognises the importance of reliable information, both in terms of the clinical management of individual patients and the efficient management of services and resources. The **Information Governance Toolkit** is a performance tool produced by the Department of Health (DH) and now hosted by the Health and Social Care Information Centre (HSCIC). It draws together the legal rules and central guidance and presents them in one place as a set of information governance requirements. CCGs and other health bodies are required to carry out self-assessments of their compliance against the IG requirements. The CCG's self-assessment must be completed and uploaded by **31 March 2015.** The Department of Health requires that CCG's achieve at least the minimum level 2 standard against all elements of the toolkit by this date. The CCG was able to achieve the required standards in 2013/14. During the current year, under the oversight of the IG Group, the CCG has implemented an improvement plan to further embed information governance within the CCG. A recently completed Internal Audit review of the CCG's process to complete the Toolkit assessment, and the evidence to support a sample of the standards, provided a significant assurance opinion. As a result, the Governing Body can be assured that the CCG will again meet the required standards in its 2015-16 IG Toolkit submission. The CSU IG Lead is currently uploading all the necessary evidence to support the Toolkit. Once this process is complete it is proposed that the Head of Assurance reviews and signs off the evidence to ensure it is accurate and complete before seeking IG Group's approval to submit the Toolkit by 27 March at the latest. The Governing Body is asked to authorise the IG Group to submit the IG Toolkit on its behalf.
3.	**THE GOVERNING BODY IS ASKED TO:** • Consider and agree whether the risks on the GBAF are appropriately scored and whether there is sufficient assurance that they are being effectively managed as at 12 March 2015 • Review the Corporate Risk Register, and in particular review the risks rated as extreme on the Risk Register • Review the risks escalated from the Risk Register as gaps in control against risks on the Assurance Framework • Authorise the IG Group to submit the IG Toolkit on its behalf.

GB/Pu/15/03/15

Agenda time allocation for report:	10 minutes.
Report of:	Vicky Peverelle
Designation:	Chief of Corporate Affairs
Report Prepared by:	Richard Walker
Designation:	Head of Assurance

1.	**SUPPORTING INFORMATION**	
1.1	**Links to the Assurance Framework**	
	The requirement for the CCG to have an Assurance framework and Risk Register is documented in the Integrated Risk Management Framework 2013/14.	
1.2	**Links to Objectives**	
	To have the highest quality of governance and processes to support its business	✓
	To commission high quality health care that meets the needs of individuals and groups	✓
	Wherever it makes safe clinical sense to bring care closer to home	✓
	To support a safe and sustainable local hospital, supporting them to transform the way they provide services so that they are as efficient and effective as possible for the people of Barnsley	✓
	To develop services through real partnerships with mutual accountability and strong governance that improve health and health care and effectively use the Barnsley £.	✓
1.3	**Governance Arrangements Checklist**	**Has the area been considered (yes / no / not relevant)?**
	Financial Implications	Not relevant – report for information
	Contracting Implications	As above
	Quality	As above
	Consultation / Engagement	As above
	Equality and Diversity	As above
	Information Governance	As above
	Environmental Sustainability	As above
	Human Resources	As above

Barnsley CCG: Summary of Governing Body Assurance Framework 2014/15

Introduction

The Governing Body Assurance Framework aims to identify the principal or strategic risks to the delivery of the CGG's strategic objectives. It sets out the controls that are in place to manage the risks and the assurances that show if the controls are having the desired impact. It identifies the gaps in control and hence the key mitigating actions required to reduce the risks towards the target or appetite risk score. It also identifies any gaps in assurance and what actions can be taken to increase assurance to the CCG. The table below sets out the strategic objectives, lists the principal risks that relate to them, and highlights where gaps in control or assurance have been identified. Further details can be found on the support pages for each of the Principal Risks.

Strategic Objective	Principal Risk(s)	Risk Owner	Initial score	Current score	Risk app'tite	Gaps in control	Gaps in ass'ce
Commission high quality health care that meets the needs of individuals and groups	1.1 If the CCG is unable effectively to manage the tension between BHNFT, SWPPFT, and BMBC's roles as both partners and providers of services to the CCG, there is a risk that the CCG will fail to work effectively with its key providers, resulting in failure to commission high quality health care that meets the needs of individuals and groups.	QPSC	16	20	12	Monitor license cond'ions	HCAI, HSMR, A&E, YAS, IC beds
	1.2 If the CCG does not engage effectively with the people of Barnsley there is a risk that it will not fully understand the needs of individuals and groups in the area, resulting in failure to commission high quality health care that meets their needs.	PPE	6	6	12		
	1.3 If the CCG's commissioning priorities are not ambitious, sufficient, outcome focused, and appropriate there is a risk that required improvements in health care will not be achieved, resulting in the needs of individuals and groups not being met.	FPC	12	12	12		Tracking impact due to time lags
	1.4 If the CCG's contracting arrangements are not effective, there is a risk that commissioning priorities, CQUINS, and Quality Premium outcomes will not be delivered, leading to poorer quality care and a negative impact on the CCG's financial position.	FPC	9	9	12	Monitor license cond'ions	HCAI, A&E, PYLL. YAS, Diag'tics
	1.5 If (with support where appropriate from the CCG) our providers cannot effectively manage the financial pressures they are facing, there is a risk that those pressures will lead to a deterioration in the quality and safety of services provided, resulting in failure to commission high quality health care that meets the needs of individuals and groups.	QPSC	12	12	12	Monitor license cond'ions	BMBC balanced plan; issues at BHNFT

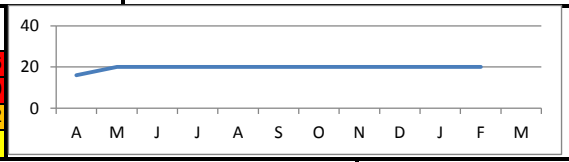
Barnsley CCG: Summary of Governing Body Assurance Framework 2014/15

Strategic Objective	Principal Risk(s)	Risk Owner	Initial score	Current score	Risk app'tite	Gaps in control	Gaps in ass'ce
Wherever it makes safe clinical sense to bring care closer to home	2.1 If the CCG fails to deliver the Primary Care Strategy, due to failure to engage with GP Practices, lack of capacity within the CCG, OR failure to ensure primary care workforce development, there is a risk that care will be moved closer to home inappropriately or inconsistently across the district, resulting in an adverse effect on health inequalities in Barnsley.	QPSC	12	12	12	Lead time to build capacity	IC beds
To support safe and sustainable local hospital	3.1 If the CCG is not sufficiently clear on where it wants to be after 5 years, there is a risk that its operational business planning will not be appropriately integrated with or aligned to its long term objectives, resulting in a failure to support BHNFT in delivering safe and sustainable local hospital services, whilst transforming the way they provide services so that they are as efficient and effective as possible for the people of Barnsley.	FPC	12	20	12		Fin pressure at main providers could affect quality
To develop services through real partnerships with mutual accountability and strong governance	4.1 If the CCG is unable effectively to influence partners through the Health & Wellbeing Board, there is a risk that the Board will not articulate a clear 'sense of place' (strategy for Barnsley) or develop a strong sense of mutual accountability (eg for the Better Care Fund), which could result in failure to deliver more joined up, higher quality, efficient and effective services for the people of Barnsley which address the priority areas in the JSNA.	FPC	12	16	12		Gov'ce re BCF still being developed
Highest quality governance and processes	5.1 If the CCG does not appropriately identify and assess client need in relation to safeguarding there is a risk of failure to commission services that safeguard vulnerable clients; AND if the CCG does not ensure our support to direct commissioning of care homes (BMBC) with professional advice is effectively acted upon there is a risk of failure to deliver our adult safeguarding responsibilities to people in Care Homes.	QPSC	8	12	12		
	5.2 If the CCG fails to deliver its statutory duties, due to weaknesses in its corporate governance and control arrangements, it will result in legal, financial, and / or reputational risks to the CCG and its employees.	AC	8	8	12		

Objective 1: To commission high quality health care that meets the needs of individuals and groups	***NHSE Domains:*** ***1, 3, 4, 6*** ***Risk register: Extreme - 13/1, 13/3/ 13/10, 13/35, 14/5a, 14/13, 14/15; High - 13/15, 13/17, 14/6, 14/7, 14/8.***	*Clinical / Lay Lead* *Executive lead* MG, BR *Committee* QPSC

What would success look like?	**Principal threat(s) to delivery of the objective**
Improved outcomes for patients. Improved performance by providers in delivery of all key performance measures inc A&E waits, HCAI, and HSMR.	1.1 If the CCG is unable effectively to manage the tension between BHNFT, SWPPFT, and BMBC's roles as both partners and providers of services to the CCG, there is a risk that the CCG will fail to work effectively with its key providers, resulting in failure to commission high quality health care that meets the needs of individuals and groups.

Risk rating	Likelihood	Consequence	**Total**
Initial	4	4	16
Current	4	5	20
Appetite	3	4	12
Approach	**Treat**		



Date reviewed	**Mar-15**

Rationale: Historic poor performance by BHNFT & SWYPFT against some key quality measures means likelihood of failure is high. Consequence of failure catastrophic owing to impact on patient care.

Key controls to mitigate threat:	**Sources of assurance**
Contract monitoring meetings with BHNFT & SWPFT	Minutes go to FPC
Quality & Performance Group meetings with BHNFT & SWYPFT	Quality & performance group minutes go to QPSC
CCG represented at Quality Surveillance Group	QSG updates go to QPSC
Quality Team reviews incident reports	Patient Safety Report to every meeting of QPSC
CQUINs built into contracts & monitored through Quality & Performance Meetings	Quality & Performance group minutes go to QPSC
Joint commissioning arrangements with BMBC	Minutes of Joint Commissioning meetings
Self assessment for NHSE assurance process	Delivery dashboard; NHSE assurance letters taken to GB
Real time assurance via Clinically Led Quality Assurance visits to main providers	Reports back to QPSC
CCG to work with Healthwatch to develop a grass roots report to understand public perceptions of the quality of services	To be included in Integrated Performance Reports to F&PC
Regular reports on Quality to Governing Body	QPSC minutes and (from May 2014) Quality Highlights Reports to Gov Body every month; annual QPSC report is presented; ad hoc reports to GB on specific issues.

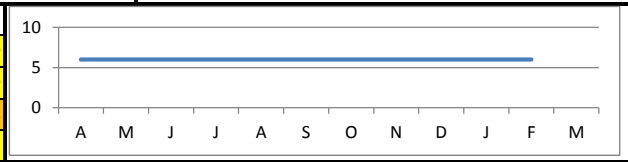
Gaps in control	**Positive assurances received**
Monitor has applied licence conditions and enforcement undertakings in relation to the A and E performance pursuant with conditions under FT4 ((5)a,(5)c,(6) & (7)	Mar-15: there has been a significant improvement in BHNFT's performance throughout the year. Monitor's license condition re A&E has now been lifted although financial conditions remain in place. There were positive findings from unannounced visit to A&E 9.6.2014. As a result this risk has been de-escalated to a 12 on the risk register and removed from the GBAF.

Gaps in assurance	**Actions being taken to address gaps in control / assurance**
HCAI rates above target in 2014/15 (RR 13/1). (Mar-15: no cases of MRSA in year to date and incidence of Cdiff below trajectory).	Cdiff action plan; additional commissioning capacity for infection control; project to identify future service models and commissioning arrangements progressing at pace; regular reports on infection control to QPSC
HSMR rate at BHNFT higher than expected (RR 13/10).	Ongoing monitoring of mortality rates eg MD attends mortality review meetings at BHNFT; reporting via QPSC; work with Trust and Aqua. The CCG has now received a copy of the Advancing Quality Alliance (AQuA) independent “deep dive” review report of hospital mortality for BHNFT. The Trust is developing an action plan in response to the review. The Quality & Patient Safety Committee will continue to seek assurance from the Trust that the action plan is being delivered.
YAS is currently under achieving against the Category A response standard of 75% within 8 minutes for Barnsley residents, with potential impacts on the quality of care for Barnsley residents (RR 14/5a).	Ongoing work with YAS to better understand and mitigate impact of under performance on the quality and safety of care for Barnsley residents, through breach analysis, review of serious incidents etc. YAS senior managers will be meeting with the CCG Governing Body on 26 March in light of ongoing poor performance.
Potential for harm to patients if the quality and completeness of D1 discharge letters is not improved. (RR 14/15)	Audit undertaken, results shared with Trust, action plan requested. Follow up audit to be carried out. Issue raised with Trust's medical director. D1 completion to be included within the core contract for 2015/16 with financial penalties if not met.

Objective 1: To commission high quality health care that meets the needs of individuals and groups	***NHSE Domains:***	***1, 2, 3, 4, 6***	*Clinical / Lay Lead*	CR
	Risk register:	***High: 13/13***	*Executive lead*	VP
			Committee	PPE

What would success look like?	**Principal threat(s) to delivery of the objective**
Commissioning plans clearly reflect the stated needs and preferences of individuals and groups in the area.	1.2 If the CCG does not engage effectively with the people of Barnsley there is a risk that it will not fully understand the needs of individuals and groups in the area, resulting in failure to commission high quality health care that meets their needs.

Risk rating	Likelihood	Consequence	**Total**
Initial	2	3	6
Current	2	3	6
Appetite	3	4	12
Approach	**Tolerate**		



Date reviewed	**Mar-15**
Rationale: Risk judged unlikely to occur due to well established arrangements in place. Consequence of risk occurring is moderate as patients are affected indirectly.	

Key controls to mitigate threat:	**Sources of assurance**
Robust management structure (Lay Member, Officer, & CSU leads in place)	Monitored through PPE Committee & PPE Operational Delivery Group
Committee report & business case template prompt consideration of engagement	Reports & business cases reviewed by relevant committees of the CCG
PPE strategy in place (updated strategy approved April 2014)	Monitored through PPE Committee & PPE Operational Delivery Group
PPE Committee in place with a work plan in place to ensure delivery of its ToR	ToR approved by GB; annual report to GB provides assurance re delivery of ToR
Commissioning Plan includes a section on engagement	Commissioning plan signed off by GB and membership Council & subject to NHSE review & challenge
OPEN network established	
Patient Council now well established	Patient Council minutes to PPE Committee
Regular engagement with Barnsley Healthwatch	Intelligence Sharing feedback via PPE committee. Healthwatch now attends Equality Steering Group and will also attend the Primary Care Commisiioning Committee when it commences in April 2015.
Patient Reference Groups established, PRG DES in place, PPE project work underway.	Annual evaluation of PRG effectiveness. PPE Committee (Jan-15) agreed to extend the project by 6 months to 30 September 2015.
Community Assets Model approved by Governing Body	Monitored through PPE Committee & PPE Operational Delivery Group
NHSE Assurance process includes assessment of effectiveness of engagement	NHSE assurance letters to GB

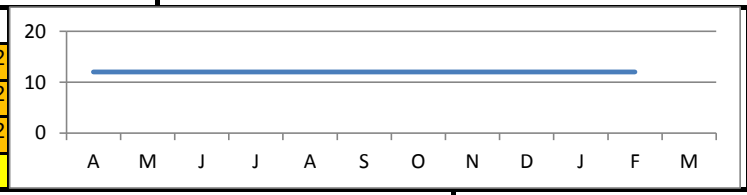
Gaps in control	**Positive assurances received**
	PPE Committee members attended the BMBC Overview and Scrutiny Committee for a Q & A session on the PPE Strategy. The meeting went well.
	PPE Committee has been assured that the CCG has recently been named 35th out of 50 top tweeting NHS organisations. It was also advised that the CCG had 8,000 followers on twitter and 500 Facebook friends.

Gaps in assurance	**Actions being taken to address gaps in control / assurance**

Objective 1: To commission high quality health care that meets the needs of individuals and groups	***NHSE Domains:*** ***1, 3, 4, 6***	*Clinical / Lay Lead*	
	Risk register: Moderate 13/23, 13/28, 13/45	*Executive lead*	LJS
		Committee	FPC

What would success look like?	**Principal threat(s) to delivery of the objective**
Commissioning Plan includes ambitious but deliverable targets and trajectories. Programme Boards on target to deliver targets and trajectories. Programme Board activities impact on health outcomes.	1.3 If the CCG's commissioning priorities are not sufficiently ambitious, outcome focused, and appropriate there is a risk that required improvements in health care will not be achieved, resulting in the needs of individuals and groups not being met.

Risk rating	Likelihood	Consequence	**Total**
Initial	3	4	12
Current	3	4	12
Appetite	3	4	12
Approach	**Tolerate**		



Date reviewed	**Mar-15**

Rationale: Likelihood is possible. Ability of CCG to deliver priorities, and impact on outcomes, will become apparent over the year. Major impact on CCG credibility and on patients if priorities not delivered.

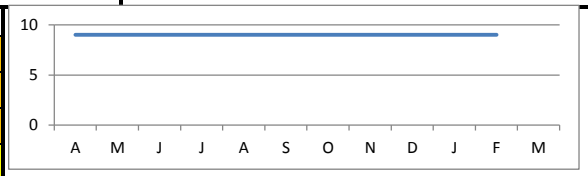
Key controls to mitigate threat:	**Sources of assurance**
Commissioning Plan includes ambitious targets and trajectories reflecting the priorities of the Membership, Governing Body, service users, and other stakeholders.	Commissioning Plan signed off by Governing Body and Membership Council. Revised plan approved by GB June 2014.
Commissioning Plan subject to review & challenge by NHSE at key stages in its development. Revised strategic plan and commisssioning plan are being completed bu January 2015 to reflect 2015/16 planning guidance.	Feedback on the plan from NHSE.
NHSE Assurance Process - quarterly checkpoint submissions, meetings, delivery dashboard	Quarterly feedback and action planning; NHSE assurance letters to GB
Financial Plan and QIPP programme supports delivery of CCG ambitions	Financial Plan signed off by GB (March 2014). Ongoing monitoring & reporting of financial position via FPC to GB.
Delivery of commissioning priorities is via 6xProgramme Boards, and the Primary Care Development Programme group, each with senior membership, terms of reference, PIDs, budgets, and Service Development support	Projects monitored by programme Boards via highlights reports; programmes monitored through major and minor reviews at FPC. H&WB has oversight of some Programme Boards.
Regular reports to Governing Body on commissioning priorities	Integrated Performance Reports; annual FPC Committee report.
Gaps in control	**Positive assurances received** Commissioning Plan was fully assured by NHS England following submission.

Gaps in assurance	**Actions being taken to address gaps in control / assurance**
	The CCG has approved additional investment in Service development support to Programme Boards to facilitate increased pace of change.
	The Programme Board structurehas been reviewed with a view to bringing all service developments under the remit of a single Clinical Transformation Board. In addition a thorough prioritisation exercise of all planned investments has been undertaken in order to focus activity on a smaller number of areas most likely to deliver the CCG's commissioning priorities.
Time lags in data for some priority areas (eg Cancer) means it can be difficult to measure and track the impact of activities on outcomes.	

Objective 1: To commission high quality health care that meets the needs of individuals and groups	*NHSE Domains:* *1, 3, 4, 6* ***Risk register: Extreme - 13/1, 13/3, 14/5b, 14/11, 14/15; High - 13/15, 14/4, 14/7, 14/8, 14/9; Moderate - 13/5, 13/9***	*Clinical / Lay Lead* *Executive lead* CH *Committee* FPC

What would success look like?	Principal threat(s) to delivery of the objective
Contracts with all providers deliver the required CQUINs and Quality Premium outcomes.	1.4 If the CCG's contracting arrangements are not effective, there is a risk that commissioning priorities, CQUINS, and Quality Premium outcomes will not be delivered, leading to poorer quality care and a negative impact on the CCG's financial position.

Risk rating	Likelihood	Consequence	Total
Initial	3	3	9
Current	3	3	9
Appetite	3	4	12
Approach	Tolerate		



Date reviewed	Mar-15

Rationale: it is possible that quality premium outcomes will not be achieved based on historic performance. Consequence set as moderate as this risk relates more to the financial risk than to the quality (see 1.1).

Key controls to mitigate threat:	Sources of assurance
Contracts in place with all providers	Contracting Updates to all FPC meetings
Contract monitoring meetings with BHNFT & SWYPFT	Minutes and Contracting Updates go to FPC
Quality & Performance Group meetings with BHNFT & SWYPFT	Quality & performance group minutes go to QPSC
CQUINs built into contracts & monitored through Quality & Performance Meetings, and escalated as necessary	Quality & performance group minutes go to QPSC
Delivery of local targets is via Programme Boards which have PIDs, senior membership, and Service Development support.	Projects monitored by programme Boards via highlights reports; programmes monitored through major and minor reviews at FPC.
Local targets agreed system wide, fostering a shared sense of ownership.	H&WB has oversight of some Programme Boards & monitors performance against plans. CCG is represented on the H&WB Board. Minutes go to GB.
Integrated performance reports include provider performance against contracts	IPRs considered at every meeting of FPC
Regular reports to GB on contracting arrangements	Integrated Performance Reports; annual FPC Committee report.
Self assessment for NHSE assurance process, inc UNIFY submissions	Delivery dashboard; NHSE assurance letters to GB

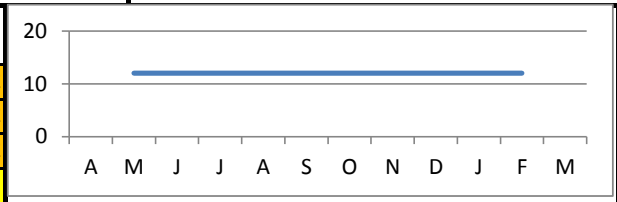
Gaps in control	Positive assurances received
Controls over contracts where Barnsley CCG is not lead commissioner are less well developed.	
Monitor has applied licence conditions and enforcement undertakings in relation to the A and E performance pursuant with conditions under FT4 ((5)a,(5)c,(6) & (7)	Mar-15: there has been a significant improvement in BHNFT's performance throughout the year. Monitor's license condition re A&E has now been lifted although financial conditions remain in place. There were positive findings from unannounced visit to A&E 9.6.2014. As a result this risk has been de-escalated to a 12 on the risk register and removed from the GBAF.
Monitor has applied licence conditions and enforcement undertakings in relation to the Financial Management pursuant with conditions under FT4 (2),(4), FT 4 (5 a,b,d,e & f) & FT4(7)	

Gaps in assurance	Actions being taken to address gaps in control / assurance
YAS is currently under achieving against the Category A response standard of 75% within 8 minutes for Barnsley residents, and targets for handover times and turn around times (RR 14/5b).	YAS has agreed a rectification plan to meet the standard following discussions at the CCG Governing Body. BCCG contracts staff working closely with lead commissioner (SCCG) contracts lead. Local discussions are held regularly and local actions agreed to improve performance in Barnsley. YAS senior managers will be meeting with the CCG Governing Body on 26 March in light of ongoing poor performance.
HCAI rates missed national target in 2013/14 (RR 13/1). (Mar-15: no cases of MRSA in year to date and incidence of Cdiff below trajectory).	Cdiff action plan; additional commissioning capacity for infection control; alternative service models being considered
Potential Years of Life Lost (PYLL) missed local target in 2013/14.	Programme Board activities re healthier lifestyles intended to impact on this measure.
Poor BHNFT performance in respect of people waiting > 6 weeks for diagnostic tests (RR 14/11).	Action plan in place but will not recover the required performance until end of October 2014 and consequently the risk score has been increased
Potential for harm to patients if the quality and completeness of D1 discharge letters is not improved. (RR 14/15)	Audit undertaken, results shared with Trust, action plan requested. Follow up audit to be carried out. Issue raised with Trust's medical director. D1 completion to be included within

Objective 1: To commission high quality health care that meets the needs of individuals and groups	***NHSE Domains:*** ***1, 3, 4, 6*** ***Risk register: High - 14/4.***	*Clinical / Lay Lead* *Executive lead* BR, MG *Committee* QPSC

What would success look like?	**Principal threat(s) to delivery of the objective**
With appropriate support from the CCG, partners are able to manage the financial pressures they face in a way which does not impact adversely on quality or patient safety.	1.5 If (with support where appropriate from the CCG) our providers cannot effectively manage the financial pressures they are facing, there is a risk that those pressures will lead to a deterioration in the quality and safety of services provided, resulting in failure to commission high quality health care that meets the needs of individuals and groups.

