NHS
Barnsley Clinical Commissioning Group

Putting Barnsley People First

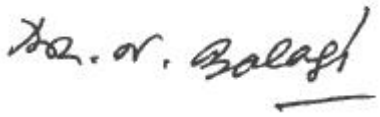
A meeting of the NHS Barnsley Clinical Commissioning Group Governing Body will be held on Thursday 11 January 2018 at 9.30 am in the Boardroom Hillder House, 49/51 Gawber Road, Barnsley S75 2PY

AGENDA
(Public)

Item	Session	GB Requested to	Enclosure Lead	Time
1.	Apologies	Note		9.30 am
2.	Quoracy	Note		
3.	Patient Story	Note		9.35 am 10 mins
4.	Declarations of Interest relevant to the agenda	Assurance	**GB/Pu/17/01/04** Nick Balac	9.45 am 5 mins
5.	Patient and Public Involvement Activity Report	Assurance	**GB/Pu/17/01/05** Lesley Smith	9.50 am 10 mins
6.	Minutes of the meeting held on 14 December 2017	Approval	**GB/Pu/17/01/06** Nick Balac	10.00 am 5 mins
7.	Matters Arising Report	Note	**GB/Pu/17/01/07** Nick Balac	10.05 am 5 mins
	Strategy			
8.	Chief Officers Report	Information	**GB/Pu/17/01/08** Lesley Smith	10.10 am 10 mins
9.	Accountable Care Update	Information	**Presentation** Jeremy Budd	10.20 am 10 mins
	Quality and Governance			
10.	Commissioning of Children's Services Quarterly Monitoring Report.	Assurance	**GB/Pu/17/01/10** Brigid Reid	10.30 am 10 mins
11.	Risk & Governance Exception Report.	Assurance	**GB/Pu/17/01/11** Richard Walker	10.40 am 10 mins

	Finance and Performance			
12.	Integrated Performance Report	Assurance and Information	**GB/Pu/17/01/12** Jamie Wike / Roxanna Naylor	10.50 am 15 mins
13.	QIPP Delivery Update	Assurance and Information	**GB/Pu/17/01/13** Jamie Wike	11.05 am 10 mins
	Committee Reports and Minutes			
14.	Minutes of the Finance and Performance Committee Meeting held on 7 December 2017	Assurance	**GB/Pu/17/01/14** Nick Balac	11.15 am 5 mins
15.	Minutes of the Audit Committee Held on 30 November 2017	Assurance	**GB/Pu/17/01/15** Nigel Bell	11.20 am 5 mins
16.	Primary Care Commissioning Committee Assurance Report (21 December 2017 meeting)	Assurance	**GB/Pu/17/01/16** Chris Millington	11.25 am 5 mins
17.	Minutes of the South Yorkshire and Bassetlaw Sustainability and Transformation Partnership Collaborative Partnership Board held on 10 November 2017	Assurance	**GB/Pu/17/01/18** Lesley Smith	11.30 am 5 mins
18.	Questions from the Public on Barnsley Clinical Commissioning Group business	Note	Nick Balac	11.35 am 10 mins
19.	Reflection on how well the meeting's business has been conducted: • Conduct of meetings • Any areas for additional assurance • Any training needs identified	Assurance	Nick Balac	11.45 am 5 mins
	General			
20.	**Date and Time of the Next Meeting:** Thursday 8 February 2018 2018 at 9.30 am in the Boardroom, Hillder House, 49-51 Gawber Road, Barnsley, S75 2PY			11.50 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
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Putting Barnsley People First

GOVERNING BODY

11 January 2018

Declarations of Interests, Gifts, Hospitality and Sponsorship Report

PART 1A – SUMMARY REPORT

1. THIS PAPER IS FOR

Decision		*Approval*		*Assurance*	x	*Information*	

2. REPORT OF

	Name	*Designation*
Executive Lead	Richard Walker	Head of Governance and Assurance
Author		

3. EXECUTIVE SUMMARY

Conflicts of interest are defined as a set of circumstances by which a reasonable person would consider that an individual's ability to apply judgement or act, in the context of delivering, commissioning, or assuring taxpayer funded health and care services is, or could be, impaired or influenced by another interest they hold.

The table below details what interests must be declared:

Type	**Description**
Financial interests	Where individuals may directly benefit financially from the consequences of a commissioning decision e.g., being a partner in a practice that is commissioned to provide primary care services;
Non-financial professional interests	Where individuals may benefit professionally from the consequences of a commissioning decision e.g., having an unpaid advisory role in a provider organisation that has been commissioned to provide services by the CCG;
Non-financial personal interests	Where individuals may benefit personally (but not professionally or financially) from a commissioning decision e.g., if they suffer from a particular condition that requires individually funded treatment;
Indirect interests	Where there is a close association with an individual who has a financial interest, non-financial professional interest or a non-financial personal interest in a commissioning decision e.g., spouse, close relative (parent, grandparent, child, etc.) close friend or business partner.

	Appendix 1 to this report details all Governing Body Members' current declared interests to update and to enable the Chair and Members to foresee any potential conflicts of interests relevant to the agenda. In some circumstances it could be reasonably considered that a conflict exists even when there is no actual conflict. Members should also declare if they have received any Gifts, Hospitality or Sponsorship.
4.	**THE GOVERNING BODY IS ASKED TO:**
	• Note the contents of this report and declare if Members have any declarations of interest relevant to the agenda or have received any Gifts, Hospitality or Sponsorship.
5.	**APPENDICES**
	• Appendix 1 – *Governing Body Members Declaration of Interest Report*

Agenda time allocation for report:	5 minutes

PART 1B – SUPPORTING INFORMATION

1.	Links to the Governing Body Assurance Framework	Risk ref(s)
	This report provides assurance against the following risks on the Governing Body Assurance Framework:	n/a
2.	**Links to CCG's Corporate Objectives**	**Y/N**
	To have the highest quality of governance and processes to support its business	Y
	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 £.	
3.	**Governance Arrangements Checklist**	
3.1	**Financial Implications**	
	Has a financial evaluation form been completed, signed off by the Finance Lead / CFO, and appended to this report?	*NA*
3.2	**Consultation and Engagement**	
	Has Comms & Engagement Checklist been completed?	*NA*
3.3	**Equality and Diversity**	
	Has an Equality Impact Assessment been completed and appended to this report?	*NA*
3.4	**Information Governance**	
	Have potential IG issues been identified in discussion with the IG Lead and included in the report?	*NA*
	Has a Privacy Impact Assessment been completed where appropriate (see IG Lead for details)	*NA*
3.5	**Environmental Sustainability**	
	Are any significant (positive or negative) impacts on the environment discussed in the report?	*NA*
3.6	**Human Resources**	
	Are any significant HR implications identified through discussion with the HR Business Partner discussed in the report?	*NA*

NHS
Barnsley Clinical Commissioning Group

Putting Barnsley People First

NHS Barnsley Clinical Commissioning Group Register of Interests

This register of interests includes all interests declared by members and employees of Barnsley Clinical Commissioning Group. In accordance with the Clinical Commissioning Group's Constitution the Clinical Commissioning Group's Accountable Officer will be informed of any conflict of interest that needs to be included in the register within not more than 28 days of any relevant event (e.g. appointment, change of circumstances) and the register will be updated as a minimum on an annual basis.

Register: Governing Body

Name	Current position (s) held in the CCG	Declared Interest
Adebowale Adekunle	GP Governing Body Member	• GP Partner at Wombwell Chapelfields Medical Centre
		• The practice is a member of Barnsley Healthcare Federation which may provide services for Barnsley CCG
		• Clinical sessions with Local Care Direct Wakefield
		• Clinical sessions at IHeart
		• Member of the British Medical Association
		• Member Medical Protection Society
Nick Balac	Chairman	• Partner at St Georges Medical Practice (PMS)

Name	Current position (s) held in the CCG	Declared Interest
		• Practice holds AQP Barnsley Clinical Commissioning Group Vasectomy contract
		• Member of the Royal College of General Practitioners
		• Member of the British Medical Association
		• Member of the Medical Protection Society
		• The practice is a member of Barnsley Healthcare Federation which may provide services for Barnsley CCG
Nigel Bell	Lay Member - Governance	• Lay Advisor at Greater Huddersfield CCG
		• Ad hoc provision of Business Advice through Gordons LLP
Mehrban Ghani	Medical Director	• GP Partner at The Rose Tree Practice trading as the White Rose Medical Practice, Cudworth, Barnsley
		• GP Appraiser for NHS England
		• Directorship at SAAG Ltd, 15 Newham Road, Rotherham

Name	Current position (s) held in the CCG	Declared Interest
		• The practice is a member of Barnsley Healthcare Federation which may provide services for Barnsley CCG
Madhavi Guntamukkala	GP Governing Body Member	• GP partner at The Grove Medical Practice
		• Husband is a partner at The Grove Medical Practice and Lakeside Surgery
		• Member of the Royal College of General Practitioners
		• Member of the British Medical Association
		• The practice is a member of Barnsley Healthcare Federation which may provide services for Barnsley CCG
John Harban	GP Governing Body Member	• GP Partner at Lundwood Medical Centre and The Kakoty Practice, Barnsley
		• AQP contracts with the Barnsley Clinical Commissioning Group to supply Vasectomy, Carpal Tunnels and Nerve Conduction Studies services
		• Owner/Director Lundwood Surgical Services
		• Wife is Owner/Director of Lundwood Surgical Services

Name	Current position (s) held in the CCG	Declared Interest
		• Member of the Royal College of General Practitioners
		• Member of the faculty of sports and exercise medicine (Edinburgh)
		• The practice is a member of Barnsley Healthcare Federation which may provide services for Barnsley CCG
James Holloway	GP Governing Body Member	• Salaried GP at Dr Mellor and Partners
		• Former employee of KPMG LLP
		• Former employee of BDO Stoy Hayward
Anne Marie Hoyle	Practice Manager Member	• Business Manager at The Kakoty Practice, Barnsley
		• Cllr Alice Cave, BMBC Elected Councillor is related
		• Rotarian, Barnsley (Rockley) Rotary Club
		• Director Barnsley Enterprise for Living Well (CIC)

Name	Current position (s) held in the CCG	Declared Interest
		• Member of the Institute of Healthcare Management
		• Director/ Company Secretary Jaxon's Gift, Charity Organisation
		• The practice is a member of Barnsley Healthcare Federation which may provide services for Barnsley CCG
		• Board Member for South Yorkshire Credit Union Ltd
M Hussain Kadarsha	GP Governing Body Member	• GP Partner in Hollygreen Practice
		• Director of FGGP which hold the PMS contract for Dodworth Medical Practice
		• The practice is a member of Barnsley Healthcare Federation which may provide services to Barnsley CCG
		• Member of the British Medical Association
		• Director of YAAOZ Ltd, with wife
Sudhagar Krishnasamy	Associate Medical Director	• GP Partner at Royston Group Practice, Barnsley

Name	Current position (s) held in the CCG	Declared Interest
		• Member of the Royal College of General Practitioners
		• GP Appraiser for NHS England
		• Executive member of Barnsley Local Medical Committee (ceased July 2017)
		• Member of the Medical Defense Union
		• Director of SKSJ Medicals Ltd • Wife is also a Director
		• The practice is a member of Barnsley Healthcare Federation which may provide services for Barnsley CCG
		• Undertakes sessions for IHeart Barnsley
Chris Millington	Lay Member	• Partner Governor Barnsley Hospital NHS Foundation Trust
Roxanna Naylor	Acting Chief Finance Officer	• Partner works at NHS Leeds West Clinical Commissioning Group.
Brigid Reid	Chief Nurse	• Volunteer registered Nurse, St Gemma's Hospice, 329 Harrogate Road, Moortown, Leeds LS17 6QD

Name	Current position (s) held in the CCG	Declared Interest
		• Partner works at Leeds Teaching Hospital NHS Trust which provides services to Barnsley patients via Specialised Commissioning and could tender to supply others.
Mike Simms	Secondary Care Clinician	• No interests to declare
Mark Smith	GP Governing Body Member	• Senior Partner at Victoria Medical Centre also undertaking training and minor surgery roles.
		• Director of Janark Medical Ltd
Lesley Smith	Governing Body Member	• Husband is Director/Owner of Ben Johnson Ltd a York based business offering office interiors solutions, furniture, equipment and supplies for private and public sector clients potentially including the NHS.
Sarah Tyler	Lay Member for Accountable Care	Volunteer Governor / Board Member, Northern College
		Voluntary trustee / Board Member for Steps (community care provider for early years / nursery)
		Interim contract supporting NHS England (ceased July 2017)
		Interim Health Improvement Specialist for Wakefield Council

Barnsley Clinical Commissioning Group

Putting Barnsley People First

Governing Body

11 January 2018

Patient and Public Involvement Activity Report

1.	**THIS PAPER IS FOR**						
	Decision		*Approval*		*Assurance*	x	*Information*	
2.	**REPORT OF**						

	Name	*Designation*
Executive Lead	Lesley Smith	Chief Officer
Author	Kirsty Waknell	Head of Communications and Engagement

3.	**EXECUTIVE SUMMARY**
	This report gives an overview of patient and public involvement activity over the past month and planned activity for the coming month. The CCG will be taking part in a health and equality event this month, hosted by the Barnsley equality forums. This will be an opportunity to work alongside health and care providers and forum members on their recommendations for services. It is also be an opportunity to learn from what has been working well. The national consultation on reducing prescribing of over-the-counter medicines has now launched and the CCG is encouraging people to review the recommendations for the 33 minor, short-term health concerns.
4.	**THE GOVERNING BODY IS ASKED TO:**
	• Consider and note the contents.