Risk rating	Likelihood	Consequence	**Total**
Initial	3	4	12
Current	3	4	12
Appetite	3	4	12
Approach	**Tolerate**		



Date reviewed	**Mar-15**

Rationale: Likelihood is possible as provider financial & recovery plans still in development. Impact is major due to potentially serious impact on quality of care etc.

Key controls to mitigate threat:	**Sources of assurance**
CCG quality impact assessment of BHNFT & SWYPFT CIPs	To be reported via QPSC
CCG to remain appraised of BMBC service planning to manage deficit	Managed through H&WB (at which CCG is represented, minutes go to GB)
Cross system economic modelling of impact of CCG Commissioning Plans on key system stakeholders	CCG representation on Senior Strategic Development Group (SSDG), reporting to Health & Wellbeing Board and to CCG via Chief Officer Reports to the Governing Body. BCCG CFO leads the Finance Group, leading on the economic modeliing work.
Real time assurance via Clinically Led Quality Assurance Visits to main providers	Reports back to QPSC, key messages to GB via Quality Highlights reports
See also risks & assurances for 1.1, 3.1, and 4.1	

Gaps in control	**Positive assurances received**
Monitor has applied licence conditions and enforcement undertakings in relation to the Financial Management pursuant with conditions under FT4 (2),(4), FT 4 (5 a,b,d,e & f) & FT4(7)	

Gaps in assurance	**Actions being taken to address gaps in control / assurance**
BMBC yet to confirm their plans to balance their budget	A system wide medium term financial plan is being developed, led by BCCG CFO.
BHNFT Turnaround Plan agreed and in delivery. Impact on CCG priorities and plans not fully articulated.	The CCG is working closely with the Trust to understand the implications of the 2 year recovery plan for the wider system. CCG has sought & received assurance that BHNFT has undertaken EQIA of CIP plans aligned to the two year turnaround plan. Plans for 2015/16 onwards need to incorporate impact of changes.

Objective 2: Wherever it makes safe clinical sense to bring care closer to home.	***NHSE Domains:*** ***1, 2, 3, 5, 6*** ***Risk register: High - 14/2, 14/3, 14/10; Moderate - 13/22.***	*Clinical / Lay Lead* NB, MG *Executive lead* VP *Committee* FPC

What would success look like?

To move services closer to home in a way which does not destabilise BHNFT.

Principal threat(s) to delivery of the objective

2.1 If the CCG fails to deliver our Primary Care Development work programme due to
- Failure to engage with GP Practices
- Lack of capacity within the CCG, or
- Failure to ensure primary care workforce development,

there is a risk that care will be moved closer to home inappropriately or inconsistently across the district, resulting in an adverse effect on health inequalities in Barnsley.

Risk rating	Likelihood	Consequence	**Total**
Initial	3	4	12
Current	3	4	12
Appetite	3	4	12
Approach	**Tolerate**		

Date reviewed	**Mar-15**

Rationale: Likelihood remains possible but is reducing given that programme is progressing at pace. Consequence major given importance of building capacity in primary care to delivery of our commissioning priorities.

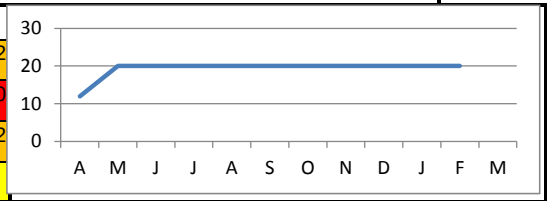
Key controls to mitigate threat:	**Sources of assurance**
NHSE's Primary Care Strategy	Delivery monitored via CCG COM, attended by CCG's Chair & CO
Primary Care Development Programme PID	Oversight via FPC
NHSE Primary Care Strategy Leads group	Attended by Chair & Medical Director
Primary Care Development Programme Group with PID and project support	Barnsley Quality Framework (BQF) Phases 1 and 2 business cases presented to and approved by the Governing Body. Detailed specifications for implementation are progressing at pace.
Practice Delivery Agreement (PDA) concept being developed in conjunction with Governing Body and Practices to support delivery of primary care at scale	PDA has been signed off by Governing Body and Membership Council, along with the Innovation Fund and the House of Care
Primary Care Development Strategy for Barnsley developed	Submitted to Governing Body for approval December 2014
Primary Care Commissioning Steering Group	Chair and Chief of Corporate Affairs represent BCCG and report back to BCCG via Primary care Development Group which reports into FPC
Equalisation of Primary Care Funding work to support primary care development and investment	CoCA, Elected member (Jim Logan), Medical Director and Primary Care Development Lead represent the CCG. Report back to BCCG via Primary care Development Group which reports into FPC.
Gaps in control	**Positive assurances received**
	Internal Audit Review of primary care development (Nov-14) provides significant assurance over CCG's arrangements, with 3 medium priority recommendations which the CCG is taking forward.
	CCG's application to take on delegated responsibility for commissioning of primary medical services has been approved by NHS England (Feb-14).

Gaps in assurance	**Actions being taken to address gaps in control / assurance**
Addressing shortage of clinicians / capacity in primary care will take time and any positive impact on outcomes may not be apparent in the short term.	

Objective 3: To support safe and sustainable local hospital services, supporting them to transform the way they provide services so that they are as efficient and effective as possible for the people of Barnsley.	***NHSE Domains:***	***1, 3, 4, 5, 6***	*Clinical / Lay Lead*	NB
	Risk register:	***High - 14/4.***	*Executive lead*	LJS
			Committee	FPC

What would success look like?	**Principal threat(s) to delivery of the objective**
Less 'short termism' in the way investment decisions are made (fewer reactive business cases, better /earlier planning for winter pressures etc)	3.1 If the CCG is not sufficiently clear on where it wants to be after 5 years, there is a risk that its operational business planning will not be appropriately integrated with or aligned to its long term objectives, resulting in a failure to support BHNFT in delivering safe and sustainable local hospital services, whilst transforming the way they provide services so that they are as efficient and effective as possible for the people of Barnsley.
Greater clarity within the CCG about our long term objectives and how these are to be measured / quantified so that we know whether we're on track	
Deeper understanding of how our objectives link (or conflict?) with BHNFT's transformation Strategy in order to deliver 'win / win' solutions	
Improvement in unplanned care performance (A&E waits etc)	

Risk rating	Likelihood	Consequence	**Total**
Initial	3	4	12
Current	4	5	20
Appetite	3	4	12
Approach	**Treat**		



Date reviewed	**Mar-15**

Rationale: Likelihood is likely as we are currently developing plans across the system & wider SY&B footprint to reconfigure services. Consequence catastrophic given serious impact on quality, finance, & reputation.

Key controls to mitigate threat:	**Sources of assurance**
5 year plan included in CCG Commissioning Plan based on the Health & Wellbeing Strategy. Refreshed strategic plan being developed to reflect amibitions for new care models set out in the NHS Five Year Forward View.	Plan approved by GB, signed off by membsership Council. Revised plan approved by GB June 2014.
5 year plan includes performance measures and trajectories	NHSE provides challenge & sign off over long term ambitions and trajectories. NHSE assurance letters taken to GB.
Working Together Programme - supporting acute providers across South Yorkshire to work more effectivly together to ensure safe effective and sustainable local services.	CCG represented by Chair & CO. Working Together & CCG COM reports to GB.
Start of the Year Conference with main providers and BMBC	Actions agreed and to be monitored via GB
Mid Year 'refresh' of Start The Year Conference	As above
Cross system economic modelling of impact of CCG Commissioning Plans on key system stakeholders	CCG representation on Senior Strategic Development Group (SSDG), reporting to Health & Wellbeing Board and to CCG via Chief Officer Reports to the Governing Body
BHNFT service sustainability review (Aug-Dec 2014), leading to production of a 5 year strategy.	CCG Governing Body members are engaged in the BHNFT sustainability review.
Health & Wellbeing Board provider Forum	CCG reps at meetings, minutes produced
Gaps in control How will conflicts become apparent and get resolved?	**Positive assurances received** The CCG's Strategic Vision and 5 Year Narrative is currently being refreshed and will be presented to membership Council and Governing Body in March 2015 prior to submission in April 2015.
Gaps in assurance Financial pressures at providers may impact on quality of care (see Risk 1.5)	**Actions being taken to address gaps in control / assurance** See Risk 1.5

Objective 4: To develop services through real partnerships with mutual accountability and strong governance that improve health and health care and effectively use the Barnsley £.	***NHSE Domains:***	***1, 3, 4, 5, 6***	*Clinical / Lay Lead*	NB
	Risk register:	***High - 13/7; Moderate - 13/25, 13/35.***	*Executive lead*	LJS
			Committee	FPC

What would success look like?	**Principal threat(s) to delivery of the objective**
A highly effective health & wellbeing board. Seamless services – service users are unaware which part of the system is delivering their services.	4.1 If the CCG is unable effectively to influence partners through the Health & Wellbeing Board, there is a risk that the Board will not articulate a clear 'sense of place' (strategy for Barnsley) or develop a strong sense of mutual accountability (eg for the Better Care Fund), which could result in failure to deliver more joined up, higher quality, efficient and effective services for the people of Barnsley which address the priority areas in the JSNA.

Risk rating	Likelihood	Consequence	**Total**
Initial	3	4	12
Current	4	4	16
Appetite	3	4	12
Approach	**Treat**		

Date reviewed	**Mar-15**

Rationale: Likelihood is likley as H&WB remains immature and partnerships are developing across the system. Consequence major given significance of partnerships to delivery of CCG priorities.

Key controls to mitigate threat:	**Sources of assurance**
CCG Chair & Chief Officer sit on Health & Wellbeing Board, and develeopment work underway on H&WB management arrangements	Minutes & Reports to Governing Body
Priority areas in JSNA reflected in H&W Strategy and CCG Commissioning Plan	Plan approved by GB & membership Council and reviewed / challenged by NHSE
H&WB developing a Medium Term Financial Strategy	Report received & reviewed by GB (Jun-14)
NHSE quarterly assurance process considers effectiveness of partnership working.	NHSE assurance letters to GB.
Better Care Fund Plan approved Novmeber 2014. Section 75 agreement and underpinning risk share agreement under development and will go live from 1 April 2015.	DoH assessment of the plan - assurance has now been received that the BCF Plan is fully approved (Dec-14).
Contracts in place with key providers and delivery monitored (see 1.4)	Monitored via FPC
Delivery of shared objectives is via Joint Programme Boards which have PIDs, senior membership, and Service Development support.	Projects monitored by programme Boards via highlights reports; programmes monitored through major and minor reviews at FPC.
Cross system economic modelling of impact of CCG Commissioning Plans on key system stakeholders	CCG representation on Senior Strategic Development Group (SSDG), reporting to Health & Wellbeing Board and to CCG via Chief Officer Reports to the Governing Body
Gaps in control	**Positive assurances received** BCF submission fully approved (Dec-14).

Gaps in assurance	**Actions being taken to address gaps in control / assurance**
Governance arrangements re Better Care Fund still being developed	BCF submission fully approved as of December 2014. Section 75 agreement and underpinning risk share agreement under development and will go live from 1 April 2015 subject to Health & wellbeing Board sign off.
	The Programme Board structure has been reviewed with a view to bringing all service developments under the remit of a single Clinical Transformation Board which will include commissioner and provider partners.

Objective 5: To have the highest quality of governance and processes to support our business.	***NHSE Domains:*** ***1, 3, 4, 5***	*Clinical / Lay Lead*	
	Risk register: HIGH - 13/14, 14/1, 14/6.	*Executive lead*	BR
		Committee	QPSC

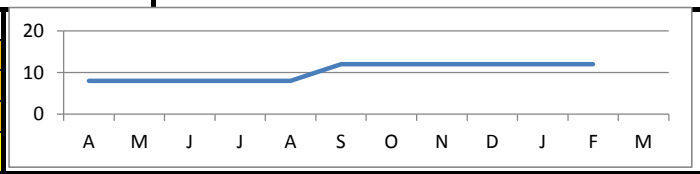
What would success look like?

Services commissioned safeguard vulnerable clients. Partnership responsibility for safeguarding in care homes is delivered.

Principal threat(s) to delivery of the objective

5.1 If the CCG does not appropriately identify and assess client need in relation to safeguarding there is a risk of failure to commission services that safeguard vulnerable clients; AND if the CCG does not ensure our support to direct commissioning of care homes (BMBC) with professional advice is effectively acted upon there is a risk of failure to deliver our vulnerable adult safeguarding responsibilities to people in Care Homes.

Risk rating	Likelihood	Consequence	**Total**
Initial	2	4	8
Current	3	4	12
Appetite	3	4	12
Approach	**Tolerate**		



Date reviewed	**Mar-15**

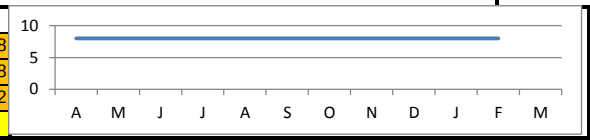
Rationale: Likelihood increased to 'possible ' due to concerns relating to a care home within Barnsley. Consequence scored as major due to impact on patient care should risk crystallise.

Key controls to mitigate threat:	**Sources of assurance**
Safeguarding vulnerable clients policy	Patient Safety reports to QPSC include Safeguarding issues
Specialist Safeguarding Nurses & Designated Doctor employed by CCG	Patient Safety reports to QPSC include Safeguarding issues
Quality Schedules in contracts with providers	Monitored via contract monitoring arrangements
Membership of Barnsley wide Safeguarding Board	Reports & feedback from Safeguarding Board to QPSC
Incident Reporting arrangements & serious case reviews - (NOTE Serious Incident Reporting Guidance for Care Homes was approved by QPSC in September 2014)	Patient Safety reports to QPSC include Safeguarding issues
Francis Action Plan	Regular Francis updates to QPSC and GB
New Care Homes Service Spec includes clear PIs	Contract Monitoring, & QPSC Patient Safety reports
CHC team (CSU) does health, safety, & wellbeing checks on CHC patients	Reported back via QPSC
Infection Control team does unannounced visits	Reported back via QPSC
CQC inspects and certifies all Care Homes against national standards	Reported back via QPSC
Work of Barnsley Safeguarding Children Board re Child Sexual Exploitation	Regular reports on CSE to GB
NHSE quarterly assurance process considers patient safety issues	NHSE assurance letters to GB
Gaps in control	**Positive assurances received**
Previous draft contract between BMBC and Care Homes did not reflect CCG input	Deputy Chief Nurse has worked with BMBC to ensure health care is integral to BMBC's contract with Care Homes
	The Care Quality Commission inspection of Safeguarding and Looked after Children Services in November 2014 identified no significant new issues for the CCG.
	The Ofsted Inspection of Safeguarding and Looked after Children of Barnsley Metropolitan Borough Council in June 2014 resulted in an improved overall judgement of requires improvement, a step forward from the previous inspection in 2012, and the Improvement Notice in place following the previous Joint Ofsted/CQC Inspection has been lifted with immediate effect.
Gaps in assurance	**Actions being taken to address gaps in control / assurance**
	Process for reporting & investigating incidents in Care Homes being developed

Objective 5: To have the highest quality of governance and processes to support our business.	***NHSE Domains: 2, 4, 6*** ***Risk register: HIGH - 13/15,16,19,20,41; MODERATE - 13/5,6,29,30,31,34; LOW - 13/32,38.***	*Clinical / Lay Lead* AA *Executive lead* All *Committee* AC

What would success look like?	**Principal threat(s) to delivery of the objective**
Delivery of all the CCG's statutory responsibilities: deliver statutory financial duties & VFM; Improve quality of primary & secondary services; Involve patients and public; Promote Innovation; Promote education, research, and training; Meet requirements of the Equality Act; meet good governance standard.	5.2 If the CCG fails to deliver its statutory duties, due to weaknesses in its corporate governance and control arrangements, it will result in legal, financial, and / or reputational risks to the CCG and its employees.

Risk rating	Likelihood	Consequence	**Total**
Initial	2	4	8
Current	2	4	8
Appetite	3	4	12
Approach	**Tolerate**		



Date reviewed	**Mar-15**
Rationale: Likelihood is 'unlikely' as arrangements now well established. Consequence is major due to significant financial & reputational impact of failure.	

Key controls to mitigate threat:	**Sources of assurance**
Constitution, Corporate Manual, Prime Financial Policies, and suite of corporate policies	Audit Committee provides oversight, supported by internal & external audit reports & opinions, LCFS work etc
Governing Body & Committee Structure underpinned by clear terms of ref and work plans (reviewed and signed off by GB May 2014)	GB members sit on Committees. All Committee minutes taken to GB and significant issues are escalated. Committees produce annual reports for the GB.
Management Structure - responsibilities clearly allocated to teams and individuals	Management action monitored by regular formal and informal management team meetings
Risk management framework (GBAF and RR) provides assurance that risks have been identified and are being managed (GBAFrefreshed Apr-May 2014, Integrated Risk Management Framework updated July 2014)	GBAF and Risk register updated monthly and considered at all Committees and meetings of the GB
Budgetary control, contract monitoring & QIPP monitoring arrangements. HFMA finance training for all staff. Reporting template amended to ensure finance team reviews and sign off of all Committee reports & business cases with financial implications.	Financial Plan signed off by GB (Mar-14). Monthly finance report to FPC and GB; internal & external audit reviews and opinions; GB formally adopt annual report & accounts.
Performance monitoring arrangements	Integrated Performance Reports to FPC provides assurance across all NHS Constitution pledges. Summary reports to GB.
6xProgramme Boards with senior membership, terms of reference, PIDs, budgets, and Service Development support	Projects monitored by programme Boards via highlights reports; programmes monitored through major and minor reviews at FPC. H&WB has oversight of some Programme Boards.
Equality Strategy; Equality Action Plan; E&D CSU Lead; E&D training provided to all staff; EQIA policy in place and EQIAs attached to GB papers where appropriate; Staff survey results considered & acted upon; Links with PPE committee clarified; HR policies approved & embedded.	Progress monitored by Equality Steering Group. Minutes to GB every month, plus Annual Report prepared annually.
Statutory & Mandatory training programme in place for all staff, inc GB members, as well as OD Plan, IPR reviews, development sessions for Governing Body inc conflicts of interest, risk management & assurance etc	CSU L&D team provides dashboard which is considered by management team on a regular basis.
Information Governance strategy & policies in place, SIRO / Caldicott Guardian identified, training provided for all staff, information asset register in place, committee report & business case template prompts consideration of IG issues.	IG Toolkit compliance (minimum Level 2) & delivery of Improvement Plan monitored via IG Group reporting to QPSC.
Health & Safety Group established to oversee compliance with statutory Fre & Health & Safety requirements	Annual Report & update reports taken to Audit Committee
NHSE quarterly assurance process inc UNIFY submissions	NHSE dashboard; assurance letters taken to GB

Gaps in control	**Positive assurances received**
	Updates and amendments to Constitution (inc strengthened policy on conflicts of interest) approved by GB, Membership Council, and NHS England.

Gaps in assurance	**Actions being taken to address gaps in control / assurance**
Arrangements for reporting outcomes of Programme Board decisions still being finalised	A full review of Programme Board structure is underway, which includes consideration of reporting into Committees.
	Format of Integrated Performance Reports has been reviewed and enhanced.