Agenda time allocation for report:	*10 minutes*

PART 1B – SUPPORTING INFORMATION

1.	Links to the Governing Body Assurance Framework	Risk ref(s)
	This report provides assurance against the following risks on the Governing Body Assurance Framework:	1.2
2.	**Links to CCG's Corporate Objectives**	**Y/N**
	To have the highest quality of governance and processes to support its business	Y
	To commission high quality health care that meets the needs of individuals and groups	Y
	Wherever it makes safe clinical sense to bring care closer to home	Y
	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	Y
	To develop services through real partnerships with mutual accountability and strong governance that improve health and health care and effectively use the Barnsley £.	Y
3.	**Governance Arrangements Checklist**	
3.1	**Financial Implications**	
	Has a financial evaluation form been completed, signed off by the Finance Lead / CFO, and appended to this report?	*N*
	Are any financial implications detailed in the report?	*NA*
3.2	**Consultation and Engagement**	
	Has Comms & Engagement Checklist been completed?	*NA (general update report for assurance)*
	Is actual or proposed engagement activity set out in the report?	*NA*
3.3	**Equality and Diversity**	
	Has an Equality Impact Assessment been completed and appended to this report?	*NA*
3.4	**Information Governance**	
	Have potential IG issues been identified in discussion with the IG Lead and included in the report?	*NA*
	Has a Privacy Impact Assessment been completed where appropriate (see IG Lead for details)	NA
3.5	**Environmental Sustainability**	
	Are any significant (positive or negative) impacts on the environment discussed in the report?	*NA*
3.6	**Human Resources**	
	Are any significant HR implications identified through discussion with the HR Business Partner discussed in the report?	*NA*

PART 2 – DETAILED REPORT

1	**INTRODUCTION**
1.1	This report gives an overview of our recent and future patient and public involvement activity in Barnsley CCG.
2	**INVOLVEMENT ACTIVITY**
2.1	**How public and patient involvement is influencing the decisions we make.**

Recent Activity	**Outcomes/findings**
Primary care support to people in care homes During November and December we asked for feedback from residents, relatives and carers on their experience of support from primary care to people in care homes.	Feedback is currently being analysed.
GP practices The Cope Street/Park Grove practice has been asking for feedback on the proposals for a new surgery site, based near the Alhambra roundabout in Barnsley. The proposal would see their existing three sites move to two.	Engagement with patients & stakeholders closed end of December, with around 60 responses coming back in. The GP practice is analysing the results, which will form part of their submission to the Primary Care Commissioning Committee on 25 January 2018.
Current Activity	**Outcomes/findings**
Get Fit First patient information Getting fit for surgery and reducing the increased risks associated with being overweight and/or smoking was discussed at the December Governing Body meeting. Here is the patient and public feedback, which was presented at that meeting. We asked people if the supporting patient leaflet, which will be given to people in conjunction with a conversation with their GP,	As a result of the feedback, highlighted below, the patient leaflet will be updated to reflect the following: • **Signposting**. Add contact details for local services to make it easier for people to get support. • **Access.** There was some feedback on making the leaflet more accessible to all. Some said it is too wordy and also suggestion for the use of more graphics. • **Clarity**. The following points were made about how the leaflet needs to be clearer about what happens if people do not lose weight or stop smoking. One person also suggested that it needs to address people's anxiety both of the outcome of the six month's activity and surgery. One person also recommended the following wording "People

	was the following: • Is the information clear and easy to understand? • Is there any more information that needs to be added? • Is there anything we could do to improve the information? • Any other feedback on the patient information.	who are severely overweight or who smoke can take longer to recover from surgery and can have a small, but significant risk, of dying as a result of their surgery than people who are healthy" should include the word *'increased'* as all surgery carries a risk of death for even the fittest. It was suggested that we add something on what the BMI is and why it's a good measure. • **Approach.** People said the tone of the leaflet could be more motivational in the way it approaches these lifestyle changes. A summary of what people told us is available on the CCG website here.
	Health and equality forum event 2018	A health and equality event is being hosted by the Barnsley equality forums on 31st January. Forums attending will be: • Barnsley Deaf Forum • My Barnsley Too Disability Forum • Barnsley Together Forum • Barnsley LGBT Forum • Gender Equality Forum The CCG will be joining other health and care commissioners, providers and Healthwatch Barnsley to respond to and review progress on previous recommendations made at a similar event in 2017.
	Health and care working together in Barnsley There are a range of ways Barnsley people, local communities and organisations can get involved and help shape the future of joining up care in Barnsley. For more information visit: https://www.healthandcaretogethersyb.co.uk/local-plans/Barnsley	Two priorities have been chosen to focus on where partners and local communities feel they can make a big difference. The first is cardiovascular, or heart-related, disease. For example, the North East Area Council has highlighted it as a priority for their area to tackle. The second is care, support and needs of older people. Work will start shortly with local communities, health and care teams and partners to help design and develop these two areas.

		Help shape the future of hospital services. Healthcare teams across South Yorkshire, Bassetlaw and Chesterfield are coming together with patients and the public to help shape how hospital services could be delivered in the future to ensure local people continue to get safe, sustainable, high quality care. The five hospital services are: urgent and emergency care; maternity services; hospital services for children who are particularly ill; services for stomach and intestines conditions (gastroenterology), including investigations (endoscopy); and stroke (early supported discharge and rehabilitation).	The session on December 6 2017 to discuss the latest developments of the hospital services review saw around 70 people attend, including foundation trust governors, patient group representatives and members of the public. The next session will be in March in Sheffield. There will also be other local sessions. Dates and locations for all will be available in the coming weeks. The newly formed Citizens' Panel met in December for a session run by NHS England called, "10 steps to even better engagement." The workshop provided the panel with a helpful opportunity to start thinking about their role in increasing public participation in across the local areas, with the real-life examples of the five services within the hospital services review. Further work is ongoing to widen the representation of the panel to our various populations. As part of the mental health and learning disabilities programme, joint work with the DEEP (Dementia Engagement and Empowerment Project) and tide (together in dementia everyday) is being developed to ensure that the work programme is co-produced with people living with dementia and family carers. For more information visit the following website, where you can also sign up for the latest updates: https://www.healthandcaretogethersyb.co.uk/about-us/whychange/latest-news/help-shape-future-hospital-services

Reducing prescribing of over-the-counter medicines – national consultation NHS England has launched a public consultation on **reducing prescribing of over-the-counter medicines** for 33 minor, short-term health concerns. NHS England has partnered with NHS Clinical Commissioners to carry out the consultation after CCGs asked for a nationally co-ordinated approach to the development of commissioning guidance in this area to ensure consistency and address unwarranted variation. The intention is to produce a consistent, national framework for CCGs to use. Subject to the outcome of the consultation, the commissioning guidance will need to be taken into account by CCGs in adopting or amending their own local guidance to GPs in primary care.	In the year prior to June 2017, the NHS spent approximately £569 million on prescriptions for medicines which can be purchased over the counter from a pharmacy and other outlets such as supermarkets. These prescriptions include items for a condition: • That is considered to be **self-limiting** and so does not need treatment as it will heal of its own accord; • Which lends itself to **self-care**, i.e. that the person suffering does not normally need to seek medical care but may decide to seek help with symptom relief from a local pharmacy and use an over the counter medicine. Vitamins/minerals and probiotics have also been included in the consultation proposals as items of low clinical effectiveness which are of high cost to the NHS. For more information and to feedback visit: https://www.engage.england.nhs.uk/consultation/over-the-counter-items-not-routinely-prescribed/
Future activity	
Improving Access to General Practice	NHS England is hosting an event in February for patient representatives and lay members to find out more about the next steps for improving access to general practice, including plans for national rollout by March 2019. Content will cover the seven core requirements for improving access and what this means for patients and how they can advise on supporting service changes in their area. Barnsley practice patient group members are invited to attend the event.

		Improving Access to Psychological Therapies (IAPT). The IAPT service will be re-commissioned in Barnsley during spring and summer 2018, to ensure Barnsley people have access to high quality services, which meet the national standards and offers value for money for the Barnsley health budget. Further details of how to get involved will be available in the coming weeks.	Around one in six adults in England have a common mental health disorder, such as depression or anxiety. IAPT is an NHS programme that offers therapies approved by the National Institute for Health and Care Excellence (NICE) for treating people with depression or anxiety. There are national standards for IAPT services, listed below: **Waiting times:** 75% of people referred to IAPT services should start treatment within 6 weeks of referral, and 95% should start treatment within 18 weeks of referral. **Access:** IAPT services should be providing timely access to treatment for at least 15% of those who could benefit people with anxiety disorders and depression. **Recovery:** At least 50% of people who complete treatment should recover.
		Review of Independent Living Services across Barnsley	In partnership with Barnsley Council we will be talking to services users to collect their experiences of current services, with a view to co-producing a new service model.
		Barnsley mental health and wellbeing commissioning strategy 2016-2020 – review & refresh	This is likely to start in February 2018 and we'll be working alongside the local mental health groups (as well as others) to shape this.

GB/Pu/18/01/06

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 14 December 2017 2017 at 9.30 am in the Boardroom, Hillder House, 49-51 Gawber Road, Barnsley, S75 2PY

MEMBERS PRESENT

Dr Mehrban Ghani (Acting Chair)	Medical Director
Dr Adebowale Adekunle	Member
Nigel Bell	Lay Member for Governance
Dr Madhavi Guntamukkala	Member
Dr James Holloway	Member
Marie Hoyle	Practice Manager Member
Dr M Hussain Kadarsha	Member
Dr Sudhagar Krishnasamy	Member & Associate Medical Director
Roxanna Naylor	Acting Chief Finance Officer
Brigid Reid	Chief Nurse
Mike Simms	Secondary Care Clinician
Lesley Smith	Chief Officer
Dr Mark Smith	Member
Sarah Tyler	Lay Member for Accountable Care

IN ATTENDANCE

Jeremy Budd	Director for Accountable Care
Kay Morgan	Governance & Assurance Manager
Kirsty Waknell	Head of Communications and Engagement
Richard Walker	Head of Governance and Assurance
Jamie Wike	Head of Planning, Delivery and Performance

APOLOGIES

Dr Nick Balac	Chairman
Dr John Harban	Member
Chris Millington	Lay Member for Patient and Public Engagement & Primary Care Commissioning

MEMBERS OF THE PUBLIC

Tony Conway	Member of the Public
Alan Higgins	BHNFT Governor
Cllr Margaret Sheard	BMBC
Janet Williams	Member of the Public

The Head of Governance and Assurance reported that Dr Nick Balac, CCG Chairman and Chris Millington Vice Chairman (Lay Member for Patient and Public) were unavoidably absent from the meeting.

UNADOPTED

The CCG's Constitution specified in the absence of the CCG Chairman and Vice Chair at a Governing Body meeting, Governing Body members could select and agree a chairperson for that meeting, thereby allowing the business of the meeting to proceed. The Medical Director was proposed to chair the meeting and this was agreed by all members present.

The Chair welcomed the members of the public to the December meeting of the Governing Body.

Agenda Item		Action	Deadline
GB 17/12/01	**QUORACY**		
	The Chairman declared the meeting quorate.		
GB 17/12/02	**PATIENT STORY**		
	The Governing Body received a patient story which reflected the positive experiences of a patient who had participated in a new initiative, 'Get Fit First in Barnsley'. The patient had requested knee surgery but had a high BMI which would increase the risk of complications following surgery. The patient undertook a weight loss and exercise programme, with positive outcomes; losing weight and feeling much healthier. So much so the patient was going to consult her GP with a view to delaying referral for surgery at this time.		
	The Chairman opened up discussion for comments about the Patient Story and the following main points were noted: • The Patent Story was a common Practice scenario. It was important to promote lifestyle interventions and prevention at all consultations. • Improved health outcomes and delay of any surgery was a great outcome for patients. Joint replacement usually lasted 10 years and subsequent revision surgery posed greater risks for patients. • Weight loss linked to diabetes would reap positive benefits for patients in managing and improving their condition and for the NHS in terms of resource.		
	The Governing Body noted the Patient Story.		