RISK REGISTER – 05 March 2015

Domains
1. Adverse publicity/ reputation
2. Business Objectives/ Projects
3. Finance including claims
4. Human Resources/ Organisational Development/ Staffing/ Competence
5. Impact on the safety of patients, staff or public (phys/psych)
6. Quality/ Complaints/ Audit
7. Service/Business Interruption/ Environmental Impact
8. Statutory Duties/ Inspections

Likelihood		Consequence		Scoring Description			Current Risk No's	Review
Almost Certain	5	Catastrophic	5	Red	Extreme Risk	(15-25)	6	Monthly
Likely	4	Major	4	Amber	High Risk	(8- 12)	23	3 mthly
Possible	3	Moderate	3	Yellow	Moderate Risk	(4 -6)	13	6 mthly
Unlikely	2	Minor	2	Green	Low Risk	(1-3)	2	Yearly
Rare	1	Negligible	1					
				Total = Likelihood x Consequence				

The initial risk rating is what the risk would score if no mitigation was in place. The residual/current risk score is the likelihood/consequence (impact) of the risk sits when mitigation plans are in place

			Initial Risk Score						Residual Risk Score					
Ref	**Domain**	**Risk Description**	**Likelihood**	**Consequence**	**Score**	**Mitigation/Treatment**	**Lead Owner of the risk**	**Source of Risk**	**Likelihood**	**Consequence**	**Score**	**Date Risk Assessed**	**Progress/ Update**	**Date for re-assessment**
CCG 14/5a	1,2	If Yorkshire Ambulance Service (YAS) continues to under achieve against the Category A response standard of 75% within 8 minutes for Barnsley residents there is a risk that: (a) the quality and safety of patient care will be compromised	3	4	**12**	**Re risk of adverse impact on quality & patient safety**: Paper taken to April 2014 QPSC. Proposed that a breach analysis is undertaken to better understand the impact on patient experience & outcomes resulting from breaches of the target. Lay Member Representative for Patient & Public Engagement attended an awareness meeting with a non executive from YAS in May 2014 and met with Chair of YAS in November 2014..	BR (Quality & Patient Safety Committee)	Risk Assessment	5	5	**25**	03/15	**March 2015** Following discussion at the February GB, and in the light of serious incidents and ongoing failure to meet operational targets in Barnsley, it was agreed to further escalate this risk to 25. Concerns are to be raised with NHSE as well as YAS directly and a meeting with YAS senior management is	04/15

			Initial Risk Score						Residual Risk Score					
Ref	**Domain**	**Risk Description**	**Likelihood**	**Consequence**	**Score**	**Mitigation/Treatment**	**Lead Owner of the risk**	**Source of Risk**	**Likelihood**	**Consequence**	**Score**	**Date Risk Assessed**	**Progress/ Update**	**Date for re-assessment**
													scheduled for 26 March 2015. **December 2014** Red 1 and Red 2 response times have begun to improve over the past few months and for November the combined Red 1 and Red 2 response rate was70.3%. UCP workers x 5 have been recruited to Barnsley and commenced early December. Local meetings with YAS Operational team continue. **November 2014** Local Remediation meetings continue. Barnsley specific actions being undertaken to improve Red 1	

			Initial Risk Score						Residual Risk Score					
Ref	**Domain**	**Risk Description**	**Likelihood**	**Consequence**	**Score**	**Mitigation/Treatment**	**Lead Owner of the risk**	**Source of Risk**	**Likelihood**	**Consequence**	**Score**	**Date Risk Assessed**	**Progress/ Update**	**Date for re-assessment**
													and Red 2 response times (e.g use of ASV vehicles and ring-fencing resources to Barnsley to reduce 'crew-drift'. YAS performing well in relation to Ambulance Quality Indicators (AQI's) – ranked 1st among all 9 Ambulance Trusts for Survival Rates.	
CCG 14/5b	5,6	If Yorkshire Ambulance Service (YAS) continues to under achieve against the Category A response standard, and the targets for handover and turn around times, for Barnsley residents there is a risk that the reputation of the CCG with its stakeholders	3	4	**12**	**Re risk of Non delivery of target agreed in contract**: YAS management invited to a 'confirm and challenge' meeting. Progress will be monitored through the CCG's contract monitoring procedures. There is a financial penalty for the ambulance handover measure, that has been applied since April 2014. An improvement plan will be	CH (Finance & Performance Committee)	Risk Assessment	5	4	**20**	12/14	**March 2015** Considerable discussions were held at the February GB, and in light of significant media interest in ambulance performance and the fact that Barnsley's performance continues to be an outlier in terms	01/15

			Initial Risk Score						Residual Risk Score					
Ref	**Domain**	**Risk Description**	**Likelihood**	**Consequence**	**Score**	**Mitigation/Treatment**	**Lead Owner of the risk**	**Source of Risk**	**Likelihood**	**Consequence**	**Score**	**Date Risk Assessed**	**Progress/ Update**	**Date for re-assessment**
		damaged.				agreed with YAS and monitored, and monies retained by commissioners as a result of the implementation of financial penalties will be used to improve outcomes							of South Yorkshire. The score was maintained at 20. The Governing Body requested a detailed report and action plan to be presented in March to address both the patient safety and reputational issues associated with this continues unacceptable performance. **December 2014** As in previous months focus is on monitoring local arrangements longer term. However, the position has significantly worsened in the second half of December. This is a regional and	

			Initial Risk Score						Residual Risk Score					
Ref	**Domain**	**Risk Description**	**Likelihood**	**Consequence**	**Score**	**Mitigation/Treatment**	**Lead Owner of the risk**	**Source of Risk**	**Likelihood**	**Consequence**	**Score**	**Date Risk Assessed**	**Progress/ Update**	**Date for re-assessment**
													national trend rather than purely a Barnsley issue and is directly related to the volume of calls. **October 2014** Performance improved during September. Local arrangements are working well. The focus is on maintaining these local arrangements over long term. **August 2014** The regional position of achievement of the target has worsened. Contractual discussions are ongoing and the initial YAS action plan rejected by commissioners. A further plan is in development.	

			Initial Risk Score						Residual Risk Score					
Ref	**Domain**	**Risk Description**	**Likelihood**	**Consequence**	**Score**	**Mitigation/Treatment**	**Lead Owner of the risk**	**Source of Risk**	**Likelihood**	**Consequence**	**Score**	**Date Risk Assessed**	**Progress/ Update**	**Date for re-assessment**
													Application of sanctions is under consideration. A further meeting for a Barnsley action plan is being set up for September. The August Governing Body agreed to escalate the likelihood of this risk to 20 due to consistent underperformanc e.	
CCG 13/1	1,5, 6, 8	Lack of clarity, accountability, and capacity in support provided by SWYPFT infection control team to the CCG as commissioner could lead to non achievement of Health Care Acquired Infection Trajectories (C. Difficile and MRSA) **Clinical Risk**	5	4	**20**	RCA Reports Monthly performance Reports See outcome of August ICP Summit in progess/update 'Deep Dive' on infection control shared with Q&PS committee March 2014. There was an independent review of all PIR documents relating to CDiff cases in the period March to October 2013, which was reported to QPSC	BR (Quality & Patient Safety Committee)	Risk Assessment	4	4	**16**	03/15	**March 2015** This service is being re-tendered. **January 2015** A decision has been made on 20.1.15 to abandon the IPC procurement following receipt of 2 bidders tenders and initial review of their bids against the	04/15

			Initial Risk Score						Residual Risk Score					
Ref	**Domain**	**Risk Description**	**Likelihood**	**Consequence**	**Score**	**Mitigation/Treatment**	**Lead Owner of the risk**	**Source of Risk**	**Likelihood**	**Consequence**	**Score**	**Date Risk Assessed**	**Progress/ Update**	**Date for re-assessment**
		Trajectories for 2013/14 was reduced for PCO from 87 to 67. Outturn was 70. Trajectory for 2014/15 has been increased from 67 to 73.				in March 2014. The key finding was that all cases had been unavoidable. There is a monthly PIR Review Group meeting, chaired by Public health and attended by both providers and the CCG. This reviews every case of CDiff and MRSA to ensure lessons are learned.							specification and financial envelope. FMT were informed of the failed procurement at the meeting on 21.1.15 and the preferred option from the options paper presented is to continue to co-commission the service with BMBC and undertake re-procurement via a negotiated tender process. **December 2014** IPC service contract has been advertised in the Tenders & Public Procurement Official Journal of the European Union (OJEU) on 28.11.14 with closing date for tender submission 6.1.15 within the	

			Initial Risk Score						Residual Risk Score					
Ref	**Domain**	**Risk Description**	**Likelihood**	**Consequence**	**Score**	**Mitigation/Treatment**	**Lead Owner of the risk**	**Source of Risk**	**Likelihood**	**Consequence**	**Score**	**Date Risk Assessed**	**Progress/ Update**	**Date for re-assessment**
													Gantt timeline	
CCG 13/10	1,5, 6, 8	The HSMR for the BHNFT higher than expected **Clinical Risk**	5	5	**25**	Rebasing undertaken by the Trust Clinical Coding issues addressed Mortality review meetings in place within the organisation. The CCG Medical Director is a member of the Mortality Steering Group at BHNFT. Audit being undertaken by the Trust across identified specialties. Action plan and regular Reports to BHNFT Trust Board Aqua Review	MG (Quality & Patient Safety Committee)	Risk Assessment	4	4	**16**	03/15	**March 2015** HSMR performance has improved but QPS felt that they wanted to see a sustained trajectory of improvement before reducing this risk on the Risk Register. Monthly monitoring will continue. **Sep 2014** The CCG has now received a copy of the AQuA independent "deep dive" review report of hospital mortality for BHNFT. The Trust is developing an action plan in response to the review. The report was considered at	04/15

			Initial Risk Score						Residual Risk Score					
Ref	**Domain**	**Risk Description**	**Likelihood**	**Consequence**	**Score**	**Mitigation/Treatment**	**Lead Owner of the risk**	**Source of Risk**	**Likelihood**	**Consequence**	**Score**	**Date Risk Assessed**	**Progress/ Update**	**Date for re-assessment**
													the September Quality & Patient Safety Committee, after which the Chief Nurse & MD are to write to the Trust requesting sight of the action plan and the process for taking this forward. **July 2014** Barnsley is no longer showing as an outlier on HSMR, however as this data is volatile it was agreed by QPSC in July to keep the current risk ratings at the present time. **June 2014** BHNFT MD has confirmed the AQUA report has been received. An action plan & exec summary is	

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													going to the Board next month. Both will be shared widely in the Trust & the CCG. The MD states '…I can assure you that there are no major immediate concerns identified in the report…'	
14/15	1, 5, 6	If the quality and completeness of D1 discharge letters is not improved there is a risk that patients may not be prescribed the correct medication following hospital discharge thereby increasing the risk of harm (An audit of 355 D1 discharge letters from BHNFT undertaken by the medicines management team identified that in 55%	4	4	**16**	The results of the audit have been shared with BHNFT and raised with the Trust's medical director. The CCG is to request an action plan from the Trust. D1 completion to be included within the core contract for 2015/16 with financial penalties if not met. A follow up audit will be undertaken in due course.	MG (Quality &Patient Safety Committee)	Risk Assessment & audit of discharge letters	4	4	**16**	03/15	**March 2015** This issue is being addressed as part of the contract negotiations and CQUINN development discussions.	04/15

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		of cases the TTO section had not been completed or was incorrect).												
CCG 14/11 *(Inc CCG 14/9 merged Sep-14)*	1, 2, 5, 6	If BHNFT does not improve its performance in respect of people waiting > 6 weeks for diagnostic tests (eg due to lack of ultrasound capacity) there is a risk to the reputation of the CCG and the quality of care provided to the people of Barnsley in respect of this service.	4	3	**12**	The CCG provided additional funding during 2013/14 to support additional clinics and increased capacity to address the issue. Diagnostic performance is monitored as part of contract performance. Contracting team is working with the Trust on options to increase capacity and performance, with a view to bringing a business case to Governing Body later in the year. An action plan is in place at BHNFT to increase capacity to address non - obstetric ultrasound waiting time pressures. Performance to be monitored through quality and performance meetings and contract monitoring.	VP (Finance & performance Committee)	Risk assessment	5	3	**15**	03/15	**March 2015** Performance continues to be inconsistent although assurance has been received that it is the reporting rather than performance that is the problem and that an improvement should be seen by next month. **December 2014** Performance has improved at Barnsley overall just above target now as a result of issues at Doncaster **October 2014** Performance against the recovery action	04/15

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													plan continues to be closely monitored through contracting arrangements. **September 2014** Performance is still not achieving the required standard the action plan will not recover the required performance until end of October 2014 and consequently the risk score has been increased. **August 2014** Additional funding to reduce diagnostic waits provided through contract agreements. The situation is being monitored closely. Performance is still not achieving	

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													the required standard the action plan will not recover the required performance until end of October 2014 and consequently the risk score has been increased	
CCG 13/3	1,3, 5,6, 8	A&E 4 hour wait targets for BHNFT are not being achieved failure to deliver performance in 2013/14 Q1 will affect the Trusts Monitor Governance Risk Rating. Failure of BHNFT to achieve this target impacts on CCG's delivery of NHS constitution a pre-requisite of Quality Premium.	4	5	**20**	Health Community whole system wide response lead by the CCG Health Community whole system wide response lead by the CCG Jointly developed action plan will include actions from IST visit the CCG's Commissioning Plan and BHNFT work on transformation Urgent Care Working group oversight Daily Reporting Winter Planning arrangements	VP (Finance & Performance Committee)	Risk Assessment	3	4	**12**	03/15	**March 2015** Following discussions at Finance and Performance Committee this risk was reduced to possible and major rather than likely and major. Reducing it to an amber risk. The rational for this was that performance in Q4 year to date is at 95.14% and the year to date position is at 95.87% it is therefore	06/15

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						Director of Operations role at BHNFT from April 2014							possible, even likely, that the Trust will achieve the 95% year cumulative position. Additionally Monitor have removed the licensing condition associated with A & E performance. **December 2014** Performance remains good despite excessive demand as at 7.12.14 performance is November 95.5% Quarter 3 to date 96.27% Year to Date 96.79% **October 2014** Performance remains good as at 28.10.14 position is as follows:-	

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													October 98% Quarter 1 96.97% Quarter 2 96.94% Quarter 3 to date 96.75% and Year to date 96.93% System resilience funding is supporting additional acute hospital resources as well as strengthening out of hospital services to maintain this performance during winter.	
CCG 13/7	2,4, 8	Insufficient role, structure and contracting support from Joint Commissioning Unit (JCU)	5	3	**15**	High level discussions between Local Authority and NHS Barnsley CCG regarding the residual JCU function and staff. Full engagement by staff in both teams in the joint working approach. Development of more robust commissioner discussions as part of the contracting	CH (Finance & Performance Committee)	Risk Assessment	4	3	**12**	12/14	**December 2014** BMBC revised structure has been shared. The CCG is to meet with BMBS to set out requirements through the joint arrangements. This meeting will take place in January.	03/15

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						processes. Potential for short term support to contracts team in order to meet Health commissioner requirements							**October 2014** The discussion is due to take place between the CCG and BMBC I November. **August 2014** Situation is unchanged. **May 2014** LA have undertaken a review of its commissioning function with revised structure proposed, together with recognition that the CCG will need to decide whether or not to continue funding. In order to inform this decision making a review of the CCG's requirements is being undertaken by the Chief Finance Officer	

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													and Head of Service Development.	
CCG 14/1	1 2 5 6 8	If the CCG does not ensure support to direct commissioning of care homes (BMBC) professional advice may not be effectively acted upon there could be a risk of failure to deliver our adult safeguarding responsibilities to people in Care Homes	3	4	**12**	• Barnsley Safeguarding Adults Board • Intelligence Sharing meeting BMBC Quality Improvement Framework (QIF) CHC Team (CSU) undertake health, safety, & wellbeing checks on CHC patients as requested Infection Control Team undertakes unannounced visits and produces monthly reports CQC inspect and certify all Care Homes against national standards Rolling programme of Deep Dive on Patient Safety included in January 2014 QPSC report pulls together all available assurance Deputy Chief Nurse working	BR (Quality & Patient Safety Committee)	Deputy Chief Nurse Risk Assessment	3	4	**12**	10/14	**October 2014** Work is being undertaken by the Safeguarding Adults Designated Nurse Forum to deliver on KPIs to be used as benchmarks across South Yorkshire and Bassetlaw CCGs. A study day on SIs has been set up for 14.11.14. The policy on Incident Reporting will also be included at the event. **July 14** Outcomes from the CCG led Care Homes workshop have been collated into an update paper for the Aging Well	01/15

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						with BMBC to ensure CCG perspective is reflected in BMBC contracts with care homes.							Programme Board. Further workshop planned for September. On 2nd July, twenty Care Home Managers and BMBC commissioning staff attended training delivered by Consequence UK regarding risk assessment, incident reporting and RCA investigations	
CCG 14/2	2, 6, 8	If there is insufficient sharing of information between primary care and the CCG's service development team, due to current legal constraints, there is a risk that the CCG's ability to commission appropriately could be diminished.	4	3	**12**	Since the risk relates to a legal issue over which the CCG has no direct control, the CCG's stance in relation to this risk is to tolerate, rather than to treat, it.	CH (Finance & Performance Committee)	Risk Assessment	4	3	**12**	10/14	**October 2015** The situation is unchanged. **August 2014** Situation remains to the same. **May 2014** No issues to report.	01/15
CCG 14/3	2	If the CCG fails to secure Practice	3	4	**12**	CCG Involvement with Practice Manager meeting to	VP	Risk Assessment	3	4	**12**	12/14	**December 2014** Innovation Fund	03/15

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		Manager engagement there is a risk that the Primary Care development project will fail to deliver transformation. (eg that investments new diagnostic equipment will not deliver the intended benefits).				facilitate engagement and deliver transformation CCG involvement with Practices on Primary Care Development Group	(Finance & Performance Committee)						established and 9 pilots approved to commence in January 2014 PDA Issued 10th November Practice engagement Programme established first event 14th January 2015 **October/ September 2014** A practice engagement proposal is under development and plans for implementation of the Practice Delivery Agreement are progressing these initiatives should improve **August 2014** The Primary Care	

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													Development Programme is progressing well, The Barnsley Quality Framework Phases 1 and 2 have been approved and are being implemented. An Innovation Fund and the Year of Care Model are also approved and being progressed. The group are now working on the Practice Delivery Agreement concept.	
CCG 14/4	1, 2, 3, 5, 6, 7	The unexpected financial challenges which have recently come to light at BHNFT represent a risk to the CCG's reputation with the public and external stakeholders, as well as to its	3	4	**12**	CCG response currently being considered by Management Team and the Governing Body.	CH (Finance & Performance Committee)	Risk assessment	3	4	**12**	12/14	**December 2014** Progress against the recovery plan for 2014/15, as reported to the December contract meeting, is that performance is ahead of plan in	03/15

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		financial position in the short and medium term.											achieving the required cost reductions. The situation continues to be monitored through contract meetings. **October 2014** Progress against recovery plan trajectory continues to be mentioned through contract meetings. The CCG have been included within BHNFT's arrangements for considering future sustainability. **August 2014** Impact of the recovery plan has been included within the contract settlement. Joint meetings continue with BHNFT. CCG'S CFO and	

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													BHNFT's DOF now meet weekly. The impact of the BCF and CCG's Commissioning Plan under discussion via joint agency meetings.	
CCG 14/6	1, 5, 6, 8	If the issues identified in the CCG Commissioned report into Children's Continuing Health care are not addressed, eg due to a lack of capacity within the CCG to provide designated clinical leadership in this area, then the CCG faces quality, governance, and financial risks in relation to this vulnerable group	4	4	**16**	CCG commissioned an independent healthcare consultant to review each locality's arrangements and make both local and system wide recommendations Interim resources secured via MT to progress the recommendations Substantive appointment to Lead Nurse role for Children with Complex Health Needs to be established (in partnership with another CCG) Work ongoing across the Barnsley system and across South Yorks to address the recommendations	BR (Quality & patient Safety Committee)	CCG Commissioned report into Children's Continuing Health Care (May 2014)	3	4	**12**	10/14	**October 2014** QA of existing children packages did not identify any significant concerns, CHC assessment process via CSU now being pursued and Interim Lead Nurse attending SEN panels as well as CRAG, Aiming for permanent Lead Nurse across 3 CCGs by April 2015 **July 2014** Interim Lead Nurse for	01/15

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													Children with Complex health Needs is part way through a quality assurance exercise for those C&YP with a current Continuing Health Care package in place. CRAG processes and function evolving. Personalised budgets framework under development.	
CCG 14/7	1, 5, 6, 8	If the performance of BHNFT's Stroke dept remains below the required standard, due to lack of capacity and resilience within the service, there is a risk that: (a)actions required in response to a recent Peer Review may not	5	4	**20**	Contract query has been raised by BCCG to understand the full scope of the issue and the actions that have been identified to address and improve performance. Performance will be monitored through the Q&P meeting, with Stroke data provided as soon as is available.	BR (Quality & patient Safety Committee)	BHNFT contract risk register	3	4	**12**	10/14	**October 2014** Action plan submitted by BHNFT to CCG. Further clarification responses provided to give further certainty around the robustness of required	01/15

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		be delivered (b) BHNFT's Stroke dept may lose its accreditation (c)they provide an unsafe service.				BHNFT have appointed a Stoke Service Manager and a Stroke nurse to take direct action on the ward and within the hospital to make the necessary improvements. The CVD Workstream of the Working Together programme is working to design the most appropriate pathway and network coverage for the benefit of patients.							actions. Service Manager in post to provide business support to improvement of the service against required actions. BHNFT are conducting an audit of the service to understand the root cause of problems to identify remedial action. The mitigated score will be recalculated once the action plan has formally been agreed.	
14/8	1, 5, 6	If cases of TB occurring in Barnsley are not appropriately reported and escalated, due to a lack of capacity or understanding of procedure within the TB team, there is a risk that the disease	**4**	**4**	**16**	Clinical Reference group set up, chaired by Dr Andrew O'Shaugnhessy (Consultant in Public Health in Bradford & specialist in TB) Health Protection Board investigation underway. Learning event to be held	BR (Quality & patient Safety Committee)	Risk Assessment	3	4	**12**	10/14	**October 2014** TB Summit has been scheduled for 06.11.14 where we will review the current pathway for TB services. **July 2014**	11/15

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		could spread within the local population.				with the TB team. 'Deep Dive' review of service provision at SWYPFT currently being undertaken by WSYBCSU. Public Health England is leading a Cohort Review of all TB cases in the last 4 years to check process & pathway. TB summit planned for September to include all interested parties.							A cohort review is being planned and led by Dr Nachi Arunchalam CCDC Public Health England throughout August for every patient treated by the services in the last 4 years. This will be peer reviewed by external clinical TB teams in September 2014 of the providers within Barnsley against agreed national standards. Dr Andrew O 'Shaughnessy will be feeding back his initial review findings on the 23rd of July to the CCG project team. The first working group took place on the 22nd of	

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													July, feedback from the meeting will be with the providers by the first week in August 2014. The risks to patients and the public until we have assurance that action has been identified by BHFT and SWYFT from the 2 serious incidents and project findings. Liz Pengelly updating Health Protection Board 25th July 2014.	
CCG 13/2b	1, 3, 6 6	CHC Retrospective Close Number of applications now known 300. Pending completion of retrospective reviews, there is a risk that patients may be receiving inappropriate	5	4	**20**	National Guidance Screening process in place Cluster wide approach to manage retrospective reviews Internal Audit Review of CHC Claims.	BR (Quality & patient Safety Committee)	Risk Assessment	3	3	**9**	10/14	**October 2014** Ongoing Retro CHC team continues to meet BCCG on a quarterly basis to discuss any concerns/issues. Currently there are 30 live cases for Barnsley.	01/15

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		packages of care, or not receiving care which they are entitled to, leading to poor quality outcomes.												
CCG 14/14	5, 6, 7	If the problems with telephony in the Goldthorpe LIFT building are not resolved there is a risk that Barnsley patients may be unable to access services and / or that the safety of patients will be compromised.	4	3	**12**	At the CCG & CSU's request BHNFT has put temporary work arounds in place (although to date these have not succeeded in eradicating the problems). The CSU is coordinating Root Cause Analyses on telephony outages which have occurred previously. The outcomes will be reported back to the CCG. A new telephony circuit has been installed and will go live from 29 November 2014.	MG (Quality & Patient Safety Committee)	Risk Assessment	4	3	**12**	11/14	**January 2015** Goldthorpe practice shave continued to experience telephony problems even after the installation of the new telephony circuit. The CCg's frustration with this ongoing issue has been conveyed to CSU and a solution is being sought.	02/15
CCG 13/41	1,2, 4,8	Lack of completed Declarations in respect of the Policy on the Managing Conflicts of Interest and the Acceptance of Sponsorship, Gifts and Hospitality	3	3	**9**	Policy on the Managing Conflicts of Interest and the Acceptance of Sponsorship, Gifts and Hospitality Reminders to Membership Council to submit declarations	VP (Audit Committee)	Risk Assessment Identified by Audit Committee 30.05.13	3	3	**9**	12/14	**December 2014** Claims will not be processed without completed declaration **October 2014** The Audit	03/15

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													Committee Chair attended Membership Council meeting to remind members of requirements and will follow up in writing to improve compliance	
CCG 14/10	2, 5, 6	If the Barnsley area continues to experience a lack of GPs in comparison with the national average, due to GP retirements, inability to recruit etc there is a risk that: (a) Some practices may not be viable, (b) Take up of LES / DES or other initiatives could be inconsistent (c) The people of Barnsley will receive poorer quality healthcare services	**3**	**3**	**9**	NHS England's Primary Care Strategy includes a section on workforce planning The CCG's Primary Care Development Programme has a workforce workstream. Links have been developed with the Medical School to enhance attractiveness of Barnsley to students	MG (Quality & Patient safety Committee)	Governing Body	**3**	**3**	**9**	07/14		10/14

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		(d) Patients services could be further away from their home.												
CCG 13/17	1, 5, 6	Capacity to effectively fulfill national requirements for clinical accreditation of Local and Directly Enhanced Services. Added 16.05.2013 by BR **Clinical Risk**	3	3	**9**	Currently scoping methodology and resources to undertake accreditation assessments	BR (Quality & Patient Safety Committee)	Risk Assessment	3	3	**9**	10/14	**October 2014** The CCG currently has 3 GP local enhanced services where it is the CCG's responsibility to ensure that the national requirements for clinical accreditation are fulfilled. The services to which this applies are Vasectomies, Carpal Tunnel and DMARDS. The CCG will ensure that practitioners provide appropriate evidence which supports their	01/15

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													clinical accreditation to provide these services.	
CCG 13/19	**1, 5, 8**	CCG as Level 2 Responder Barnsley CCG does not meet legislation and standards in relation to protecting Barnsley people from harm related to major incidents and other emergencies.	4	3	**12**	Contribute to Barnsley Health and Social Care Emergency planning group and work programme, including testing of plans and training Continue to Local Health Resilience Partnership (LHRP) either directly or through Lead CCG rep. Nominated CVCG "Accountable Emergency Officer" Ensure contracts with provider organisations contain relevant emergency preparedness and response elements including Business Continuity Emergency Preparedness Memorandum of Understanding with Public Health Public Health (including CCG??) Incident Response	MG VP (Finance & Performance Committee)	Risk Assessment	3	3	**9**	12/14	**December 2014** BCCG Business continuity table top exercise planned for January 2015 **October 2014** Operation Cygnus was cancelled but is being replaced by E Bola exercise that will be undertaken in early November 2014 **September 2014** The CCG are involved in NHSE's "Operation Cygnus" to test plans in October 2014 Business Continuity Plans	03/15

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						Plan Reports to Governing Body on emergency resilience issues, including Business Continuity Management NHS England Area Team monitoring report re Emergency Planning Winter Planning Arrangements								agreed **August 2014** The CCG are involved in NHSE's "Operation Cygnus" to test plans in October 2014	
14/13		Potential impact on the urgent care system in Barnsley as a result of the loss of 30 intermediate care beds from April 2015	5	4	**20**	Operational Resilience Funding from NHSE funded the spot purchase of intermediate care to strengthen intermediate care system resilience, in order to mitigate the impact of intermediate bed closures, beds will be spot purchased to meet the needs of the system. The SRG Committee will monitor impact as bed closures start affecting the system in early 2015 . Daily sitreps, weekly teleconferences will provide intelligence	VP (SRG/ Finance & Performance Committee)	Risk Assessment	2	4	**8**	03/15	**March 2015** A discussion was held at Finance and Performance Committee in March and in considered that these beds will now be funded by the Better Care Fund the likelihood of this risk materializing has been reduced to unlikely Consequently reducing the risk from a red to an amber risk.	04/15

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						System resilience funding scheme for 15/16 will need to be priorities in February /March.							**December 2014** Risk rescored at FPC and increased to 20 Task and Finish Group established	
CCG 13/14	1, 5, 6, 8	An Ofsted Inspection in June 2014 rated Barnsley's safeguarding arrangements as 'requires improvement.' Although this represents a step forward from the previous inspection in 2012 (overall rating inadequate) if further progress is not made to sustain and improve the rating there is a risk: (a) that vulnerable people will not be appropriately safeguarded (b) specifically that issues in Rotherham recently reported through the media	5	4	**20**	Multi Agency Improvement Plan in place and being monitored by Improvement Board until improvement notice removed when monitoring will be via BSCB. Once Improvement Board no longer in place its independent Chair will attend the Safeguarding Childrens Board for 6 months to ensure improvement programme effectively progressed. Multi Agency Improvement Group (CCG represented by designated nurse for Safeguarding Children) ensuring the improvement plan is progressed and momentum maintained. Health & wellbeing of Children in Care Steering	BR (Quality & Patient Safety Committee)	CQC/ Ofsted Inspection. Risk Assessment	2	4	**8**	01/15	**January 2015** The DFE 18 month review was held 15.10.14 resulted in a decision by the Minister to lift the Improvement Notice. The Ofsted Improvement Board (OIB) met for the last time on 19.11.14. The responsibility for monitoring the continuous service Improvement plan has now passed to the BSCB. The chair of the OIB is attending BCSB. Monthly updates	04/15

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		could occur (or have occurred) in Barnsley. **Clinical Risk**				Group established to ensure issues are identified and addressed quickly re health of LAC. CCG represented at the BSCB by Chief Nurse, Designated Nurse and Named Doctor. BSCB has CSE work as part of its work plan and a September briefing will identify current activity and undertake a benchmarking exercise against governance issues identified in Rotherham re historical activity.							to the Governing Body on the CSE position in Barnsley are ongoing. Barnsley CCG were notified on Thursday 13th November 2014 by the CQC that they planned to conduct a review of services for LAC and Safeguarding in Barnsley commencing Monday 17th November for a week, ending on Friday 21st November. At the end of the inspection feedback was given to key representatives from all health agencies including BMBC Children and	

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													Families Directorate. There will be no grading on the final report however there will be suggested recommendations for improvement. The inspectors found nothing of concern throughout the week that required immediate remediation. They reported that the CCG had good leadership in place. The inspectors said the report of their findings may take six weeks before it is sent to the CCG to enable a factual accuracy check to be made. The report has not been received to	

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													date.	
CCG 13/13b	1,2	Potential failure of the CCG to engage with patients and the public in the commissioning of services.	4	4	**16**	CCG Patient and Public engagement Governing Body Committee in place Patient and Public Engagement Strategy and OPEN CCG Patient & Public Engagement Strategy & Plan in place Oct 2012 Well-developed relationships being developed with Health Watch. PPE Committee Operational Delivery Group Patient Council PRG project work	VP (Governing Body) (Patient & Public Engagement Committee)	Risk Assessment	4	2	**8**	12/14	**December 2014** Business case re community asset model to be presented to January PPE Committee **September/ October 2014** The CCG are developing a Community Asset model to support the delivery of meaningful inclusive PPE **August 2014** Public version - Executive summary of the CCG's Patient and Public Engagement was approved at August Governing Body Meeting to be posted on the CCG's website	03/15

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CCG 14/16	1, 4, 8	If a culture supportive of equality and diversity is not embedded across the CCG there is a risk that the CCG will fail to discharge its statutory duties as an employer and will not adequately consider issues of equality within the services we commission.	3	4	**12**	CCG has an Equality Objectives Action Plan, developed & monitored by Equality Steering Group, chaired by Chief Nurse and with membership from across the CCG, Healthwatch also attends. Expert support & advice from CSU E&D lead and HR Lead. Full suite of HR policies in place supported by robust EIA. Robust EIA required to support all policies and proposals – audit has been undertaken and training provided. E&D training is a mandatory requirement for all staff (93% compliant). Values & behaviors included within corporate performance review documentation. Regular staff surveys with resulting action plans.	BR (Equality Steering Group)	Risk Assessment	2	4	**8**	01/15		07/15

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						ESG undertakes annual self-assessment of its effectiveness.								
CCG 14/12	1, 6, 7	If, during the reprocurement of the Out of Hours Service, the quality of that service declines, and / or if no suitable alternative provider can be found there is a risk to patient safety and of damage to the CCG's reputation.	2	4	**8**	Reprocurement process currently underway. Although current contract co-commissioned with Rotherham CCG Barnsley holds its own contract monitoring meetings with Care UK, with clinical input from a GB member.	CH Finance & Performance Committee	Risk Assessment	2	4	**8**	12/14	**December 2014** Discussions are ongoing as to a way forward. **October 2015** PIN is underway and will conclude at the end of October. The procurement is to be concluded in February 2015. The specification will be considered by the Governing Body in December.	03/15
CCG 13/15	1,2, 3,6, 8	Failure to receive assurance on performance targets	2	4	**8**	Monthly integrated performance report. Performance Report to Finance and Performance Committee and Governing Body Contract Monitoring meetings	VP (Finance & Performance Committee) (Governing Body)	Risk Assessment	2	4	**8**	10/14	**December 2014** New reporting regime now well established **October 2014** Position is being monitored	01/15

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						between commissioner and Providers Quality & Patient Safety Dashboard to Quality and Patient Safety Group Clinical quality performance reports Contract Compliance visits Independent Contractors Internal Audit Report Independent Contractor Quality frameworks (13 June 2012) Senior Manager sign off process for information issued outside of the organisation Performance Report to Finance and Performance Committee and Governing Body								**September 2014** Revised report presented to September Governing Body **August 2014** New Integrated Performance Report format to be used for September meetings. **June 2014** New Integrated Performance Report format currently being developed.	
CCG 13/16	1, 8	Failing to meet the requirements of the regulatory Reform (fire safety) Order to effectively, manage	3	4	**12**	Fire Brigade inspections (Held by H & S department) HSE inspections Reviewed Health and Safety	VP (Finance & Performance Committee)	Risk Assessment	2	4	**8**	09/14	**December 2014** Annual Health and Safety and fire inspection completed in	12/14

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		our fire safety arrangements				Training within CCG Mandatory training reports Reviewed Health & Safety arrangements in relation to the Commissioner CSU provide oversight health and safety and fire advice through corporate services team							September 2014 **September 2014** Annual Health and Safety and fire inspection completed in September 2014	
CCG 13/20	1, 6	Conflicts of interest re commissioning, decommissioning and procurement processes. In anticipation of National scrutiny of commissioning decisions made by Clinical Commissioning Group we need to ensure we have: • Robust processes in place for the review of services which are auditable resulting in the commissioning or	3	4	**12**	CCG has a conflict of interest policy and declarations of interest are included on every agenda. Audit Committee has a standing item regarding declarations of interest and provides scrutiny of its application. Governing Body development sessions have taken place and conflict of interest is likely to be the subject of future Governing Body development sessions. In relation to implementation of the CCG Commissioning Plan there is a robust system of Programme Boards in place to	VP (Finance & Performance Committee)	Risk Assessment	2	4	**8**	10/14	**October 2014** Position is being monitored and recorded as part of the minutes **September 2014** Staff and Governing Body members reminded of policy and requirements at the start of each formal meeting. **August 2014** Staff and Governing Body members reminded of policy	01/15

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		decommissioning of services; • Clear and consistent documentation of declarations of interest				drive through change and implement developments. A Business Case process and format has been developed and will shortly be rolled out							and requirements at the start of each formal meeting.	
CCG 13/8	1, 3	Inability of SWYPFT block contract arrangements to evidence value for money in the services provided	5	3	**15**	Undertake a review of contract specifications in order to set out patient focused outcome requirements. During 2014/15 Programme Boards will be reviewing specs and contract arrangements for various elements of the contract (see progress / Update). As part of these reviews the proposals will include arrangements to ensure that future services are commissioned on a more transparent basis with clear performance outcome requirements. Mental Health PbR is operating in shadow form during 2014/15 therefore these services are no longer contracted on a block basis.	CH (Finance & Performance Committee)	Risk Assessment	2	3	**6**	12/14	**December 2014** SWYPFT's released prices have been received and CCG staff are considering these together with activity information as part of contract negotiations for 2015/16. **October 2014** In readiness for contract negotiations of the 2015/16 contract, SWYPFT are releasing block contract prices according to reference costs. This work is due	06/15

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													for completion by February 2015 and the contract is likely to reflect more activity based prices in future years. **August 2014** Decisions have been made regarding the Memory Assessment Service and Intermediate Care based on significant efficiently gains. Mental Health PbR s now operating in shadow form. Through these developments all Mental Health contracts and a significant proportion of community service will provide more robust evident of	

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													value for money**.**	
CCG 13/6 and CCG 13/33 Merged July 2013	2, 3, 8	Inadequate support from Commissioning Support Unit (CSU) particularly procurement support and Business Intelligence. WSYB CSU ability to deliver Finance and Procurement Support providing issues with delivery of financial duties	5	3	**15**	Review of the service specifications to get a better understanding of the services commissioned from CSU. Manage the relationship with the WYSB CSU through Customer Relationship Manager and Customer Delivery Board Agree and finalise KPIs for delivery of all aspects of the process. Monthly monitoring and reporting of such performance and the escalating of issues with CSU Support CSU in its own Workforce Development Ensure presence of CSU representatives at Hillder House as required and manage these as part of the team Monthly reporting against KPIs to Customer Delivery Board and Finance and Performance Committee	CH (Finance & Performance Committee)	Risk Assessment	2	3	**6**	12/14	**December 2014** Significant issues have been raised with CSU regarding IT support and GP IT Draft Recovery Plan has been received and is being considered. Contract information communicated included potential changes to IT, finance and the intention to pull back BEST in 2015/16. Discussions are currently ongoing. **October 2014** BEST returned to CCG during 2014/15. Contract negations for 2015/16 are currently being developed.	06/15

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						Internal Audit reviews and reports on performance and links between CSU and CCG CSU Performance Reports to Customer Delivery Board Report of Performance against Financial and Procurement KPIs								**August 2014** Scores remain good, areas where performance is less than optimum i.e BEST being considered to return to the CCG.	
CCG 13/45		Breast Cancer Radiologist Shortage	4	3	**12**	In reach Support to breast radiology provided by Doncaster and Bassetlaw NHSFT	VP (Cancer Programme Board)	Risk Assessment	3	2	**6**	12/14	**December 2014** Position is being monitored via Cancer Programme Board **October 2014** Position is being monitored via Cancer Programme Board **August 2014** Doncaster Hospital renewed SLA for in reach support to BHNFT Review on Breast Screening arrangements for	06/15

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													South Yorkshire is currently being undertaken by NHSE.	
CCG 13/22	2, 6	Variation in performance – capacity within the CCG to support and improve quality in primary care	3	4	**12**	Performance monitoring FPC Quality Surveillance Group meetings across the system. Primary Care workstream with significant investment planned in primary care during 2014/15. Proposal for co-commissioning of primary health care planned to be submitted June 2014.	VP (Finance & Performance Committee)	Identified by Audit Committee 21/02/13	3	2	**6**	12/14	**December 2014** The Barnsley Quality Framework Phases 1 and 2 have been approved and have been implemented. The Innovation Fund and the Year of Care Model are being progressed. The Practice Delivery Agreement was issued on 10th November all of which should all support reducing variation in practice. **October 2014** The Barnsley Quality Framework Phases 1 and 2	06/15

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													have been approved and are being implemented. An Innovation Fund and the Year of Care Model are also approved and being progressed. The groups are now working on the Practice Delivery Agreement concept. Which should all support reducing variation in practice.	
CCG 13/23	2	Transformational change from secondary to primary settings is not achieved through the Programme Boards	3	3	**9**	Contract Reviews Performance Management Framework Refreshed Commissioning plan for 2015/16 Ensure key targets for implementation are met Barnsley Quality Framework Phase 1 and 2	LJS & Programme Board Chairs (Finance & Performance Committee)	Risk Assessment	2	3	**6**	08/14	**August 2014** The CCG has responded to the SY&B Primary Care Strategy by developing a Primary Care Development Plan which was approved by the Governing Body in February 2014. In June 2014 the Governing Body	02/15

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						Practice Delivery Agreement Primary Care Development Programme							approved a Barnsley Quality Framework to enable practices to provide quality services across the range of its contracts. Phase 1 was areas that could be implemented quickly by July 2014, and subsequent phases will include more ambitious schemes including a 'Year of Care' model and an Innovation Fund to improve Primary Care access.	
CCG 13/29	1,2, 3,4, 5,6, 7, 8	PCT Policies currently adopted by the CCG need review and formal approval by the Governing Body	3	3	**9**	Review Schedule regularly updated	VP (Finance & Performance Committee)	Risk Assessment	2	3	**6**	12/14	**December 2014** Annual reviews of policies has commenced and the first 4 will be presented to the next ESG	06/15

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													September 2014 Full suite of policies now approved.	
CCG 13/28	1,2, 3, 8	The CCG not spending its Programme Board funding allocation and unallocated allocation through these Boards .	2	3	**6**	Plans developed for unallocated funding through Programme Boards.	J Harban - Cancer PB, C Bannon - Planned Care PB, S Krishnaswamy – Unplanned Care PB, M Ghani – Ageing well PB, CHobson Finance & Performance Committee	Risk Assessment	1	5	**5**	06/14	**December 2014** Plans have been developed to utilize all unallocated funding in 201415 to support programme expenditure pressures. **June 2014** F&PC have agreed enhanced arrangements for reporting Programme Board activity in 2014/15 which should contribute to assurance of PB readiness to spend and delivery of plans.	12/14
CCG 13/30	1, 5, 8	NHS Barnsley does not operate within the	1	5	**5**	Annual information governance toolkit and	VP	Risk Assessment	1	5	**5**	12/14	**December 2014** Development plan	06/15

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		legal information processing framework **Clinical Risk**				associate improvement programme Updated NHS Barnsley IG Framework approved September 2011 Annual Report IR 1 process Internal Audit Report Information Governance Toolkit Version 9 Audit Verification (30 April 2012) Trust wide induction training on information governance Mandatory Training report Caldicott guardian appointed Patient consent forms Consent policy Review partnership information governance arrangements All but 1 GP Practice completed IGSoC	Governing Body (Finance & Performance Committee)						being delivered progressing work to submit March 15 toolkit **September/ October 2014** Information Governance Development Plan agreed and CCG Publication scheme is being progressed. **August 2014** Information Governance Development Plan agreed and CCG Publication scheme ids being progressed. **May 2014** IG toolkit submitted at the end of March 2014.Level 2 achieved across all standards.	

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						Updated Acceptable Use of Communication Technology Policy								
CCG 13/31	1,2, 3, 8	CCG does not achieve its statutory financial	1	5	**5**	Budget Clinics and Monthly Budgetary Management	CH	Risk Assessment	1	5	**5**	12/14	**December 2014** The Mid Year	06/15

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		duties				meetings with Budget Holders to review performance Development of QIPP programmes and savings schemes in consultation with Programme Boards Ongoing Monitoring and Reporting to the Finance and Performance Committee with robust forecasts on income and expenditure on a monthly basis Budget Holders receive adequate training and advice from Management Accountants to hold each area's financial performance to account and provide sufficient notice of variation from plan Prime Financial Procedures and Standing Orders are in place Work to be undertaken with Budget Managers and Service Improvement Leads to develop QIPP schemes to mitigate against risk	Governing Body (Finance & Performance Committee)						Financial Review concluded November 2014 with actions for implementation commencing. Close monitoring of financial position, contract activity and risks continue. **October 2014** The position is unchanged. **August 2014** The CCG is on track to deliver its statutory financial duties for 2014/15 **June 2014** Annual Report & Accounts 2013/14 now audited with an unqualified opinion. Financial Plans have been submitted to NHS England for 2014/15. The risk of the CCG not	

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						Internal Audit Reports on general financial procedures and Budgetary Control Procedures (including review of functions delivered by WSYB CSU) Monthly Reports on the financial position to Governing Body and Finance and Performance Committee as part of Integrated Performance Report Annual Governance Statement Local Counter Fraud Specialist Progress Reports to Audit Committee Losses and Special Payments report to Audit Committee Annual Report & Accounts subject to statutory external audit by KPMG, reported via Annual Governance (ISA260) Report, and Annual Audit Letter. Monthly reporting to NHS England of position							achieving statutory financial duties in 2014/15 is minimal at this stage. **May 2014** An external auditor review is underway.	