UNAUDITED

Agenda Item		Action	Deadline
GB 17/12/03	**DECLARATIONS OF INTEREST, SPONSORSHIP, HOSPITALITY AND GIFTS RELEVANT TO THE AGENDA**		
	The Governing Body considered the Declaration of Interests, Gifts, Hospitality and Sponsorship Report. No new declarations of interests were received.		
GB 17/12/04	**PATIENT AND PUBLIC INVOLVEMENT ACTIVITY REPORT**		
	The Head of Communications and Engagement introduced the Patient and Public Involvement (PPI) Activity Report to the Governing Body. The Governing Body were pleased to note that the CCG had received a rating of significant assurance from an independent internal audit review of the CCG's governance arrangements in relation to patient and public involvement. The CCG had been awarded a rating of 'good' from an NHS England assessment of the CCG's patient and community engagement. The Governing Body acknowledged that the excellent results could not have been achieved without the support and engagement of members of the public.		
	The Governing Body noted the Activity Report. **Agreed Action** **To acknowledge the contribution made by members of the public towards the CCG's positive results from an internal audit and NHSE assessment.**	**KW**	
GB 17/12/05	**QUESTIONS FROM THE PUBLIC ON BARNSLEY CLINICAL COMMISSIONING GROUP BUSINESS**		
	The Chairman invited questions from the public on Barnsley CCG business. The following questions / comments and answers were noted: • **Closure of Keresforth Day Centre & Support to Patients** The Chief Nurse advised that a meeting would be held in February 2018 to consider the individual needs of patients and support required.		

UNADOPTED

Agenda Item		Action	Deadline
	• **Dementia Champions** A presentation given by the Alzheimer's Society to the Patient Council had prompted a BHNFT Governor and others to undertake training to become a Dementia Champion, all helping towards the Barnsley Dementia Friendly Town initiative. The Governing Body applauded the steps taken by members of the public to complete Dementia Champion training. It was noted that most Governing Body members were already Dementia Champions. The BHNFT Governor advised the Governing Body that Morrison's Supermarket were match funding monies raised by Barnsley Hospice, to refurbish the inpatient unit at the Hospice which would be a dementia friendly environment. • **Get Fit First – Service providers** A view was expressed that the South West Yorkshire NHS Partnership Trust had some concerns regarding the increased numbers of patients accessing smoking cessation and weight management services as a result of the 'Get Fit First in Barnsley' scheme and questioned whether they had sufficient capacity to deliver services. It was queried if the CCG had considered engaging with other companies / providers such as slimming world and weight watchers? The Chief Nurse advised that the commissioning of weight loss services was the responsibility of the Barnsley Metropolitan Borough Council. • **GP Telephone Consultations** The BHNFT Governor informed the Governing Body of the informative service provided by receptionists and excellent patient telephone consultation model at the Ashville Medical Centre. The Practice Manager Member commented that demand and capacity initiatives were shared and discussed at meetings of the Practice Managers Group. Additionally all Practice reception staff were undertaking 'navigation' training to effectively sign post patients to the most appropriate services.		

UNADOPTED

Agenda Item		Action	Deadline
	The Acting Chairman thanked members of the public for their questions. **Agreed Action** **All Governing Body Members to become Dementia Champions.** **To raise the alternative options re commissioning of weight loss services with the Director of Public Health, Barnsley Metropolitan Borough Council.**	 **ALL** **BR**	 **11.01.18** **11.01.18**
GB 17/12/06	**MINUTES OF THE PREVIOUS MEETING HELD ON 9 NOVEMBER 2017**		
	The minutes of the previous meeting were verified as a correct record of the proceedings subject to the following amendment: • **Minute reference GB 17/11/13 Integrated Performance Report – Finance** Last sentence to read: - The CCG is working with the Trust to review the overspend position.	 **KM**	 **11.01.18**
GB 17/12/07	**MATTERS ARISING REPORT**		
	The Governing Body considered the Matters Arising Report and agreed to remove the items marked as complete. The following main points were noted: • **Minute reference GB 17/04/12 - Yorkshire and Humber Fertility Policy 2017** The Chief Nurse reported that a note had been posted on the CCG's website to indicate that the Fertility Policy was under review. National work in relation to fertility was ongoing and it was important that the CCG Policy was in line with nationally established guidelines.		
	The Governing Body noted the Matters Arising Report.		
STRATEGY			

UNDOPTED

Agenda Item		Action	Deadline
GB 17/12/08	**HYPER ACUTE STROKE SERVICES – UPDATE ON DECISION MAKING BUSINESS CASE**		
	The Chief Officer presented an update on the Decision Making Business Case for Hyper Acute Services in South Yorkshire and Bassetlaw. The decision taken by the Joint Committee of Clinical Commissioning Groups was made against a compelling clinical case for change. In future Barnsley patients in the hyper acute phase of a stroke would be treated by acute providers in Sheffield, Doncaster or Wakefield. Patients would be repatriated to Barnsley within 72 hours for continuing care.		
	The Chief Officer emphasised that this was not a cost cutting decision but about securing best outcomes and care for patients. It was noted that the tariff for specialised treatments such as hyper acute services was higher than normal tariff and although this would cost more, there were more positive outcomes for patients. Five percent of all stroke cases in Barnsley presented outside of the window of opportunity for acute treatment and this signalled the need for local stroke awareness campaigns.		
	The Governing Body noted the decision and next steps.		
GB 17/12/09	**ACCOUNTABLE CARE PROGRAMME UPDATE**		
	The Director for Accountable Care gave a presentation which provided feedback from the general public, councillors received at the Accountable Care Shadow Delivery Board Meeting in public session held on 23 November 2017. The Governing Body noted the main themes of what people had said and responses provided**.**		
	The Chief Officer explained that the terminology used around accountable care was unhelpful to development of accountable care and this had been raised at national level. The term accountable care was seen as an American privatisation model. In reality accountable care was about the provision of integrated care. The terminology of accountable care in Barnsley should not be a barrier to development and provision of integrated services for the people of Barnsley.		

UNADOPTED

Agenda Item		Action	Deadline
	The questions raised and responses provided around the accountability arrangements for the Shadow Delivery Board were noted. The Chief Officer advised that additional clarity could be provided to include current statutory responsibilities and future landscape. The Director for Accountable Care advised that future meetings of the Accountable Care Shadow Delivery Board in public session would be held in suitable venues across the borough.		
	The Governing Body noted the Update. **Agreed action** • **To consider and propose alternative names for Accountable Care in Barnsley to the Barnsley Accountable Care Partnership Board.** • **To explicitly define responses to the public about who the Accountable Care Shadow delivery Board was actually accountable to.**	**JB** **JB**	**11.01.18** **11.01.18**
QUALITY AND GOVERNANCE			
GB 17/12/10	**GET FIT FIRST**		
	The Secondary Care Clinician introduced a Report about the mobilisation of the Get Fit First in Barnsley Programme. The aim of the Programme was to support lifestyle changes for the people of Barnsley to improve long term health. The Patient's Story received at the start of the meeting reflected the positive experiences of a patient engaging with the programme. Promotion of the service was being considered and Practices encouraged to use the service to refer appropriate patients at earliest opportunity**.** The Governing Body noted the tabled paper which provided a summary of public involvement with development of the Get Fit in Barnsley First Programme.		
	An open discussion took place and the following main points noted:		

UNADOPTED

Agenda Item		Action	Deadline
	• A public perception may be that patients who were obese or smoked would not be allowed to have surgery. The programme was in fact about trying to help people to become healthier. Referrals to the programme should be classed as business as usual rather than just for patients considering surgery. • It was determined that those patients who had a definite date for surgery could be given the option to engage with the programme. Patients considering surgery should be referred to the Programme. The BHNFT could identify from waiting lists information the patients who were awaiting surgery and smoked or had a high BMI and refer accordingly to the Programme. • The Get Fit First in Barnsley Programme had been communicated to Partners and positively received by GPs. The required capacity to meet the needs of patients had been raised at locality meetings. It was noted that Heath Trainers at some Practices were not fully utilised. In response the Chief Officer advised that the Barnsley Plan included the need to reduce the rates of smoking prevalence and obesity. Therefore it is expected that partners will have commissioned sufficient capacity to deliver the Barnsley Plan. • Patients may be more motivated early in the New Year and this would be a good time for Practices to refer patients to the programme. The My Best Life scheme was also available for Practices to refer patients.		
	The Governing Body: **Approved** • **The implementation and mobilisation plans for the Get Fit First in Barnsley Programme** • **The commissioning statement for the weight management element of Get Fit First in Barnsley** • **The commissioning statement for the smoking cessation element of Get Fit First in Barnsley**		

UNAPPROVED

Agenda Item		Action	Deadline
	Noted • **The contents of the report regarding progress of the programme** • **The start date for Get Fit First in Barnsley as 8th January 2018** **Agreed Action** **To produce a joint letter from the CCG and BHNFT for patients already in the system to advise of the requirements of the Get Fit in Barnsley Programme** **To advise the BHNFT about the need to identify those patients awaiting surgery with a high BMI or who smoke and refer to the Get Fit in Barnsley Programme.**	 **MS** **RN**	 **11.01.18** **11.01.18**
GB 17/12/11	**QUALITY HIGHLIGHTS REPORT**		
	The Chief Nurse presented the Quality Highlights Report to the Governing Body. With reference to the Medical Interoperability Gateway (MIG), the Practice Manager Member reported that the 0-19 service was receiving a demonstration of the potential to view records as appropriate via the MIG.		
	The Governing Body • **Approved – The co-option of Dr Ali to the membership of the Quality and Patient Committee.** • **Noted - the Quality Highlights Report**		
GB 17/12/12	**RISK AND GOVERNANCE REPORT**		
	The Head of Governance and Assurance presented the Risk and Governance Report to the Governing Body. For the three 0-19 risks, on the Risk Register it was noted that meetings were being held with CCG representatives to monitor the 0-19 action plan as mitigation for the risk. Good progress was being made with the action plan and the Primary Care Work stream would consider the rating of these risks in January 2018.		

UNADOPTED

Agenda Item		Action	Deadline
	The Governing Body: ***GBAF:*** • Reviewed the GBAF for 2017/18, and determined that the risks on the GBAF are appropriately described and scored, and that there is sufficient assurance that they are being effectively managed as at 14 December 2017 • Did not Identify any positive assurances relevant to the risks on the GBAF ***Risk Register:*** • Reviewed the Corporate Risk Register to confirm all risks are appropriately scored and described. • Approved inclusion of risk 17/06 • Approved the removal of risk reference 14/7 to the Risk Register. • Did not identify any potential new risks. ***Other matters:*** • Noted that the ratification of the preferred bidder for the Diabetes procurement currently underway will be taken by the Primary Care Commissioning Committee • Approved the proposed amendments to the Terms of Reference of the CCG's Committees • Noted the Register of Interests and Register of Gifts, Hospitality & Sponsorship update.		
GB 17/12/13	**PRIMARY CARE QUALITY IMPROVEMENT TOOL**		
	The Associate Medical Director introduced the Primary Care Quality Improvement Tool and updated dashboard to the Governing Body. Going forward, indicators may be added or removed from the dashboard as appropriate subject to the approval of the Governing Body.		
	It was clarified that the Primary Care Quality Improvement Group would meet on a bi monthly basis to monitor the dashboard and report any concerns to the Quality and Patient Safety Committee. The Primary Care Team with clinical input will take up any areas of concern and support practices.		
	The Governing Body approved:		

UNAPPROVED

Agenda Item		Action	Deadline
	• **The dashboard with a start date of 1 January 2018.** • **The Terms of Reference for the Primary Care Quality Improvement Group**		
GB 17/12/14	**CANCER PROGRAMME UPDATE**		
	Dr Kadarsha provided an update to the Governing Body on the Cancer Alliance Delivery Plans and an overview of the entirety of Cancer Programme Workload.		
	Discussion took place and the following main points were noted: • The CCG monitored performance of the cancer system as a whole and performance was excellent. . • Going forward the key priorities were to provide an awareness campaign for members of the public, a BEST event for Primary Care and that protocols were adhered to in Secondary Care • It was important to ensure that patients were in the most appropriate pathway of care. To avoid delays, it was queried why a CT or X-ray could not be initially undertaken prior to referral or whilst on waiting list. The Medical Director commented that there was some work to be done to avoid delays into pathways of care. The Governing Body applauded the BHNFT on their excellent achievements within cancer services.		
	The Governing Body noted: • **The programmes of work that are led by the Cancer Alliance Board.** • **The programmes of work that are happening in Barnsley**		
FINANCE AND PERFORMANCE			
GB 17/12/15	**INTEGRATED PERFORMANCE REPORT**		
	Finance The Acting Chief Finance Officer presented the key messages from Financial Report. The CCG was on track to deliver all financial duties.		