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CCG 13/34	1, 3, 8	The failure of the Integrated Single Financial Environment with SBS system providing issues with the raising and paying of invoices	1	5	**5**	Ledger system is national system and therefore controls in place at SBS and CSU to deal with issues Any failure can be mitigated against by making direct payments from the CCG Bank Account with full audit trail of transactions. Internal Audit Reports on ISFE both at CCG and CSU Monthly meetings of the ISFE Programme Group detailing any issues and dealing with the consequences ISFE national programme board External Audit review of financial process and procedures Final Accounts	CH (Finance & Performance Committee)	Risk Assessment	1	5	**5**	12/14	**December 2014** No issues to report. **October 2014** No issues to report. **August 2014** No issues to report.	06/15
CCG 13/13a	6	Risk that the CCG would not achieve its statutory duty to involve and consult with patients and the	4	4	**16**	CCG Patient and Public engagement Governing Body Committee in place Patient and Public	VP Governing Body	Risk Assessment	1	4	**4**	12/14	**December 2014** Business case re community asset model to be presented to	06/15

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		public.				Engagement Strategy and OPEN Produced the Annual Report (statutory requirements) in line with national guidance and through consultation with key stakeholders SLA in place with Commissioning Support Unit to support this duty CCG Patient & Public Engagement Strategy & Plan in place Oct 2012 Well-developed relationships being developed with Health Watch. PPE Committee Operational Delivery Group Patient Council PRG project work	(Patient & Public Engagement Committee)							January PPE Committee **September/ October 2014** The CCG are developing a Community Asset model to support the delivery of meaningful inclusive PPE **August 2014** Public version - Executive summary of the CCG's Patient and Public Engagement was approved at August Governing Body Meeting to be posted on the CCG's web	
CCG 13/5	3, 6	The CCG cannot currently access data and cannot therefore undertake robust contract monitoring &	5	4	**20**	Act of Parliament to be passed to allow Clinical Commissioning Groups to access patient level data.	CH (Finance & Performance Committee)	Risk Assessment	1	4	**4**	12/14	**December 2014** No issues to report. **October 2014**	06/15

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		management – particularly contract reconciliation, invoice processing and cost per case.				Development of the Data Services for Commissioners Regional Office (DSCRO) and links to Barnsley facing representatives will allow NHS Barnsley CCG to be able to validate data at patient level to enable it to undertake its statutory duties. Interim arrangements are in place via DH section 251 agreement, which has currently been extended to 31 October 2014							No issues to report. **August 2014** No further developments to report. **May 2014** Situation as per Nov 2013. Longer term issue still to be resolved nationally.	
CCG 13/25	4	If there is insufficient capacity within the Joint Commissioning Unit, currently or as a result of any future restructure, there is a risk that projects may not be delivered with potential adverse consequences for the delivery of the CCG's commissioning priorities.	3	3	**9**	Senior managers to consider future option of current JCU activities. Head of Service Development meets regularly with individuals in JCU. Additional capacity / support has been recruited into the Service Development team. Delivery is monitored via Programme Boards.	MG Programme Board Clinical Leads (Finance & Performance Committee)	Risk Assessment	2	2	**4**	06/14	**June 2014** Additional capacity recruited into CCG Service development Team to increase resilience.	01/15

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CCG 13/38	1, 3, 8	Loss of resources and reputation to the CCG from Fraud	1	3	**3**	Annual Budgets and review of these on a periodic basis Budgetary control system Regular Financial Reporting Cashflow Projections Fraud Policy in place Fraud Awareness Fraud locally agreed work plan Prime Financial Procedures, Standing Orders and Scheme of Delegation Audit Reports to Governance Risk and Audit Group and Audit Committee Local Counter Fraud Specialist Progress Reports to Audit Committee Internal Audit Reports on Treasury Management Financial Controls Counter Fraud Officer in place External Audit Reports	CH (Finance & Performance Committee)	Risk Assessment	1	3	**3**	12/14	**December 2014** No issues to report. **October 2014** No issues to report. **August 2014** No issues to report. **May 2014** No significant issues identified**.**	12/15

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						Annual Report Compound Indicators Level 3 Annual Local Counter Fraud Reports								
CCG 13/32	3	Local impact of tariff is greater than national impact	5	1	**5**	NHSB plans to re-invest 1.5% net reduction in tariff	CH (Finance & Performance Committee)	Risk Assessment	2	1	**2**	12/14	**December 2014** No issues to report. **October 2014** No issue to report and it is proposed that this issue is deleted as impact would be seen in CCG 14/4. **August 2014** No issues to report. **April 2014** Contract negotiations with SWYPFT concluded. BHNFT not yet concluded. Impact of CIPs on both contracts still to be identified.	12/15

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NEW RISK JANUARY 2015

14/15	1, 5, 6	If the quality and completeness of D1 discharge letters is not improved there is a risk that patients may not be prescribed the correct medication following hospital discharge thereby increasing the risk of harm (An audit of 355 D1 discharge letters from BHNFT undertaken by the medicines management team identified that in 55% of cases the TTO section had not been completed or was incorrect).
14/16		If a culture supportive of equality and diversity is not embedded across the CCG there is a risk that the CCG will fail to discharge its statutory duties as an employer and will not adequately consider issues of equality within the services we commission.

NEW RISK DECEMBER 2014

CCG 14/14		If the problems with telephony in the Goldthorpe LIFT building are not resolved there is a risk that Barnsley patients may be unable to access services and / or that the safety of patients will be compromised

NEW RISK NOVEMBER 2014

14/13	Potential impact on the urgent care system in Barnsley as a result of the loss of 30 intermediate care beds from April 2015

NEW RISK SEPTEMBER 2014

CCG 14/12		If, during the reprocurement of the Out of Hours Service, the quality of that service declines, and / or if no suitable alternative provider can be found there is a risk to patient safety and of damage to the CCG's reputation.

RISK REMOVED MARCH 2015

CCG 13/35	5, 6	Impact of Local Authority actions around minimum council and social care reductions	4	1	**4**	Will need consideration in the usage of reserves Discussion and planning with Joint Commissioning Executive	CH (Finance & Performance Committee)	Risk Assessment	5	4	**20**	12/14	**March 2015** Removed as covered under Risk 14/13. **December 2014** Reductions to Intermediate Care beds being accessed by the Ageing Well Programme Board. This will have a significant impact on the CCG's ability to implement required changes and achieve reduced admissions. BMBC's plan to reduce mental health budgets by £0.5m raises significant risk to system resilience moving forward.	01/15

RISKS REMOVED APRIL 2014

None.

RISKS REMOVED MAY 2014

None.

RISKS REMOVED JUNE 2014

CCG 13/2a	1, 3, 6 6	CHC Retrospective Close Number of applications now known 300. Financial risk of significant variance from provision assessed as at 31 March 2013 (over or under)	5	4	**20**	National Guidance Screening process in place Cluster wide approach to manage retrospective reviews Monthly financial forecast in place to monitor conversion rate Financial Modeling has been undertaken to assess the financial risk Financial contingency reserves Internal Audit Review of CHC Claims.	CH (Finance & Performance Committee)	Risk Assessment	1	4	**4**	05/14	**June 2014** This risk has been removed as the financial risk has been fully mitigated. However a closely related risk, 13/2b (relating to the quality risks associated with retrospective CHC applications) remains on the Register.	11/14
CCG 13/9	2, 7	Failure of the CSU to provide adequate IT services from 1 April 2013	5	5	**25**	SLA and KPIs between CCG and CSU Finance & Performance Committee Contract monitoring	CH (Finance & Performance Committee)	Risk Assessment	1	3	**3**	04/14	**June 2014** Risk now fully mitigated, removed from register. **April 2014**	04/15

						KPIs Action plan in place							No significant issues in 2013/14. ICT Strategy in development.	
CCG 13/21	2, 4	Insufficient capacity within the Finance Contracting Team and leading to inability to deliver strategic and medium term financial plan	4	3	**12**	Revised structure proposals to MT on 16 July 2013. Additional capacity being sought to undertake short term pieces of work eg specification reviews. Assessment of likely need for procurement support from CSU is underway. This will support any procurement undertaken in 2013/14. Identified potential option of securing interim support to undertake one-off pieces of work.	CH (Finance & Performance Committee)	Risk Assessment	1	3	**3**	05/14	**June 2014** Capacity issues in finance team now addressed, risk fully mitigated and removed from register. **May 2014** No changes to this risk. Discussions are taking place on whether it is appropriate to remove this risk from the risk register.	05/15
CCG 13/11	1,5, 6, 8	Issues have been raised by NHS Barnsley and the Joint Commissioning Unit around aspects of SWYPFT performance related to IAPT services in Barnsley. This is in relation to recruitment and more specifically retention of staff, in particular Psychological Wellbeing Practitioners (PWP's)	4	3	**12**	Remedial action in place Recruitment and retention of staff has been recognised as an issue regionally and nationally and has had a significant impact on performance against KPIs Recruitment of staff being undertaken by provider Key Performance Indicators reported monthly Monthly Quality/contract meetings Contract sanctions have been	CH (Finance & Performance Committee)	Risk Assessment	1	3	**3**	04/14	**June 2014** Risk now fully mitigated, removed from risk register. **April 2014** IAPT Interjectory and targets for 2013/14 have been met through the contract.	04/15

						introduced and penalties will be applied for failure to deliver contract target levels								

RISKS REMOVED JULY 2014

CCG 13/44	2,1	Assurance provided to meet key actions in the Commissioning Strategy linked to the commissioning of NHS Health Checks	3	3	**9**	Highlight reports on a quarterly basis Support to access practice data via CSU Clinical input into reviewing practice variation	MG Quality & Patient Safety Committee	Identified by Public Health July 2013	2	3	**6**	08/13	**July 2014** This risk is now removed due to an Information Sharing Protocol now in place between LA's, CCG's and the CSU. **June 2014** CCG Medical Director contacting Sharon Stolz to obtain an update on this risk.	02/14

GOVERNING BODY

5 March 2015

INTEGRATED PERFORMANCE REPORT

1.	**PURPOSE OF THE REPORT**
1.1	To provide the Governing Body with: • The headline Performance Dashboard including performance against the Key Performance Indicators, along with an update on key performance issues by exception. • An overview of the key risks or challenges in achieving performance indicators along with any actions being taken to improve performance. • An update on workforce information and performance. • The financial position as at 31 January 2015 together with forecasts for the year end
2.	**EXECUTIVE SUMMARY**
2.1	The Governing Body Integrated Performance Report aims to provide an overview of performance, of NHS Barnsley Clinical Commissioning Group (BCCG) up to the end of January 2015. The report also highlights the financial performance of the CCG up to 31 January 2015.
2.2	The performance report attached at Appendix 1 provides a high level dashboard and an exception report which covers the NHS constitution standards, quality indicators, key performance indicators linked to programme board performance and financial performance. This is supplemented by finance appendices A and B which provide details of achievement of financial duties and an executive summary of the financial position for the month.
2.3	The Finance and Performance Committee have received a more detailed report containing all indicators monitored by the CCG and detailed financial analysis to enable them to maintain an oversight of performance and finance and provide assurance to the Governing Body.
2.4	There are a number of performance measures which are currently rated at 'Red' or 'Amber' for the month of January 2015. Where these are new ratings or where new data has become available since the last report and performance continues to be a concern, a narrative is provided in the performance report attached at appendix 1. A number of the measures which are currently flagged red are annual targets and therefore no narrative is included.
2.5	Key issues which are identified within the report are : • Waiting times for diagnostic tests (Red)

<table>
<tr><td></td><td>

Yorkshire Ambulance Service performance for category R1 and R2 calls, ambulance handover times and crew clear delays. (Red)
Friends and Family, % patients who would recommend their Hospital - A&E (Red)
People receiving thrombolysis following an acute stroke (Red)
Cancer patients seen within 62 days following consultant upgrade (Red)

</td></tr>
<tr><td>2.6</td><td>The Barnsley CCG January 2015 workforce information is currently showing that:

The CCG workforce has 93 employees (75.4 full time equivalents) an increase of 3 from December.
The sickness rate in January has increased to 5.7%, the highest for the year to date and above the target of 2.5%. The year to date rate has also risen to 2.86%.

</td></tr>
<tr><td>2.7</td><td>The CCG is expected by NHS England to deliver a revised surplus of £10,480k and plans to achieve this position.</td></tr>
<tr><td>2.8</td><td>The CCG is currently forecasting an overspend of £242k before risk-adjustment, after accounting for delivery of a projected £10,480k surplus. This represents an improvement of £1,831k on the £2,073k overspend projected at month 9. The components of this overall movement are expanded upon in the body of this report.</td></tr>
<tr><td>2.9</td><td>The risk-adjusted year-end forecast is an overspend of £214k, as shown at paragraph 3.23. This represents an improvement of £220k on the risk-adjusted position projected at month 9.</td></tr>
<tr><td>2.10</td><td>This level of anticipated overspend represents 0.06% of our total resource allocation. Therefore, it is expected that management action in the remaining months will ensure that the required surplus is delivered.</td></tr>
<tr><td>2.11</td><td>The position before risk-adjustment is set out below:
<table>
<tr><th></th><th>£'000s</th><th>£'000s</th></tr>
<tr><td>Programme Forecast Overspend (Total Commissioning Services)</td><td>2,355</td><td></td></tr>
<tr><td>Running Cost Forecast Underspend</td><td>-250</td><td></td></tr>
<tr><td>CCG Forecast Overspend (excluding reserves)</td><td></td><td>2,105</td></tr>
<tr><td>Programme Reserves Underspend</td><td>-1,372</td><td></td></tr>
<tr><td>Other Resource Requirements Overspend</td><td>516</td><td></td></tr>
<tr><td>Sub-Total Programme Board and Other Reserves</td><td></td><td>-856</td></tr>
<tr><td>Required increase in surplus for CHC Retrospectives</td><td></td><td>840</td></tr>
<tr><td>Application of Contingency</td><td></td><td>-1,847</td></tr>
<tr><td>Total Projected Overspend</td><td></td><td>2,037</td></tr>
</table>
</td></tr>
<tr><td>2.12</td><td>The financial risk assessment (see section 3.23) has been undertaken to take account of potential changes to income levels and further contract risk. This has identified a risk-adjusted forecast overspend in the order of £214k.</td></tr>
<tr><td>2.13</td><td>It should be noted that the majority of CCG programme expenditure relates to payments for variable activity levels. Therefore, the position will continue to be monitored and mitigating actions will be taken to deliver the required surplus.</td></tr>
</table>

3.	**THE GOVERNING BODY IS ASKED TO:** • Note the contents of the report, including the 2014/15 performance to date and forecast financial outturn.

Agenda time allocation for report:	5minutes.
Report of:	Vicky Peverelle / Heather Wells
Designation:	Chief of Corporate Affairs / Chief Finance Officer
Report Prepared by:	Jamie Wike / Neil Lester/Patrick Otway
Designation:	Head of Planning & Performance / Deputy Chief Finance Officer/Deputy Chief Finance Officer - Contracting

1.	**SUPPORTING INFORMATION**	
1.1	**Links to the Assurance Framework**	
	This report provides assurance to the Committee against risks 1.1, 1.3, 1.4, 3.1 and 4.1 of the Governing Body Assurance Framework. Performance and finance reporting is a key tool in providing assurance that both the risks currently identified within the Assurance Framework are being addressed and that any emerging performance risks are escalated as appropriate.	
1.2	**Links to Objectives**	
	To have the highest quality of governance and processes to support its business	✓
	To commission high quality health care that meets the needs of individuals and groups	✓
	Wherever it makes safe clinical sense to bring care closer to home	
	To support a safe and sustainable local hospital, supporting them to transform the way they provide services so that they are as efficient and effective as possible for the people of Barnsley	✓
	To develop services through real partnerships with mutual accountability and strong governance that improve health and health care and effectively use the Barnsley £.	✓
1.3	**Governance Arrangements Checklist**	**Has the area been considered**
	Financial Implications	Yes
	Contracting Implications	Yes
	Quality	Yes
	Consultation / Engagement	N/A
	Equality and Diversity	N/A
	Information Governance	N/A
	Environmental Sustainability	N/A
	Human Resources	N/A

2.	**INTRODUCTION/ BACKGROUND INFORMATION**
2.1	This monthly integrated performance report consists of a progress update against key performance indicators, details the CCG performance against its statutory and other financial duties and assesses the risks of achievement by the year end.
2.2	The headline performance report (attached at Appendix 1) covers the NHS constitution standards, quality indicators, key performance indicators linked to programme board performance, workforce indicators and financial performance. The report contains, by exception, a narrative on any key performance issues escalated by Finance and Performance Committee along with details of any actions being taken to address under performance.
2.3	Work will continue on developing and refining the performance reporting framework, in consultation with Governing Body members and lead officers across the CCG to ensure it is fit for purpose and contains the right information to provide the Governing Body with assurance of performance against the Commissioning Plan 2014/19 priorities and outcome ambitions.
2.4	The finance and contracting narrative details the financial performance of the CCG as at 31 January, along with the forecast year end outturn.
2.5	Year-end forecasts have been subject to a similar process as previous months, involving all budget holders and relevant CCG leads.
3.	**DISCUSSION/ISSUES**
3.1	**<u>Performance Report – Progress against Key Performance Indicators by Exception</u>**
3.2	There are a large number of performance indicators which are monitored by the CCG to provide assurance and measure performance in delivering improved outcomes. These are reviewed on a monthly basis by the Finance and Performance Committee with key indicators reported on a monthly basis to Governing Body.
3.3	The key issues identified for consideration by the Governing Body are: • Diagnostics – The percentage of patients waiting for diagnostic tests for more than 6 weeks from referral continues to exceed the 1% with 102 patients (3.37%) waiting longer than 6 weeks, up from 91 (2.76%) patients waiting longer than 6 weeks in December. The majority of the delays were at BHNFT where there were 77 over 6 weeks. (Red) • Yorkshire Ambulance Service performance in Barnsley has improved from December but remains below the target. Performance for Red 1 (the most urgent) calls in Barnsley remains below the target at 65.6% in January against a target of 75% and for R2 calls in Barnsley was 66%. Year to date performance in Barnsley also remains below the target for both R1 (64.51%) and R2 calls (63.69%). The level of improvement between December and January in Barnsley for all Red calls has been higher than other South Yorkshire CCG's (Red).

- Ambulance turnaround efficiency measures were also below targeted expectations in January:-
  - Ambulance handover times over 30 minutes, recording 41 breaches, down from 65 breaches in December. (Red)
  - Ambulance crew clear delays over 30 minutes recorded 6 breaches in December. 1 of these were over 60 minutes (Red)

- The percentage of patients recommending their hospital (A&E) has fallen as at the end of quarter 3 to 80.65% from 96.75% at the end of quarter 2. This reflects the national trend and could relate to the reduced performance against the 4 hour waiting time standard. Barnsley has the highest satisfaction rate in South Yorkshire.
- The number of people who have had a stroke who receive thrombolysis following an acute stroke fell by 2% to 4.6% between quarter 1 and quarter 2 of 2014/15. Nationally 11.7% received thrombolysis and in South Yorkshire 5.8%.

- The percentage of patients seen with 62 days following consultant upgrade was below the target in December at 83.33%. 5 out of 6 patients were seen and treated within 62 days. For Quarter 3, 84.21% of patients were seen in 62 days (16 out 19)

3.4 **Programme Board Progress and Performance**

3.5 There were no major or minor reviews scheduled for reporting to Finance and Performance Committee in March.

3.6 **Finance and Contracting Report as at 31 January 2014**

The following narrative details the financial performance of the CCG as at 31 January (month 10), along with the projected year-end outturn.

Year-end forecasts have been subject to a similar process as previous months, involving all budget holders and relevant CCG leads.

As shown at Appendix A, the CCG is planning to achieve of all of its statutory and other key financial duties. This includes the achievement of a surplus of £10,480k, in line with NHS England expectations.

Allocations to the CCG increased by £27k in month. This relates to the receipt of £39k related to seasonal resilience for Critical Care Beds, off-set by a £12k reduction for re-allocation of Specialised Commissioning resources in respect of Leeds Teaching Hospitals NHS Trust.

Appendix B provides a summary of the financial performance of the CCG to date and forecast year end position against this revised resource allocation.

3.7 **Headline Messages**

The forecast before risk-adjustment is an overspend of £242k, which represents an improvement of £1,831k compared to the forecast position last month.

Within this total movement, forecasts for Total Commissioning Services have shown an improvement of £1,274k from month 9. The components of this forecast reduction are set out below :

Acute Contract forecast movements	-£451K
Mental Health and Community forecast movements	-£37K
Continuing Healthcare	-£202K
Primary Care Expenditure (Prescribing)	-£589K
Other Programme Costs	£5k
Total Commissioning Services movement from month 9	**-£1,274k**

Underpinning the total overspend of £242k, referred to above, are the following elements:

Total Commissioning Services – forecast overspend	£2,162k
Corporate Costs/property charges – forecast overspend	£193k
Running costs – forecast underspend	- £250k
Overspend before application of contingency and reserves	£2,105k
Programme Board and Other Reserves – forecast underspend	-£856k
Contingency	-£1,847k
Forecast underspend against our original plan	-£598k

However, as reported in month 9, the CCG is now required to deliver a surplus £840k higher than plan. Therefore, in order to deliver the revised surplus (£10,480k), a further underspend of £242k is required.

In order to provide assurance in respect of the CCG's resilience to further contract risk and potential allocation changes, a financial risk assessment has been provided at paragraph 3.23.

The risk-adjusted year-end forecast is an overspend of £214k. This level of anticipated overspend represents 0.06% of our total resource allocation. Therefore, it is expected that management action in the remaining months will ensure that the required surplus is delivered.

3.8 **Programme Expenditure**

3.9 ***Acute Expenditure***

Based upon current forecasts the CCG is anticipating an overspend of £3,062k on acute contract expenditure. This is a reduction of £451k on the month 9 projection

The following paragraph highlights the main movements between month 9 and 10:

The movements are as follows;

1. BHNFT – reduction in forecast	-£762k
2. Sheffield Teaching Hospitals – increased forecast	£337k
3. Other minor contract movements	-£26k
Total Acute Contracts movement on forecast	**-£451k**

These movements are based upon latest contract monitoring information and represent the most accurate forecast, however forecasts are still subject to variation in the remaining months of the financial year. The following section provides further information on the activity position underpinning these financial forecasts and remedial actions.

It should be noted that the forecast for our main provider, Barnsley Hospital NHS FT, is subject to revision. It has previously been reported that the Trust are implementing a new patient information system, and that data reliability issues have been encountered. The Trust is currently undertaking a data validation exercise and expects to issue revised figures by end of February. This presents a risk to the reported position, therefore, an estimate of potential impact has been included within the risk-adjusted position reported at paragraph 3.23.

3.10 **Barnsley Hospital NHS Foundation Trust** (BHNFT) – The data quality issues referred to above mean that intelligence in respect of this contract is limited.

The year to date position indicates an underspend of £725k, with a forecast year-end underspend of £687k. Month 10 information suggests a continued significant underspend in both Outpatients (£975k) and Electives (£1,171k).

However, the Trust continues to state that they are aiming to achieve activity up to their planned levels across all surgical specialties for the remainder of the year. Within Trauma & Orthopaedics additional theatre sessions have been. We are assured that no activity is being undertaken that will reduce RTT to below 16 weeks. This potential impact has been factored into our risk assessment at paragraph 3.23.

3.11 **Rotherham Foundation Trust -** The position at month 10 is a year to date overspend of £309k, with a forecast year-end overspend of £381k. The forecast overspend is driven by Lucentis injections being the approved treatment of choice for 3 ophthalmic conditions (Age Related Macular Degeneration (ARMD), Diabetic Macular Oedema and Retinal Vitreous Oedema) rather than for ARMD alone, as was previously the case.

As reported previously, it is the intention that as part of the Service Development Improvement plan for 2015/16 a clinical review will be undertaken by Rotherham Foundation Trust to ascertain whether it is feasible to provide the Lucentis injections every 3 months as opposed to the current practice (every 2 months) to address the financial pressure.

3.12 **Sheffield Teaching Hospital -** A significant overspend continues to be experienced at Sheffield Teaching Hospitals (£2,157k year to date). This is partially a result of addressing the pressures with long waits.

Non-elective overspends continue to be seen in Cardiology, Urology and Obstetrics and there is an overspend of £539k (year to date) in Critical Care/ Rehabilitation. Sheffield Teaching Hospital are requesting additional support in 2015/16 for a further 4 Critical Care beds.

The Trust and the CCG expect the activity trend at Sheffield Teaching though to year-end, driving the forecast overspend up to £2,560k.

In relation to RTT funding received by Sheffield CCG, Barnsley has been allocated a share based upon actual activity (£242k). This is reflected within the risk- adjusted position reported at paragraph 3.4, and has been received in month 11.

3.13 **Sheffield Children's Hospital –** The underspend at month 10 is £168k, with a forecast year-end outturn of £230k. This is a result of continued restricted capacity due to ongoing capital works and refurbishment at the Trust.

3.14 **Mid Yorkshire Hospitals -** Month 10 shows an overspend of £356k, with a year-end forecast of £453k. Elective and day case Trauma and Orthopaedics and Plastic surgery are the areas identified as the main contributors to this position, with patient choice continuing to be a driver.

3.15 **Independent section -** The year to date position at month 10 across all Independent providers combined, shows an overspend of £327k with a forecast year end overspend of £463k. This continues to be primarily within Trauma and Orthopaedics, and reflects both patient choice and a general increase in demand for these services.

3.16 **Other Areas of Programme Expenditure**

3.17 **Mental Health and Community Contracts –** The majority of these contracts are on a block basis and therefore contracts are forecast to be broadly break-even. For Mental Health there is a £71k forecast underspend, related primarily to Non-Contract activity. Community health services are showing a forecast underspend of £68k, related to CQUINS with South West Yorkshire Partnerships NHS FT.

3.18 **Continuing Healthcare – In-Year Programme Expenditure –** The forecast year-end underspend is £1,703k. This is an increase in underspend of £201k from the position reported at month 9 and relates to a revised projection for Free Nursing Care payments to BMBC and a small movement on CHC care packages. The current forecast includes £140k for expected growth in Adults' CHC and £260k for Children's. The Children's CHC growth is expected to be utilised on 2 known cases but costs have not yet been confirmed. This area continues to be monitored closely by Finance, the CHC Team and the Chief Nurse due to the risks arising from high cost individual care packages.

It is worth highlighting that the overall CHC forecast underspend includes £840k resource related to CHC retrospective claims, which was returned to the CCG in month 9.

3.19 **Primary Care Expenditure –** Total primary care expenditure is forecast to overspend by £1,281k, representing an improvement of £588k from month 9. The key driver within this area is the prescribing budget which accounts for £1,172k of the overspend. The prescribing position has improved by £597k based upon PPA data for December. The potential for this was flagged in the risk-adjusted forecast at month 9 and has come to fruition in latest PPA reports. However, January data has recently been received and is

being validated. This indicates an increase in the number of items prescribed which could result in financial pressure, therefore, the risk of increased costs has been included within the risk-adjusted position.

3.20 **Other Programme Costs –** This area is forecast to underspend by £338k, this is broadly in line with the position reported at month 9.

3.21 **Running Costs**

It is projected that the Running Costs allocation of £6,099k will underspend by £250k. This position ensures that the CCG will meet its duty not to exceed the amount specified in Directions for Revenue Administration Resource. This underspend is being utilised to support the commissioning of front-line patient services.

3.22 **Programme Reserves and Other Resource Requirements**

There is forecast overspend against Total Programme Reserves and Other Resource Requirements of £856k. This results from;

- Total Programme Reserves projected underspend -£1,372k
- Other Resource Requirements overspend £515k

3.23 **Financial Risk Assessment**

Detailed below is a financial risk assessment taking account of the forecast positions outlined above, plus potential changes to income levels and further contract risk.

	£'000s	£'000s	£'000s
Total Projected Overspend			**242**

Potential Income Sources/Reductions in Forecasts			
RTT Funding to be transacted in month 11	-242		
IT Strategy rebate from CSU	-100		
Maximising use of £260k rebate for IT equipment	-65		
Year of Care – revised delivery timeframe	-195		
Sub-total potential changes		**-602**	
Potential Net Benefit before Further Contract Risk			**-602**

Further Contract Risk	
BHNFT forecast risk	350
Cancer Website Investment	15
Prescribing risk	209
Sub-Total Further Contract Risk	**574**

Risk-adjusted Forecast Overspend	**214**

As shown above there are potential additional income streams and reductions in forecast that are expected to improve the position of the CCG:

- RTT Funding is expected from Sheffield CCG. The result is a benefit of £242k. This has been received in month 11.
- IT strategy has not been delivered by the CSU, therefore a rebate has been agreed at £100k. In addition, a further £65k of IT equipment will be charged against a previous £260k credit. These will be transacted in month 12.
- Year of Care within the Primary Care workstream will be funded in 2 six-month tranches. The first will be payable in 2014/15, the second in 2015/16: this reduction relates to the revised schedule of delivery.

3.24 Specific Contract Risks and/or planned expenditure impacting on the CCG financial position are:

- Risk of increased costs from BHNFT following validation of data through the Lorenzo system. A response from the Trust is expected by end of February.
- Cancer Programme Board proposal to implement the Cancer Website in 2014/15 rather than 2015/16, by utilising the reduction in expenditure for End of Life Strategy
- Prescribing risk related to increased items prescribed as highlighted in paragraph 3.19.

3.25	In summary, the worst case position is that current forecasts continue, contract risk is realised and identified sources of reduction or income do not materialise. This would result in an overspend of £816k. However, it is considered that the likelihood of this scenario is minimal.
3.26	The risk-adjusted forecast overspend is £214k. This represents our current view of the most likely outturn. Therefore, it is expected that management action in the remaining months will ensure that the required surplus is delivered.
4.	**IMPLICATIONS**
4.1	Any implications of current levels of performance are included within the commentary in section 3.
4.2	On the basis of the information presented in this report, it is recommended that the committee; • Note the contents of this report.
5.	**RISKS TO THE CLINICAL COMMISSIONING GROUP**
5.1	There are a number of risks relating to the performance section of the report including those in relation to waiting times for diagnostics and ambulance service performance however these are included on the CCG risk register and are being monitored appropriately. The financial risks to the organisation are that: • The report has highlighted a potential overspend position for the year, if management action is not successful • The financial position of Barnsley Hospital NHS Foundation Trust is a continued source of risk • The implementation of a new patient administration system by the Trust has meant that robust contract information has not been available for the year to date. It is expected that it will be available for Month 11, as discussed and assured at contract meetings, however there is still a residual risk.
6.	**CONSULTATION**
6.1	All relevant functions and departments within the Clinical Commissioning Group are engaged in the development of the integrated performance report and all relevant documents or approaches have been provided to Governing Body, Management Team, the Audit Committee or Programme Boards prior to this paper.
7.	**APPENDICES TO THE REPORT**
	Performance Section • Appendix 1 – Barnsley CCG (InPhase) Monthly Performance Report to October 2014 **Finance Section** • Appendix A – Performance against Key Financial Duties

	• Appendix B – Financial Performance : Executive Summary
8.	**CONCLUSION**
8.1	Progress against all indicators will continue to be monitored and those indicators that are underperforming will be highlighted.
8.2	The Governing Body is asked to note the content of the report and the current level of performance against key indicators including 2014/15 forecast financial performance.

NHS Barnsley Clinical Commissioning Group
Performance Report

CCGs are accountable to their local populations and to NHS England for planning and delivering comprehensive and high quality care that meets the needs of their local community.

We have created within InPhase the tools that you need to ensure that your activities and operations are compliant with the targets set within the CCG Assurance Framework.

Putting Barnsley people first

Governing Body Dashboard 2014/15

NHS
Barnsley Clinical Commissioning Group

Key to Ratings:
- Improving
- Not Improving
- Area of Concern
- Not Available Yet

Performance Direction of Travel (comparison to previous period)
- Performance Improving
- No Change
- Performance Getting Worse

'?' = Awaiting Data

Performance

Outcomes	Target	Actual Period	Actual YTD	Period End Date
Potential Years of Life Lost (PYLL) from causes considered amendable to healthcare, per 100,000	2,471.30	2,445.30	2,445.30	December 2013
Improved Access to Psychological Services-IAPT: People entering treatment against level of need	3.42 %	3.42 %	3.42 %	December 2014
Improved Access to Psychological Services-IAPT: People who complete treatment, moving to recovery	50.00 %	57.78 %	57.78 %	December 2014
Estimated diagnosis rate for people with dementia	65.65 %	66.67 %	66.67 %	December 2014
Unplanned hospitalisation for chronic ambulatory care sensitive conditions	1,164.60	1,187.40	1,187.40	June 2014
Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s	363.30	338.10	338.10	June 2014
Emergency admissions for acute conditions that should not usually require hospital admission	1,649.60	1,673.30	1,673.30	June 2014
Emergency admissions for children with Lower Respiratory Tract Infections (LRTI)	480.20	524.00	524.00	June 2014
The proportion of older people (65+)still at home 91 days after discharge into rehabilitation	81.90 %	77.20 %	77.20 %	March 2014
Patient experience of hospital care	76.90	77.30	77.30	March 2014
% Patient experience of primary care - GP Services	85.18 %	84.69 %	84.69 %	September 2014
% Patient experience of primary care - GP Out of Hours services	67.90 %	66.88 %	66.88 %	September 2014
Incidence of medication errors causing serious harm	0	0	0	December 2014
Incidence of healthcare associated infection (HCAI) - C.Diff (Commissioner)	63	3	60	January 2015
Incidence of healthcare associated infection (HCAI) - MRSA (Commissioner)	0	0	1	January 2015
% Admitted patients to start treatment within a maximum of 18 weeks from referral (Commissioner)	90.00 %	91.73 %	91.97 %	January 2015
% Non-admitted patients to start treatment within a maximum of 18 weeks from referral (Commissioner)	95.00 %	97.15 %	97.26 %	January 2015
% Patients on incomplete non-emergency pathways waiting no more than 18 weeks (Commissioner)	92.00 %	92.21 %	93.92 %	January 2015
Number of 52 week Referral to Treatment Pathways Incomplete (Commissioner)	0	0	1	January 2015
% Patients waiting for diagnostic test waiting > than 6 wks from referral (Commissioner)	1.00 %	3.37 %	4.26 %	January 2015
% 4 hour A&E waiting times - seen within 4 hours (CCG)	95.00 %	95.44 %	95.43 %	February 2015
Cancer - % Patients seen within 2wks referred urgently by a GP	93.00 %	98.14 %	94.94 %	December 2014
Cancer - % Patients referred with breast symptoms seen within 2 wks of referral	93.00 %	98.15 %	95.73 %	December 2014
Cancer - % Patients seen within 31 days from referral to treatment	96.00 %	98.98 %	98.94 %	December 2014
Cancer - % Patients seen within 31 days for subsequent treatment (Surgery)	94.00 %	100.00 %	98.44 %	December 2014
Cancer - % Patients seen within 31 days for subsequent treatment (Drugs)	98.00 %	100.00 %	100.00 %	December 2014
Cancer - % Patients seen within 31 days for subsequent treatment (Radiotherapy)	94.00 %	100.00 %	99.42 %	December 2014
Cancer - % Patients seen within 62 days of referral from GP	85.00 %	91.30 %	85.19 %	December 2014
Cancer - % Patients seen from referral within 62 days (Screening Service: Breast, Bowel & Cervical)	90.00 %	100.00 %	98.86 %	December 2014
Cancer - % Patients being seen within 62 days (ref. Consultant)	85.00 %	83.33 %	84.93 %	December 2014
CatA (Red 1) 8 min response time (Yorkshire Ambulance Service - YAS)	75.00 %	69.40 %	69.56 %	January 2015
CatA (Red 2) 8 min response time (Yorkshire Ambulance Service - YAS)	75.00 %	69.00 %	69.69 %	January 2015
CatA 19min response time (Yorkshire Ambulance Service - YAS)	95.00 %	95.60 %	95.60 %	January 2015
Number of mixed sex accomodation breaches (Commissioner)	0	0	1	January 2015
Cancelled operations rebooked within 28 days	0	0	0	December 2014
Proportion of people on Care Programme Approach (CPA) who were followed upwithin 7 days of discharge	95.00 %	100.00 %	100.00 %	January 2015

Quality

Outcomes	Target	Actual Period	Actual YTD	Period End Date
Friends & Family Test: Are providers meeting 15% response rate	15.00 %	29.37 %	29.37 %	December 2014
Friends & Family Test - % of patients recommending their hospital:Acute Inpatient (Qtr)	94.27 %	95.76 %	95.32 %	December 2014
Friends &Family Test - % of patients recommending their hospital: A&E (Qtr)	86.58 %	90.41 %	92.37 %	December 2014
Patient experience of hospital care	76.90	77.30	77.30	March 2014
Incidence of healthcare associated infection (HCAI) - MRSA (Commissioner)	0	0	1	January 2015
Incidence of healthcare associated infection (HCAI) - MRSA (Provider) - BHFT	0	0	0	January 2015
Incidence of healthcare associated infection (HCAI) - C.Diff (Commissioner)	63	3	60	January 2015
Incidence of healthcare associated infection (HCAI) - C.Diff (Provider) - BHFT	17	0	9	January 2015
Number of mixed sex accomodation breaches (Commissioner)	0	0	1	January 2015

Resources

Outcomes	Target	Actual Period	Actual YTD	Period End Date
Underlying Recurrent Surplus (FORECAST)	3.20% £3.20%	3.20 %	3.20 %	January 2015
Surplus - full year forecast	£9,640,000	£10,480,000	£10,480,000	January 2015
Quality, Innovation, Productivity and Prevention (QIPP) - year to date delivery	£7,512,500	Plans for delivery - excluding £2m to be planned	Plans for delivery - excluding £2m to be planned	January 2015
Running Costs (FORECAST)	£6,099,000	£5,849,000	£5,849,000	January 2015
BCCG Headcount		93	86	January 2015
BCCG Monthly sickness rate	2.5%	5.70 %	2.86 %	January 2015

Performance

Outcomes	Target	Actual Period			Actual YTD	Period End Date
Trolley waits in A&E	0	0			0	February 2015
Urgent operations cancelled for a second time	0	0			0	September 2014
Ambulance handover delays of over 30 mins	0	41			210	January 2015
Ambulance handover delays of over 1 hour	0	4			12	January 2015

BMBC: Better Care Fund

The Better Care Fund provides an opportunity to improve the lives of some of the most vulnerable people in our society, giving them control, placing them at the centre of their own care and support, and, in doing so, providing them with a better service and better quality of life.

Below is the Dashboard to support Barnsley MBC Better Care Fund for 2014/15.

		Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Non-elective FFCEs (First Finished Consultant Episode)	Actual	2,733	2,805	2,682	2,778	2,513	2,621	2,813	2,644	2,764			
	Target	2,716	2,666	2,499	2,564	2,558	2,468	2,647	2,545	2,748	2,857	2,592	2,465
	Performance	●	▲	▲	▲	★	▲	▲	●	●	?	–	–
	Actual (YTD)	2,733	5,538	8,220	10,998	13,511	16,132	18,945	21,589	24,353			
	Target (YTD)	2,716	5,382	7,881	10,445	13,003	15,471	18,118	20,663	23,411	26,268	28,860	31,325
	Performance (YTD)	●	●	●	▲	●	●	■	●	●	?	–	–

		Mar-15
Permanent admissions of older people (aged 65+) to residential & nursing care homes, per 100,000	Actual	
	Target	640.9
	Performance	–
	Baseline 2013/14	736.5
	Direction of Change	?

		Mar-14	Mar-15
The proportion of older people (65+)still at home 91 days after discharge into rehabilitation	Actual	77.20	
	Target	81.90	85.00
	Performance	▲	–
	Baseline 2013/14		77.20

		Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Delayed transfers of care from hospital per 100,000 population (number of days delayed)	Actual	44.35	47.56	61.46	65.73	44.89	54.51	43.29	29.39	30.46			
	Target	61.20	61.20	61.20	74.80	74.80	74.80	18.30	18.30	18.30	42.40	42.40	42.40
	Performance												
	Baseline 2013/14	61.40	61.40	61.40	75.00	75.00	75.00	18.40	18.40	18.40	42.60	42.60	42.60
	Quarterly Actual	-	-	153.37	-	-	165.13	-	-		-	-	
	Quarterly Plan	-	-	183.80	-	-	224.40	-	-	55.00	-	-	127.30

		Sep-14	Mar-15
Patient/service user experience	Actual		
	Target	5.20	5.20
	Performance		
	Actual YTD (YTD)		
	Target (YTD)	5.20	5.20
	Baseline: 2012/13	5.30	5.30

		30/03/201	30/09/201
Proportion of people feeling supported to manage their condition	Actual	66.42 %	67.19 %
	Target	67.85 %	67.54 %
	Performance		
	Baseline 2013	67.70 %	67.70 %

Key Performance Indicators by Exception

Indicator	Target	Actual	RAG	Performance Direction	Period Performance	Period
% Patients waiting for diagnostic test waiting > than 6 wks from referral (Commissioner)	1.00 %	3.37 %			The percentage of patients waiting more than 6 weeks from referral for diagnostic tests in January, continues to exceed the 1% threshold, with 102 patients (3.37%) waiting longer than 6 weeks. The majority of the delays were at: BHNFT of which there were 77 over 6 weeks. Of these 32 were for Colonoscopy, 13 for Audiology assesments, 14 for Flexi Sigmoidoscopy, 8 for Echocardiography, 7 for Gastroscopy and 3 for Non-obstetric ultrasound. At Doncaster and Bassetlaw hospital there were 15 delays, of which 6 patients were waiting for CT scan, 6 for non obstetric ultrasound, 2 for MRI and 1 for Dexa Scan. Other breaches were seen at Sheffield Teachings Hospitals (3 in Echocardiography, 1 in Gastroscopy), Sheffield Children's Hospital (2 in Sleep Studies), South West Yorkshire Partnership NHS Foundation Trust (2 in Dexa Scan), Leeds Teaching Hospital (1 in MRI) and York Teaching Hospital NHS Foundation Trust (1 in CT). Performance against the diagnostics target will continue to be monitored through contract monitoring.	31/01/2015
CatA (Red 1) 8 min response time (Barnsley)	75.00 %	64.60 %			**YAS Ambulance Response Times Position:** Yorkshire Ambulance Service performance in Barnsley has improved following a dip in December. Performance for Red 1 (the most urgent) calls in Barnsley remains below the target at 65.6% in January 2015 against a target of 75% and for R2 calls in Barnsley was 66%. Year to date performance in Barnsley and for YAS overall also remains below the target for both R1 and R2 calls, with a performance of 64.6% for Red 1 and 63.9% for Red 2.	31/01/2015
CatA (Red 2) 8 min response time (Barnsley)	75.00 %	63.90 %			See Above Commentary against CatA Red1 .	31/01/2015
CatA (Red 1) 8 min response time (Yorkshire Ambulance Service - YAS)	75.00 %	69.40 %			See Above Commentary against CatA Red1	31/01/2015
CatA (Red 2) 8 min response time (Yorkshire Ambulance Service - YAS)	75.00 %	69.00 %			See Above Commentary against CatA Red1	31/01/2015
Friends & Family Test - % of patients recommending their hospital: A&E (Month)	86.19 %	80.65 %			Performance dropped from October (96.75%) to December (80.65%) 2015, in A&E, but for Qtr 3 Barnsley CCG remained the highest performing CCG in South Yorkshire.	31/12/2014

Other Key Performance Indicators by Exception (not included on dashboard)						
Indicator	**Target**	**Actual**	**RAG**	**Performance Direction**	**Period Performance**	**Period**
People who have had a stroke who receive thrombolysis following an acute stroke	11.70 %	4.60 %			Qtr 2 2014-15 data shows BHNFT are currently at 4.6%, so a 2% drop from last quarter. The national position has dropped, but only by 0.5% to 11.7%. Barnsley are the lowest reporting CCG in the south with a South Yorkshire average of 5.8% so again a drop of 1% when compared to last quarter which reported 6.8%.	30/09/2014
Cancer-% Patients being seen within 62 days (ref.consultant) (Qtr)	85.00 %	84.21 %			This measure has failed Qtr 3, with a performance of 84.21%. 16 out of 19 patients were seen and treated within 62 days. The very small number of patient doesn't help this measure. Two patients were delayed because of medical reasons, and 1 patient was delayed because of elective capacity at Sheffield Teaching Hospital.	31/12/2014
Cancer - % Patients being seen within 62 days (ref. Consultant)	85.00 %	83.33 %			For the month of December 5 out of 6 patients were seen within 62 days. The 1 breach reason was elective capacity inadequate at Sheffield Teaching Hospital, where by the Inter Trust Referral was received at day 26. The patient waited 67 days in total.	31/12/2014
Ambulance handover delays of over 30 mins	0	41			Ambulance handovers for BCCG, have seen a reduction in the number of delays, with January 2015 reporting 41 patients waiting over 30 minutes compared to the 65 in December. There were 4 delays over 60 minutes. There is a financial penalty for the Ambulance handover measure that has been applied since April 2014. An improvement plan will be agreed with YAS and monitored, and monies retained by commissioners as a result of the implementation	31/01/2015
Crew Clear delays of over 30 mins	0	6			There has been an improvement in performance for crew clear delays of over 30 minutes, with January 2015 reporting 6 cases compared to the 10 cases in December. The target is 0. 1 patient waited over 60 minutes which is an improvement from the December position. The narrative in the ambulance handover times reported above is applicable to this measure also.	31/01/2015