UNAGREED

Agenda Item		Action	Deadline
	The forecast position had improved from the position reported in month 6 due to reductions in acute contract activity and reductions in the cost and numbers of continuing care packages. The month 7 forecast of £694k is offset by a net mitigation of £852k, providing headroom of £158k. A forecast of the CCG's efficiency programme as at 31 October showed that whilst planned schemes had not delivered in line with expectations, other budget reductions had contributed to the efficiency programme to allow the target of £11.5m to be achieved. The CCG was working with the Trust to capture all risks and understand the fluctuations in activity. Early indicators show that no cheaper stock obtainable (NCSO) drug cost pressures are likely to ease during Q3. At present this pressure is estimated and would need to be confirmed via actual prescribing data.		
	Performance The Head of Planning, Delivery and Performance presented the Performance Exception Report. **Cancer targets** - As discussed and demonstrated in minute reference GB 17/12/14, cancer targets are consistently being met. **IAPT** – The position for October is improved from previously reported with all IAPT performance targets being achieved. **Four Hour Standard for Patients waiting in A&E** - A&E performance continues to be a significant challenge, for Barnsley and also other CCG areas. Performance in October 2017 at 87.62% was well below the 95% standard. November performance had improved to 92% however December, so far, was a real challenge in terms of access to beds, number of attendees to A&E and resultant admissions. Additional escalation beds at the BHNFT had been opened. Primary care streaming within A&E was in place, with 18% of all attendances being diverted to primary care. It was hoped that this figure would increase to 30% of A&E attendees being treated in primary care.		

UNAPPROVED

Agenda Item		Action	Deadline
	In terms of the Christmas period, national monies had been made available to manage demand and provide additional capacity. The national expectation was that everyone should be able to access GP appointments over the Christmas period even on Christmas Day. It was noted that practices would need to signpost patients to the most appropriate services to meet demand. **52 Week Wait** – In September 2017 there was one 52 week breach in ophthalmology. The breach was identified as part of validation work following the transfer of the service to Barnsley Hospital. The patient has since been treated		
	The Governing Body noted the contents of the report including: • **2017/18 performance to date** • **continued projected delivery of all financial duties, predicated on the assumptions outlined in this paper** • **the update on the CCG's efficiency programme and delivery of the £11.5m target.** • **the potential requirement that further efficiencies need to be explored to mitigate any financial risk associated with increasing acute contract activity pressures.** **Agreed Action** **To provide a briefing to Practices about the national campaign regarding access to a GP during the Christmas period.**	**KW**	**18.12.17**
GB 17/12/16	**QIPP DELIVERY UPDATE**		
	The Head of Planning, Delivery and Performance presented the QIPP reporting dashboard to the Governing Body. The dashboard provided an overview of progress and performance against the schemes within the CCG QIPP/Efficiency Programme. The Governing Body noted the projects rated as red from a financial perspective. It was noted that the learning from the 2017/18 QIPP would be considered when developing the 2018/19 QIPP and with a focus on what QIPP schemes will balance the books.		

UNADOPTED

Agenda Item		Action	Deadline
	For some schemes there was a positive impact on cost avoidance but maybe no reduction from the bottom line.		
	The Governing Body noted the contents of the report and the dashboard attached at Appendix 1.		
GB 17/12/17	**BARNSLEY INTEGRATION AND BETTER CARE FUND 2017-2019**		
	The Head of Planning, Delivery and Performance presented the final Barnsley Health and Wellbeing Board Integration and Better Care Fund Plan 2017-19 to the Governing Body. It was noted that the Plan had been approved by NHS England and was being delivered alongside the Barnsley Place Based Plan. It was suggested that the Better Care Fund item may have been more appropriately placed on the agenda following the Accountable Care Programme Update agenda item. This point was noted by the Head of Governance and Assurance.		
	The Governing Body noted the contents of the report and the final Barnsley Health and Well Being Board Integration and Better Care Fund narrative plan as approved by NHS England. **Agreed actions:** **To share the total amount of the Better Care Fund Plan with the Lay Member for Accountable Care.**	**JW**	
COMMITTEE REPORTS AND MINUTES			
GB 17/12/18	**COMMITTEE REPORTS AND MINUTES**		
	The Governing Body received and noted the following Committee minutes & assurance reports: • Finance and Performance Committee Meeting held on 2 November 2017. • Audit Committee held on 30 November 2017		

UNADOPTED

Agenda Item		Action	Deadline
	It was noted that the Audit Committee had recommended its terms of reference for approval by the Governing Body. The Audit Committee had approved the Policy for Losses and Special Payments and Petty Cash Procedure • Quality and Patient Safety Committee held on 21 September 2017 • Assurance Report of the Equality & Engagement Committee The Governing Body were informed that Practices were being supported with completion of their Equality and Engagement assessments and provision of accessible information. The CCG's new Equality and Engagement Specialist, Colin Brotherton would deliver an Equality and Engagement awareness briefing at a Governing Body Development session in February / March 2018. • Joint Committee of Clinical Commissioning Groups held on 18 October 2017 • South Yorkshire and Bassetlaw Sustainability and Transformation Partnership, Collaborative Partnership Board held on 13 October 2017 The Governing Body noted that the Lay Member for Governance was involved with developing the Terms of Reference and governance arrangements for the Collaborative Partnership Board.		
GENERAL			
GB 17/12/19	**HSJ Awards 2017 – CCG of the Year**		
	The Acting Chair was pleased to announce that the CCG had received 'highly commended' in the HSJ CCG of the year category. The award could not have been possible without the dedication and hard work of CCG staff past and present and this was an excellent achievement for Barnsley. Since Hull CCG received CCG of the year and other neighbouring NHS organisation also won awards, this was positive for the region as a whole.		