APPENDIX A

Barnsley Clinical Commissioning Group

NHS BARNSLEY CLINICAL COMMISSIONING GROUP

MONTHLY FINANCE MONITORING STATEMENT - KEY FINANCIAL DUTIES

FOR THE PERIOD ENDING 31 JANUARY 2015

	YEAR TO DATE				PLANNED OUTTURN			
	PLANNED YEAR TO DATE	ACTUAL TO DATE	VARIANCE TO DATE	CURRENT STATUS	PLANNED OUTTURN	FORECAST OUTTURN	FORECAST VARIANCE	CURRENT STATUS
	£'000	£'000	£'000		£'000	£'000	£'000	
REMAIN WITHIN TOTAL REVENUE RESOURCE LIMIT *	296,763	296,763	0		358,870	358,030	(840)	
REQUIRED SURPLUS (AS PER PLAN)	(8,033)	(8,033)	0		(9,640)	(10,480)	(840)	
REMAIN WITHIN CAPITAL RESOURCE LIMIT	0	0	0	N/A	0	0	0	N/A
REMAIN WITHIN RUNNING COST ENVELOPE	5,075	4,803	(272)		6,099	5,849	(250)	
REMAIN WITHIN MAXIMUM CASH DRAWDOWN **	308,963	300,635	(8,328)		360,336	360,086	(250)	
PLANNING GUIDANCE REQUIREMENTS								
UTILISATION OF 2.5% RESOURCES NON RECURRENTLY	7,550	0	(7,550)		9,060	16,959	7,899	
0.5% CONTINGENCY RESERVE ***	1,539	0	(1,539)		1,847	1,847	0	

	YEAR TO DATE			PLANNED OUTTURN		
BETTER PAYMENT PRACTICE CODE	2014-15 NUMBER	2014-15 £'000	CURRENT STATUS	2014-15 NUMBER	2014-15 £'000	CURRENT STATUS
NON-NHS PAYABLES: CCG						
TOTAL NON NHS TRADE INVOICES PAID IN THE YEAR	6,736	33,902		8,083	40,682	
TOTAL NON NHS TRADE INVOICES PAID WITHIN THE TARGET	6,575	33,653		7,890	40,384	
PERCENTAGE OF NON-NHS TRADE INVOICES PAID WITHIN TARGET	**97.61%**	**99.27%**		**97.61%**	**99.27%**	
NHS PAYABLES: CCG						
TOTAL NHS TRADE INVOICES PAID IN THE YEAR	2,082	223,066		2,498	267,679	
TOTAL NHS TRADE INVOICES PAID WITHIN THE TARGET	2,053	222,884		2,464	267,461	
PERCENTAGE OF NHS TRADE INVOICES PAID WITHIN TARGET	**98.61%**	**99.92%**		**98.64%**	**99.92%**	

* Forecast variance assumes achievement of further savings target identified at Appendix B
** Indicative Maximum Cash Drawdown figure provided from NHSE.
*** Forecast Outturn against 0.5% Contingency reserve assumes full achievement of further savings identified in Appendix B

APPENDIX B

NHS Barnsley Clinical Commissioning Group

NHS BARNSLEY CLINICAL COMMISSIONING GROUP

MONTHLY FINANCE MONITORING STATEMENT - EXECUTIVE SUMMARY

FOR THE PERIOD ENDING 31 JANUARY 2015

AREA	Appendix	TOTAL ANNUAL BUDGET (£'000)			YEAR TO DATE (£'000)			FORECAST (£'000)			
		RECURRENT	NON RECURRENT	TOTAL BUDGET (£'000)	BUDGET	ACTUAL	VARIANCE OVER / (UNDER)	OUTTURN	VARIANCE OVER / (UNDER)	VARIANCE AS % OF TOTAL BUDGET	MOVEMENT FROM PREVIOUS MONTH
RESOURCE ALLOCATION FOR CCG											
PROGRAMME RESOURCE	B5	(346,977)	(15,434)	(362,411)	(299,721)	(299,993)	(272)	(362,411)	0	0.00%	(27)
RUNNING COST RESOURCE	B5	(6,099)	0	(6,099)	(5,075)	(4,803)	272	(6,099)	0	0.00%	0
TOTAL RESOURCE ALLOCATION	**B5**	**(353,076)**	**(15,434)**	**(368,510)**	**(304,796)**	**(304,796)**	0	**(368,510)**	0	**0.00%**	**(27)**
PROGRAMME EXPENDITURE											
ACUTE	B1	186,403	5,087	191,490	160,163	162,492	2,329	194,552	3,062	1.60%	(451)
MENTAL HEALTH	B1	34,498	274	34,772	29,001	28,954	(47)	34,701	(71)	10.17%	(39)
COMMUNITY HEALTH	B1	34,094	1,082	35,176	29,322	29,266	(56)	35,107	(69)	-0.19%	2
CONTINUING CARE / FREE NURSING CARE	B2	16,902	1,312	18,214	14,568	13,469	(1,099)	16,511	(1,703)	-9.35%	(202)
PRIMARY CARE	B2	48,323	2,315	50,638	42,340	43,535	1,195	51,919	1,281	12.23%	(589)
OTHER PROGRAMME COSTS	B2	8,912	5,619	14,531	12,213	11,895	(318)	14,193	(338)	-2.33%	5
TOTAL COMMISSIONING SERVICES (EXCLUDING RESERVES)		**329,132**	**15,689**	**344,821**	**287,607**	**289,611**	**2,004**	**346,983**	**2,162**	**0.63%**	**(1,274)**
CORPORATE COSTS (NON RUNNING COSTS)		746	(11)	735	613	574	(39)	709	(26)	-3.54%	(8)
DEPRECIATION / PROPERTY CHARGES		274	425	699	623	806	183	918	219	31.33%	0
CSU RECHARGE		740	0	740	616	616	0	740	0	0.00%	0
TOTAL PROGRAMME COSTS (EXCLUDING RESERVES)		**330,892**	**16,103**	**346,995**	**289,459**	**291,607**	2,148	**349,350**	2,355	**0.68%**	**(1,282)**
RUNNING COSTS											
PAY COSTS	B4	2,718	356	3,074	2,565	2,486	(79)	3,038	(36)	-1.19%	(16)
NON PAY COSTS	B4	3,378	(75)	3,303	2,742	2,553	(189)	3,105	(198)	-6.00%	19
INCOME	B4	(225)	(53)	(278)	(232)	(236)	(4)	(294)	(16)	5.47%	(3)
RUNNING COSTS TOTAL		**5,871**	**228**	**6,099**	**5,075**	**4,803**	(272)	**5,849**	(250)	**-4.10%**	**0**
TOTAL CCG EXPENDITURE (EXCLUDING RESERVES)		**336,763**	**16,331**	**353,094**	**294,534**	**296,410**	1,876	**355,199**	2,105	**0.60%**	**(1,282)**
PROGRAMME BOARD & OTHER RESERVES (EXCLUDING CONTINGENCY)	B3	5,194	(1,265)	3,929	2,229	353	(1,876)	3,073	(856)	-21.79%	(549)
TOTAL CCG EXPENDITURE BEFORE CONTINGENCY		**341,957**	**15,066**	**357,023**	**296,763**	**296,763**	0	**358,272**	1,249	**0.35%**	**(1,831)**
APPLICATION OF CONTINGENCY FOR PROGRAMME OVERSPEND		**(274)**	**2,121**	**1,847**	**0**	**0**	0		(1,847)	-100.00%	**0**
TOTAL AFTER APPLICATION OF CONTINGENCY		**341,683**	**17,187**	**358,870**	**296,763**	**296,763**	0	**358,272**	(598)	**-0.17%**	**(1,831)**
FURTHER SAVINGS REQUIRED TO ACHIEVE PLANNED SURPLUS								**(242)**	(242)		1,831
TOTAL REQUIRED SURPLUS		**(11,393)**	**1,753**	**(9,640)**	**(8,033)**	**(8,033)**	**0**	**(10,480)**	**(840)**		

NHS
Barnsley Clinical Commissioning Group

Putting Barnsley People First

Minutes of the Meeting of the NHS Barnsley Clinical Commissioning Group FINANCE & PERFORMANCE COMMITTEE held on Thursday 5 January 2015 at 10.00am in the Boardroom, Hillder House, 49 – 51 Gawber Road, Barnsley S75 2PY.

PRESENT:

Ms Lesley Smith (Chair)	- Interim Chief Officer
Ms Anne Arnold	- Lay Member Governing Body
Dr John Harban	- Elected Member Governing Body
Mrs Cheryl Hobson	- Chief Finance Officer
Mr James Logan	- Elected Member Governing Body
Dr Nick Luscombe	- Elected Member Governing Body
Mrs Vicky Peverelle	- Chief of Corporate Affairs

IN ATTENDANCE:

Dr M Ghani	- Medical Director – Prioritisation Exercise only
Dr Sudhagar Krishnasamy	- Governing Body Member – Prioritisation Exercise only
Marie Hoyle	- Governing Body Member – Prioritisation Exercise only
Chris Ruddlesdin	- Governing Body Member – Prioritisation Exercise only
Brigid Reid	- Chief Nurse – Prioritisation Exercise only
Ms Jayne Sivakumar	- Head of Service Development – Prioritisation Exercise only
Mr Neil Lester	- Deputy Chief Finance Officer/Finance
Mrs Angela Sanderson (Minutes)	- PA to Chief Finance Officer
Mr Jamie Wike	- Head of Planning & Performance

APOLOGIES:

Dr Nick Balac (Chairman)	- Chairman of Barnsley CCG

Agenda Item	Note	Action	Deadline
	PRIORITISATION EXERCISE		
	Governing Body Members attended a Prioritisation Exercise presented by the Head of Planning and Performance and Deputy Chief Finance Officer/Finance to confirm and challenge CCG plans.		

Approved

	The Head of Planning and Performance and Deputy Chief Finance Officer/Finance agreed to summarise the discussions and decisions made and present back to the Governing Body in due course.	**JW/NL**	
FPC15/16	**DECLARATIONS OF INTEREST**		
	There were no declarations of interest relevant to the agenda received from members.		
FPC15/17	**MINUTES OF THE PREVIOUS MEETING**		
	The minutes of the meeting held on the 8 January 2015 were agreed as a true record of proceedings.		
FPC15/18	**MATTERS ARISING REPORT**		
	FPC14/118 Major Review – Primary Care Development Group The Chief of Corporate Affairs updated members that a meeting had taken place with the Procurement Team and that the Estates Survey would be going out to tender shortly. Dr J Harban asked as a CCG what we were doing to support practices in cases where they can utilise funds that have been made available to primary care. The Chief of Corporate Affairs advised that cases put forward have been supported. Additional work will be undertaken with practices re new monies for infrastructure.	**VP**	
	FPC15/14 Minutes of Children's & Adults Executive Committee The Chief Finance Officer advised that Health Visiting Services Issues had been included on the Governing Body agenda for 12 February 2015. **POST MEETING NOTE:** The Chair of Governing Body has since requested that this be taken off the February Governing Body agenda and put on the March Private agenda.	**KM**	
	FPC14/176 Risk Register CCG 13/16 Inadequate Support from CSU relating to IT support Dr J Harban felt that the action plan did not address a lot of the IT issues. The Chief Finance Officer advised that		

Approved

	Christine Joy, Relationship Manager at CSU had set up a meeting for 26 February where this would be discussed.		
FPC15/19	**UPDATE ON RECENT PUBLISHED AND EXPECTED GUIDANCE**		
	The Chief Finance Officer presented the Contract Guidance Update report which was received and noted by the Committee.		
FPC15/20	**UPDATE ON CONTRACTING CYCLE**		
	The Chief Finance Officer highlighted the key contractual issues and points to note were; BHNFT - Barnsley CCG have had notification from NHS England that the tariff consultation cannot be finalised and therefore at the BHNFT Contract meeting on 6 February it would be suggested that we operate on the basis of the 2014/15 tariff and look to adjust retrospectively back to the 1st April once the tariff guidance is accepted and formalised. Outstanding issues remaining are; • the activity baseline • price and/or currency for Ambulatory Care • Anaesthetists • The Chief Finance Officer felt it would be beneficial for Dr J Harban to attend the Contract meetings. Dr Harban agreed to attend subject to availability and practice commitments.		
	SWYPFT – the rebasing exercise has identified that the CCG currently pays around £1.8m more than the services cost. There is a requirement for SWYPFT to deliver a surplus and invest in their services particularly capital investment. The CCG have asked for more information about the £1.8m and how much of that would relate to SWYPFT delivering their surplus and how much to be invested in capital. Activity proposals for the 2015/16 contract appeared to be acceptable and there were no other significant issues to note.		
FPC15/21	**INTEGRATED PERFORMANCE REPORT**		
	The Chief Finance Officer reported a projected overspend of just over £2m for the financial year, to mitigate that the CCG have identified a number of potential income		

Approved

	sources and reductions in forecasts which are detailed in the report. This brings the position down to a risk adjusted forecast overspend of £434k achievable from a year end perspective given that the CCG have a number of levers in place to bring that back to the balanced position required by NHS England.		
	Ms A Arnold identified the last sentence of section 2.10 of the report ambiguous; this would be amended before the report was presented to the Governing Body. **POST MEETING NOTE: COMPLETED**	**NL**	
	Dr J Harban queried the "maximising use of £260k rebate for IT", the Chief Finance Officer advised that in last year's financial accounts it was identified that the CSU had double charged the CCG for GPIT, rather than at that late stage take it into the final accounts it was agreed that the CSU would hold it as a credit for us to draw against during this financial year. The Chief Finance Officer has previously notified the Finance and Performance Committee, and the Governing Body of this issue, and has been monitoring this closely with the CSU's Deputy Director of Finance.		
	The Head of Planning and Performance presented the Performance Report and advised that diagnostic performance had deteriorated above the target 1%. The YAS report December figures, for R1 showed performance at 58.1% despite previous improvement in Barnsley, the Chief Finance Officer felt there was more analysis to be done. The Head of Planning and Performance reported that the latest year to date position for YAS overall shows that the number of R1 calls responded to within the 8 minute target had gone from 78.4% in December 2013 to 69.28% in December 2014. It was felt Governing Body needed to have sight of these figures and the Head of Planning and Performance agreed to make them available for the Governing Body meeting being held on 12 February 2015. **POST MEETING NOTE: COMPLETED**	**JW**	
	The Head of Planning and Performance advised on Quarter 1, there are four measures that form the composite data around avoidable emergency admissions;		

Approved

	• July to September additional information re GP Survey had been released which indicated that the CCG had not made the progress that had been set out in terms of the targets in our plan around experience • GP Services • GP Out of Hours • Access to GP Services.		
	The Workforce Report informed that December sickness figures had decreased to 3.8% following a high in November and figures are still above our target. Mandatory training is above 85% in all areas now.		
FPC15/22	**ASSURANCE FRAMEWORK**		
	The Assurance Framework was noted and approved.		
FPC15/23	**RISK REGISTER**		
	The Risk Register was noted and approved.		
FPC15/24	**MINUTES OF THE BHNFT JOINT CONTRACT MEETING HELD ON 9 JANUARY 2015**		
	The minutes of the BHNFT Contract Meeting held on the 9 January 2015 were received and noted by the Committee.		
FPC15/25	**MINUTES OF THE 2014/15 SWYPFT CONTRACT MANAGEMENT MEETING HELD ON 18 DECEMBER 2014**		
	The minutes of the 2014/15 SWYPFT Contract Management Meeting held on the 18 December 2014 were received and noted by the Committee.		
FPC14/26	**DATE AND TIME OF NEXT MEETING**		
	The next meeting of the Finance and Performance Committee will be held at 10.00am on Thursday 5 March 2015 in the Boardroom at Hillder House.		

Approved

NHS
Barnsley Clinical Commissioning Group
Putting Barnsley People First

Minutes of the Meeting of the PATIENT AND PUBLIC ENGAGEMENT COMMITTEE held on Thursday 29 January 2015 at 12:30pm in Meeting Room 1, Hillder House, Gawber Road, Barnsley.

PRESENT:

Mr Chris Ruddlesdin (Committee Chair)	Lay Member for Patient and Public Engagement
Ms Kirsty Waknell	Communications and Engagement Manager
Ms Marie Hoyle	Practice Manager Governing Body Member
Ms Vicky Peverelle	Chief of Corporate Affairs
Ms Brigid Reid	Chief Nurse
Dr Nick Balac	CCG Chairman

IN ATTENDANCE:

Miss Lynne Richards	Governance, Assurance & Engagement Facilitator

APOLOGIES:

Ms Lesley Smith	Interim Chief Officer
Ms Clare Bannon	Governing Body Member

Agenda Item	Note	Action	Deadline
PPE 15/01/01	**APOLOGIES**		
	Apologies were received as above.		
PPE 15/01/02	**DECLARATIONS OF INTEREST RELEVANT TO THE AGENDA**		
	It was discussed whether the Communications & Engagement Manager had a Conflict of Interest over agenda item 8. It was agreed that although the Communications & Engagement Manager worked for the Commissioning Support Unit this was not a conflict of interest. The Chief of Corporate Affairs suggested a system around Declarations of Interests (DOI'S) which involved the meeting secretary supplying Committee members with their DOI's at the meeting for the Chair to oversee and members to update. It was agreed to adopt this method for future meetings and recommend this new system to other CCG Committee meetings.	**LR**	**19.03.15**

Agenda Item	Note	Action	Deadline
PPE 15/01/03	**MINUTES OF THE PREVIOUS MEETING HELD ON 04 SEPTEMBER 2014**		
	The minutes of the previous meeting held on 04 September 2014 were verified as an accurate record of the meeting.		
PPE 15/01/04	**MATTERS ARISING**		
	Members noted and agreed to remove the completed items from the Matters Arising Report. The Chair asked for an update on the actions from minute reference PPE 09/14/03 PROGRAMME BOARD UPDATES. It was advised that the Engagement Team had scheduled in engagement training with the Service Development Team.		
	The CCG Chairman informed members that he had scoped for new Membership Council representatives to fill vacancies on CCG Committees. He advised that there had been enough expressions of interests put forward to fill all vacancies on CCG Committees and it was currently being agreed which member would best fill each Committee vacancy.		
COMMITTEE REPORTS AND MINUTES			
PPE 15/01/05	**MINUTES OF THE PATIENT COUNCIL HELD ON;** • **17 SEPTEMBER 2014** • **29 OCTOBER 2014**		
	The Minutes of the September and October Patient Council meetings were received. The Chair highlighted an error within the 17 September minutes regarding private patients in NHS hospitals but it was advised that these minutes had since been adopted by the Patient Council. The Chief Nurse referred the National Nursing Review mentioned in the 29 October 2014 minutes. She queried if Healthwatch had been in contact with the CCG regarding the review. It was advised that the CCG had not received any contact and the National Nursing Review had not been raised at any Patient Council meeting since the 29 October.		

Agenda Item	Note	Action	Deadline
	Following on from discussions and presentations at recent Patient Council meetings regarding Self Care the Chair advised that he would be meeting with Hilary Mosley to discuss the potential of an event which focused on how all the self-care initiatives fit together. Members agreed that this would be useful for patients and patient Council members to gain a greater understanding on self-care. The inequality of information that patients receive around self-care was discussed and it was commented that patients being in the right place at the right time was currently the situation in patients receiving the correct self-care information. Members discussed the need for 1 look up/ access point for self-care information and it was advised that although self-care did not come under Right Care Barnsley, RCB could sign post patients to self-care information. It was queried if the HUB could also be a sign posting point for self-care – it was agreed that this could be feedback to the Promoting Independence Board who were progressing the HUB. The Chief of Corporate Affairs advised that a bid could be put into the Marginal Tariff to pull together patient Self Care information. It was added that 111 could be contacted to see what information they held on self-care. It was agreed that this would be suggested as a Commissioning Priority.	**VP**	**19.03.15**
	The Chair advised that a Patient Council member had voiced concerns over funding for enhances services which would meant that smaller practices could suffer. The Chief of Corporate Affairs advised that the member could be referring to PMS premiums but would look into this with Jon Holliday. **Post meeting note** The Patient Council member was referring to the abolition of the Minimum Practice Income Guarantee which is not anticipated to affect any Barnsley Practices.	**VP**	**19.03.15**
	Committee members were informed that Ms Karen Kelly Director of Operations, BHNFT, had attended the last Patient Council meeting to discuss the four-hour wait in A & E. It was advised that the meeting had highlighted some good news stories about the Trust such as the Barnsley A & E department being the 8th best performer		

Agenda Item	Note	Action	Deadline
	out of 122 Trusts and also that the Trust had had its breach lifted by Monitor. It was added that Ms Kelly raised some issues with the CCG around the decommissioning of 30 Intermediate Care beds and ceasing funding for out of hospital transport. The Chief of Corporate Affairs agreed to look into these issues but advised that the discharge transport was funded out of non-recurrent resilience monies.	**VP**	**19.03.15**
	The Committee noted the minutes of the Patient Council meeting held on 17 September 2014 and 29 October 2014.		
PPE 15/01/06	**MINUTES OF THE EQUALITY STEERING GROUP HELD ON 16 OCTOBER 2014**		
	Committee members noted that following on from recommendations made by Internal Audit the PPE and ESG Committee would share minutes of meetings to ensure oversight over both committees.		
	It was queried if patients requiring BSL would become the responsibility of the CCG with regards to co-commissioning Primary Care. It was advised that there was need for a clear work stream for patients who require BSL.		
	Committee members read the ESG minutes for the 16 October and noted the following: - **The ESG were currently undertaking a review of effectiveness** - **Health Watch had raise issues with the ESG over homeless people being unable to register in GP practices.** - **The ESG had commenced with patient stories** - **Elaine Barnes would be undertaking a review of policies** - **The ESG currently had 1 GP member vacancy however Dr Saxena was still attending the meeting.**		
ENGAGEMENT ITEMS			
PPE 15/01/07	**COMMUNITY ASSETS MODEL PROPOSAL**		
	The Chief of Corporate Affairs advised members that this item had been discussed and supported at a Governing Body Development Session and the next		

Agenda Item	Note	Action	Deadline
	steps were to agree funding at the next Finance and Performance Committee. It was added that the CCG would need an initial £40,000 to start Community Assets and then a further £10,000 for ongoing communication with members. It was advised that the 'Burn rate' between the CCG and CSU could be used towards engagement for the Community Assets. Members agreed that training was needed for staff to build engagement costs into business cases and that an engagement model needed to be complied to build in PPE relevant to the size of a project. It was highlighted that this model would ensure the CCG had consistent engagement over all of its projects.	**VP**	**19.03.15**
PPE 15/01/08	**PATIENT REFERENCE GROUP PROJECT REPORT**		
	The Communications and Engagement Manager presented and update on the current position of the Patient Reference Groups. It was highlighted that project was due to end on 31 March 2015. Members noted the progress of the PRG's and it was proposed whether the CCG should extend the project for 6 months as part of the Practice Delivery Agreement involved practices engaging with their PRG's. It was agreed to propose that an extra 25k be given to support the project for another 6 months however, this next phase of the project should focus on equality and representation and also seeing an increase in PRG members attending the Patient Council. Members noted that practices gained PRG money as part of the £3.30 per patient within the PDA and that the Community Assets could also be used to support PRG's.	**VP**	**19.03.15**
PPE 15/01/09	**OVERVIEW AND SCRUTINY COMMITTEE**		
	An update was given from the BMBC Overview and Scrutiny Committee meeting in which some Committee Members had been invited to attend for a Q & A session on the PPE Strategy. It was advised that the meeting had gone well and BMBC had thanked members for attending the meeting and answering questions.		

Agenda Item	Note	Action	Deadline
	The Communications and Engagement Manager added that she had raised that CCG representatives had stopped receiving Area Council invites and that since the Q & A session members had begun to receive invites once again. It was raised that initially the CCG and Governing Body members had been allocated a Are Council meeting to attend on behalf of the CCG however, due to the Area Council minutes not recording who was in attendance the CCG was unable to perform a review on who had been attending the meetings. Members agreed that since the CCG had given funding to Areas Councils to the some of £180,000 it would like a report on what this money has been spent on.	**KW**	**19.03.15**
PPE 15/01/10	**MEDIA UPDATE**		
	The Chair asked for an update on the CCG's media and social networking following on from the Internal Audit report stating that the CCG did not make full use and recording of social media interactions. The Communications and Engagement Manager advised that the CCG had recently been named 35th out of 50 top tweeting NHS organisations. It was also advised that the CCG had 8,000 followers on twitter and 500 Facebook friends. Members highlighted that social media was good for soft intelligence and transparency of the CCG. It was added that bi–annual full media summaries went to the Governing Body. It was also added that social media was good for CCG reputations and resolving negative tweets.		
QUALITY GOVERNANCE			
PPE 15/01/11	**CCG RISK REGISTER AND ASSURANCE FRAMEWORK**		
	The Chief of Corporate Affairs presented the Corporate Risk Register and Assurance Framework. It was noted that the wording around the PPE risks could be further expanded to incorporate the PRG work, Community Assets and the Practice Delivery Agreement.		

Agenda Item	Note		Action	Deadline
	The Committee noted the Risk Register and Assurance Framework.			
PPE 15/01/12	**ANY OTHER BUSINESS**			
	12.1	The Chief Nurse stated that the next meeting clashed with the Unplanned Care Board therefore Ms Gill Pepper would be attending the meeting on the Chief Nurse's behalf. It was agreed to relook at the Committee Calendar to avoid meeting clashes.	**LR**	**19.03.15**
	12.2	The CCG Chairman informed members that the next CCG newsletter would have a different look and feature more on Primary Care, Patient Reference Groups and good news stories. It was agreed to have the newsletter as an agenda item for the next meeting so that content and ideas could be discussed.	**LR**	**19.03.15**
	12.3	It was advised that System Resilience Group was looking at levers and criteria to support a proposed change in what Primary Care offered in red alerts. The Chief of Corporate Affairs advised that the CCG was going to be a pilot for a model scenario plan. It was advised that the model looked at system resilience as a whole and identified the best areas to spend money.		
	12.4	The Chair queried how the Federation Model affected the running of PRG's. It was agreed to query with the Federation if their PRG's would merge and federate. It was also highlighted that there would be a need for Patient and Public Engagement around the federation.	**VP**	**19.03.15**
PPE 15/01/13	**DATE AND TIME OF THE NEXT MEETING**			
	The next meeting of the Patient and Public Engagement Committee will be held on 19 March 2015 at 3.00pm in the Boardroom, Hillder House.			

HEALTH AND WELLBEING BOARD

Minutes of the Meeting held on 3rd February, 2015

33. Present:-

Councillor Sir Stephen Houghton CBE (Chairman) – Leader
Councillor James Andrews BEM – Deputy Leader
Councillor Margaret Bruff – People (Safeguarding) Spokesperson
Councillor Jenny Platts – Communities Spokesperson
Martin Farran – Executive Director, Adults and Communities
Rachel Dickinson – Executive Director, Children, Young People and Families
Julia Burrows –Director of Public Health
Lesley Smith – Interim Chief Officer, NHS Barnsley Clinical Commissioning Group
Nick Balac –Chair NHS Barnsley Clinical Commissioning Group
Adrian England – Barnsley Healthwatch
Liz Watson – South Yorkshire Police
Sean Raynor – South West Yorkshire Partnership NHS Foundation Trust
Steve Wragg – Barnsley Hospital NHS Foundation Trust

34. Declarations of pecuniary and non pecuniary interests.

Councillor Platts declared a non pecuniary interest in minute 39 as a Governor at Barnsley Hospital NHS Foundation Trust.

35. Minutes of the Board Meeting held on 2nd December, 2014.

The meeting considered the minutes of the previous meeting, held on 2nd December, 2014.

RESOLVED: - that the minutes be approved as a true and correct record.

36. Minutes from the Children and Young People's Trust Executive Group held on 12th December, 2014.

The meeting considered the minutes from the Children and Young People's Trust Executive Group, held on 12th December, 2014.

Attention was drawn to minute 10 – issues for escalation to other boards. It was noted that there were currently no issues requiring consideration by the Health and Wellbeing Board.

RESOLVED: - that the minutes be received.

37. Minutes from the Provider Forum held on 10th December, 2014.

The meeting considered the minutes from the Provider Forum meeting, held on 10th December, 2014.

Representation from the Barnsley Hospital NHS Foundation Trust, at the Provider Forum was discussed, and it was noted that this was currently under consideration.

UNADOPTED

RESOLVED: - that the minutes be received.

38. Healthwatch Barnsley – Progress Report.

The meeting received the progress report from Healthwatch Barnsley.

RESOLVED: - that the report be noted.

39. A&E/Acute Performance Update

The meeting received the report and noted the levels of performance highlighted. The meeting discussed need for all agencies to review their contribution to minimising hospital admissions, particularly by agencies involved in social care and by GPs. It was suggested that the charitable sector ought to be more engaged in supporting people to leave hospital. Reference was made to a joint Police / South West Yorkshire Foundation Partnership Trust pilot triage initiative that had had considerable success in reducing A&E visits. The meeting also noted the auditing of occupied beds in Barnsley District General Hospital, Mount Vernon, and Kendray Hospitals to properly analyse the reasons for admission and get at the root causes.

Concern was expressed that the current focus was on improving the existing system rather than rather adopting a more sustainable operating model. The need to establish what the future joined up health and social care system should look like, and how this differs from the current model was agreed, together with was the importance of agreeing the next steps required to be taken by each agency to get to the new model

RESOLVED: -
(i) that the report be noted;
(ii) that a workshop session be held to discuss the development of a more sustainable model for Health and Social Care.

40. SSDG Highlight Report.

The meeting received the report, noting issues currently receiving consideration by SSDG. This included the Holistic Patient Care Project; Better Care Fund; Integrated Personal Commissioning; Healthwatch; Integrated Care and Support Pioneer; and the Community Offer.

Members noted the recent visit from Geoff Alltimes, the national lead for the Pioneer Programme, on 22nd January, 2015. The visit had offered a chance to reflect and take stock of progress being made under the Pioneer programme, and to consider which areas required focus, in order to provide a unique offer in Barnsley. A detailed report would be submitted to the next Health and Wellbeing Board.

RESOLVED: -
(i) that the report be noted;
(ii) that SSDG reports back to the Board on an exception basis, highlighting emerging challenges, pressures and opportunities.

UNADOPTED

41. Pharmaceutical Needs Assessment 2015/18.

Members received the draft document. Noted was the contribution that pharmacies can make to the overall health system, particularly as an initial source of advice to patients and their ability to reduce the demand on GPs' surgeries and on Accident and Emergency. Particular reference was made to initiatives such as Pharmacy First.

RESOLVED: -
(i) that the publication of the Barnsley Pharmaceutical Needs Assessment 2015-18 be approved;
(ii) that consideration be given to how to communicate the health care facilities offered by pharmacies to the general public;
(iii) that members of the Local Pharmacy Committee be represented at the workshop session organised to consider the future model of Health and Social Care as at minute 39.

42. Better Care Fund Approval Letter and Section 75 Development.

The report was received, and members discussed the current situation with regards to the Better Care Fund and the development of a formal Section 75 Agreement between the CCG and the Council.

Attention was drawn to recent discussions regarding the funding of 21 intermediate care beds using funding currently allocated to technology development.

RESOLVED:-
(i) that the successful outcome of the BCF submission in receiving approval on 22nd December 2014, subject to the amendments now required to reallocate the technology development funding of £439,000 to provide 21 intermediate care beds, and the work taking place to establish a formal Section 75 Agreement between the Council and CCG from 1st April 2015, be noted;
(ii) that, subject to the appropriate approvals by the Council and the CCG, the Chair and Vice Chair be authorised to formally endorse the Section 75 Agreement for the Better Care Fund, on behalf of the Health and Wellbeing Board;
(iii) that SSDG be requested to ensure all BCF schemes are able to deliver the benefits agreed in the submission, in particular the national outcome of reducing emergency admissions, and report progress on an exception basis into the Board;
(iv) that the risk to the pooled budget and the need to agree risk sharing arrangements between the CCG and the Council be noted;
(v) that SSDG be requested to put in place appropriate measures to manage and mitigate risk in relation to delivery of the BCF ambitions.

43. CCG Proposal for Commissioning Primary Medical Services.

UNADOPTED

The meeting received the report, noting the application from the CCG to take on delegated responsibility from NHS England for commissioning primary medical services.

RESOLVED: -
(i) that the CCG Governing Body's decision to proceed with the application for delegated responsibility for primary care services be noted;
(ii) that the authorisation process and timetable be noted.

44. <u>Care and Support in Barnsley – Our Local Account</u>

The meeting received the recently published 'Care and Support in Barnsley – Our Local Account 2013-2014'.

RESOLVED: - that the report be noted.

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Chairman

UNADOPTED

Minutes of the Meeting of the NHS Clinical Commissioning Group Formal Management Team held on Wednesday 4 February 2015 at 9.00am in Meeting Room 1, Hillder House, 49/51 Gawber Road, Barnsley S75 2PY

PRESENT:

Dr Mehrban Ghani	Medical Director (Chair)
Mrs Cheryl Hobson	Chief Finance Officer

IN ATTENDANCE:

Mr Jim Logan	Governing Body Member
Ms Kath Harris	Assistant Executive Director – Older People and Vulnerable Adults
Ms Julia Burrows	Director of Public Health
Mrs Karen Martin	Deputy Chief Nurse
Mr Jamie Wike	Head of Planning and Performance
Ms Donna Mair	Public Health Strategic Commissioning Programme Manager (Item 7)
Mrs Fran Wickham	Executive PA to Chairman & Interim Chief Officer (minute taker)

Agenda Item	Note	Action	Deadline
FMT 04/02/01	**APOLOGIES**		
	Apologies were received from the Interim Chief Officer, CCG Chairman, Chief Nurse, Chief of Corporate Affairs and the CSU Customer Relationship Manager.		
FMT 04/02/02	**DECLARATIONS OF INTEREST RELEVANT TO THE AGENDA**		
	There were no declarations relevant to the agenda; however later in the meeting the Medical Director reported a conflict of interest under item 04/02/09 Any Other Business – Sexual Health Service.		
FMT 04/02/03	**ACTION LOG**		
	Item 1 Mental Health Strategy is to be discussed at item 5 on the agenda today. Item 2 – Innovation Approach; Head of Planning and Performance agreed to follow up on this. Members noted that in order to get the best results staff need to be fully trained on how to use different technologies.		

UNAPPROVED

Agenda Item	Note	Action	Deadline
	Item 3 – Integrated Care Homes Code of Standards; it was advised that that this item is progressing and a paper has been presented to the latest Programme Board.		
FMT 04/02/04	**MINUTES OF THE MEETING HELD ON WEDNESDAY 21 JANUARY 2015**		
	The minutes of the previous meeting held on 21 January 2015 were verified as a true record of the proceedings. In respect of Item 21/01/08 IT Strategy, the Assistant Executive Director – Older People and Vulnerable Adults confirmed that the Head of IT, BMBC had attended the IT Strategy meeting last week. The Chief Finance Officer reported that there had not been any comments received regarding the draft Strategy but that following discussion at the above meeting the Strategy will be updated. In respect of the IPC service the Deputy Chief Nurse gave a brief update. A meeting has taken place with Procurement to see what services/support will be provided; including whether a more advisory service model would be used.		
FMT 04/02/05	**MENTAL HEALTH STRATEGY**		
	Following the last Management Team meeting the Strategy has been updated to include the Mental Health Concordat; the new draft will be circulated to this group today. Any comments should be fed back to the Senior Mental Health Commissioner, who has also offered to meet with SWYPFT clinicians in order to assist with any queries. Comments should be fed back by Friday 27 February. Once all comments have been received a paper will be prepared, together with an executive summary.	**FW**	**04/02/15**
FMT 04/02/06	**BMBC COMMUNITY AND VOLUNTARY SECTOR REVIEW**		
	The Head of Planning and Performance reported that the paper detailed the proposal to appoint a provider to review the current voluntary and community sector service provision across Barnsley. There will also be a review of the potential for social enterprise growth, public service reform and different models of delivery within this sector.		

UNADOPTED

Agenda Item	Note	Action	Deadline
	The Chief Finance Officer noted that the report does not mention Children's Social Care provision or how services link in with local area councils. There are a number of opportunities to look at which need to be explicit in the report. Members were mindful that CCG/BMBC would need to be clear in commissioning plans that there are services that the organisations would wish to be delivered via the voluntary sector. The review should therefore look at expanding volunteer opportunities. A discussion took place on how smaller voluntary organisations could bid for work and how they could be supported. The Head of Planning and Performance agreed to take the comments back to the report authors.	**JW**	**11/02/15**
FMT 04/02/08	**GOVERNING BODY PUBLIC AND PRIVATE AGENDAS FOR 12 FEBRUARY 2015**		
	It was agreed to bring this agenda item forward. The agendas were discussed; the Executive PA agreed to take back the comments to the Governing Body Secretary.	**FW**	**04/02/15**
FMT 04/02/07	**BE WELL BARNSLEY**		
	The Public Health Strategic Commissioning Programme Manager joined the meeting. It was reported that over the last few months a piece of work has been undertaken to look at how the Wellness Service is commissioned for residents of Barnsley. At present there are three services contracted, these are: • Weight Management Service • Smoking Cessation Service • Physical Activities Service The report looks at pulling these services in to one contract; the services are currently with two providers. It is proposed that the Be Well Service goes to the market in February with a PQQ (pre-qualification questionnaire). A draft specification is currently being developed; the current version was tabled. The aim of the service is to improve the wellbeing of the		

UNADOPTED

Agenda Item	Note	Action	Deadline
	residents of Barnsley by encouraging people to make healthy choices. The aims, objectives and scope were detailed in the draft report. The key changes to the service going forward will be the reduction in funding from £1.7m to £1m. It is hoped that some of these efficiencies will come from managing one contract rather than three. It was advised that Be Well Barnsley is not funded by the CCG. However it was noted that there is a physical activities pathway and the CCG Planned Care Programme Board have funded some complementary elements which link in. It was advised that there will be a mobilisation period for the service so that pathways can be honed and redesigned; a three month period has been scheduled for this. The Director of Public Health noted that the reduction in budget was not that monies had been cut but that they were being moved into other areas of the Council for preventative concerns such as lifestyle, environment, healthy food and the illicit sale of tobacco to children. Members were concerned that the latter services were currently funded and in real terms the £700k is a cut to Be Well Services. The group was asked to note that the current contracts are due to cease at the end of October and therefore the new service would be in place in November 2015. Be Well Barnsley will move into the Community Directorate in the Council from 1 April 2015 and it was recognised that there will be a wider strategy put forward from this. Agreed that it would be better to have the wider strategy in place first but this is not possible and the new Be Well Service has to be commissioned for 1 November. It was advised that a market awareness event was held in January and it is hoped that the voluntary sector will also participate. At the event 46 providers were present and issues such as expected outcomes, range of services, quality indicators and challenges for small providers were discussed. Members discussed the circumstances around weight management and how the service fitted within the T1,T2 and T3 arrangements. Going forward T1 and T2 will be commissioned by Public Health, T3 by the CCG and T4 by NHS England. Currently T3 is commissioned by		

UNSIGNED

Agenda Item	Note	Action	Deadline
	Public Health. It was noted that SWYPFT had put a figure of £170k on the T3 part of the service but the Director of Public Health did not think this was a true reflection of the service. It was asked whether the CCG needs to incorporate the T3 service into our contracts and if so recognised that this would need to be looked at now. It was agreed that this needs clarification and discussion within the CCG as the policy on T3 would need to be reviewed. It was asked whether the £170k funding was to be transferred to the CCG to commission T3; this needed further discussion. It was also recognised that as the level of bariatric surgery had reduced in recent years, due to the T3 element being ambiguous, that patient numbers might increase in the future. The Director of Public Health asked the meeting to note the funding for weight management monies had not been broken down into the different Tiers. Members expressed concerns that if the Tiers are commissioned by separate organisations then this might not be a streamlined service. This could lead to increased costs and duplication. The Chief Finance Officer asked whether a Quality Impact Assessment had been undertaken. A copy of this assessment will be forwarded. The Medical Director asked whether the Health and Wellbeing Board were aware of the reduction in funding for the service going forward as a significant amount of money will be moved away from the service. Concern was raised that the £700k saving was proposed over a year ago by Guy Swindle to Management Team and it had not been raised with the Health and Wellbeing Board. This will have a significant effect on the health and wellbeing of the residents of Barnsley and the Board need to be sighted as soon as possible. It was advised that this had not been seen by the Board but the Public Health Strategic Commissioning Programme Manager agreed to put this forward for the next meeting's agenda. A discussion took place on the smoking cessation service; the Medical Director noted that evidence	**DM**	

UNAPPROVED

Agenda Item	Note	Action	Deadline
	suggests that smoking cessation is linked to three interventions and he asked whether these would continue to be provided. The interventions are the drugs Zyban and Champix, prescribing NRT and counselling. It was recognised that only NRT was mentioned in the specification. The Medical Director asked whether these services would be available through the new service. It was advised that the service will be met through outcome based procurement so bidders will look at the evidence and design a model to meet it. Members were keen that there should be a seamless transition to the new service. Public Health would be very happy for a member of the CCG to assist with the evaluation of the bids. The Committee agreed to read and digest the paper fully and feedback to the Interim Chief Officer who will liaise with the Director of Public Health. The Director of Public Health is meeting with the Chair of the Health and Wellbeing Board tomorrow (5 February 2015) and agreed to raise the Be Well Service issues with reduction of funding and the change in direction of investment.	**JB** **JB**	
FMT 04/02/09	**ANY OTHER BUSINESS**		
	Sexual Health Service The Medical Director noted that the current provider with GP Surgeries to fit Nexplanon is coming to an end. At present GPs book clinics for this service in advance; will this still be the position in the new service or will GPs stop this service. Dr Clare Bannon has been involved in this work and it was agreed to email Dr Bannon for feedback. The ambition for the new service is to continue to maintain standards.	**DM**	
FMT 04/02/10	**DATE AND TIME OF NEXT MEETING**		
	The next Formal Management Team meeting will be held on Wednesday 18 February 2015, 9.00 – 11.00am, Meeting Room 1, Hillder House		

UNADOPTED

FMT 04/02/03

ACTION / DECISION LOG

Barnsley Clinical Commissioning Group

FORMAL MANAGEMENT TEAM MEETING
for 4 February 2015 Meeting

Date of Meeting	No	Action/Decision	Target Date	Responsible Individual	RAG	Comments / update
17.06.14	01	**MATTERS ARISING – MENTAL HEALTH STRATEGY –** Kath Harris to follow up the Mental Health Strategy amendments with Alison Rumbol, then send to the Chief Finance Officer, who will share with the Governing Body.	24.06.14 01.07.14	KH CH		**The Mental Health Strategy currently at version 11. To refresh to take account of the MH Concordat. To be brought to Management team on 4 February 2015. KH to ensure that SWYPFT Assistant Medical Director has had sight of the document.**
15.07.14	02	**INNOVATION APPROACH –**The Head of Planning and Performance will speak to the Head of Service Development regarding the Apple iGenius session and ask her to liaise with Glen Collinson, IT Business Partner, to arrange this. The Head of Planning and Performance will circulate the Innovation Camp video to the Management Team and to attendees prior to use at a future CCG staff briefing. A revised paper, addressing the issues discussed will be presented for discussion at the Formal Management Team meeting on 12 August and the CCG staff briefing on 19 August.	29.07.14 29.07.14 19.08.14	JW JW JW		**This item was taken forward on the agenda for 15.10.14**

17.09.14	03	**INTEGRATED CARE HOMES TEAMS –** Kath Harris agreed to work with Karen Martin, Head of Patient Safety/Deputy Chief Nurse, on the Code of Standards between Care Homes and GPs.	29.10.14	KH		**This item has progressed to a Working Group.**

Key:

Blue (B)	**New Action (1st time to the meeting)**
Red (R)	**Outstanding (Passed target date)**
Grey (Gr)	**Update required (Not clear where action is up to)**
Amber (A)	**Progressing (Work begun but not complete)**
Green (G)	**Action Completed (to next meeting to note only then remove from log)**
White (W)	**Decision made**