UNAPPROVED

Agenda Item		Action	Deadline
GB 17/12/20	**QUESTIONS FROM THE PUBLIC ON BARNSLEY CLINICAL COMMISSIONING GROUP BUSINESS**		
	• **BHNFT Governors** It was highlighted that BHNFT Governors would benefit from a briefing / information about accountable care. The BHNFT Governor suggested that a Patient Story around accountable care be delivered at the beginning of a Hospice Board meeting. **Response -** To consider how best the CCG could work with the BHNFT Governors briefing and providing information around accountable care**.** • **A&E - Palliative Care Professional** It was reported that palliative care professionals worked within A&E Departments and this had helped eased pressures in the Department. The BHNFT Governor queried if this could this be considered for the Barnsley A&E Department? **Response -** The Chief Nurse advised that work was being undertaken to prevent palliative care patients presenting in A&E including wrap around care, advanced planning and triggers to admissions. • **Schools - lifestyle advice** The CCG's approach / performance around provision of lifestyle advice to children in schools was questioned. **Response** –The Chief Nurse advised that as part of the Children & Young People trust the CCG supported the all schools approach to healthy lifestyles across Barnsley and actively worked with key stakeholders. In relation to emotional well-being The 'Future in Mind' national monies had enabled the development of the 'Mind Space' service accessed through secondary schools. A 'Thrive' programme had been established in primary schools and consideration was being given to the extension of 'mind space' into primary schools.	**KW**	**11.01.18**

UNADOPTED

Agenda Item		Action	Deadline
	The 'Chilypep' young commissioners had established oasis (Opening up awareness and support and influencing services) which had been shortlisted for a national award. • **Apprenticeships** In response to a question raised about apprenticeships the Practice Manager Member reported that the CCG and Primary Care had worked with colleges to recruit apprentices into primary care with placements across Practices. Some apprentices had gained employment and Practices having had one apprentice were happy to look at having other apprentices. Apprentices had a positive impact of the work of the Practice Teams.		
GB 17/12/21	**REFLECTION ON HOW WELL THE MEETING'S BUSINESS HAS BEEN CONDUCTED**		
	Members felt that this had been a constructive meeting.		
GB 17/12/22	**DATE AND TIME OF THE NEXT MEETING**		
	Thursday 11 January 2018 at 9.30 am in the Boardroom, Hillder House, 49-51 Gawber Road, Barnsley, S75 2PY.		

UNADOPTED

Barnsley Clinical Commissioning Group

Putting Barnsley People First

GOVERNING BODY

11 January 2018

MATTERS ARISING REPORT

1. The table below provides an update on actions arising from the previous meeting of the Governing Body (public session) held on 14 December 2017.

Table 1

Minute ref	Issue	Action	Outcome/Action
GB 17/12/04	**PATIENT AND PUBLIC INVOLVEMENT ACTIVITY REPORT** To acknowledge the contribution made by members of the public towards the CCG's positive results from an internal audit and NHSE assessment.	**KW**	In progress. To be completed by the end of January 2018.
GB 17/12/05	**QUESTIONS FROM THE PUBLIC ON BARNSLEY CLINICAL COMMISSIONING GROUP BUSINESS** **Dementia Champions -** All Governing Body Members to become Dementia Champions**.** **Weight Loss Services -** To raise the alternative for commissioning of weight loss services with the Director of Public Health, Barnsley Metropolitan Borough Council.	**ALL** **BR**	Verbal update to be provided at the meeting.

Minute ref	Issue	Action	Outcome/Action
GB 17/12/09	**ACCOUNTABLE CARE PROGRAMME UPDATE** • To consider and propose alternative names for Accountable Care in Barnsley at the Barnsley Accountable Care Partnership Board. • To explicitly define responses to the public about who the Accountable Care Shadow delivery Board was actually accountable to.	**JB** **JB**	This was not discussed at the December 2017 meeting due to time constraints. In progress via email correspondence. Verbal update to be provided at the meeting.
GB 17/12/10	**GET FIT FIRST** • To produce a joint letter from the CCG and BHNFT for patients already in the system to advise of the requirements of the Get Fit in Barnsley Programme. • To advise the BHNFT about the need to identify those patients awaiting surgery with a high BMI or who smoke and refer to the Get Fit in Barnsley Programme.	**MS (DL)** **RN (DL)**	Further work is ongoing to explore the best method to do this.
GB 17/12/15	**INTEGRATED PERFORMANCE REPORT** To provide a briefing to Practices about the national campaign regarding access to a GP during the Christmas period.	**KW**	Complete
GB 17/12/17	**BARNSLEY INTEGRATION AND BETTER CARE FUND 2017-2019** To share the total amount of the Better Care Fund Plan with the Lay Member for Accountable Care**.**	**JW**	Complete – Details e-mailed 29/12/2017

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 16/252	**MATTERS ARISING REPORT** **Patient Partner** – It was agreed that as the service was working well for some practices more than others that Mr Millington and the Practice Manager Member could undertake work to roll out best practice across Barnsley CCG.	**CM**	**December update** Contractors are still experiencing technical difficulties in unravelling outdated software. It is now anticipated the end date of all LIFT building updates will be March 2018. **November update** There has been some slippage in installation of new telephony system in Hillder House & LIFT buildings. Mr Millington and Mike Austin to re-present the system to non-users early in 2018. **October update** Progress continues to be slow. BHNFT. v. LIFT buildings now require new/additional software to enable systems to work effectively.
GB 17/04/12	**YORKSHIRE AND HUMBER FERTILITY POLICY 2017** Chief Nurse to update the Equality Impact Assessment	**BR**	A note has posted on the CCG's website to indicate that the Fertility Policy was under review. National work in relation to fertility was ongoing and it was important the CCG Policy was in line with nationally established guidelines
	Work with the Smoking Cessation Midwife to develop GP guidance on creating a patient information leaflet	**MG**	In progress. The issues around the inclusion of an exclusion of women who smoke as part of the Fertility Policy will be

			brought back to the Governing Body once national specialist advice received. Chief Nurse has spoken to the national team but no timescale yet forthcoming.
GB 17/08/09	**LOCAL MATERNITY SYSTEM UPDATE** To seek representation (via Membership Council) to sit on the LMS Board.	**NB**	See GB 17/10/08.
GB 17/08/16b	Member of the public to seek evidence of how other CCG's manage questions from the public at Board meetings in public and provide feedback to the CCG.	**NE**	In progress.
GB 17/09/17	**QUALITY HIGHLIGHTS REPORT** Chief Nurse to give consideration to one specialised service for Cervical Screening for people with Learning Disabilities.	**BR**	In progress.
GB 17/09/19b	The Governing Body Development Session plan to be shared with members.	**KM**	In progress – plan being updated.
GB 17/10/05	**QUESTIONS FROM THE PUBLIC ON BARNSLEY CCG BUSINESS** Lay Member for Patient and Public Engagement to meet with member of BSONHS regarding how the CCG knows whether it has captured the public view.	**CM**	In progress - at least four meeting dates offered to members of BSONHS; none taken up to date. Mr Millington to follow up.
GB 17/10/08	**SOUTH YORKSHIRE AND BASSETLAW – LOCAL MATERNITY SERVICES** Chief Nurse to invite expressions of interest from the wider GP audience for the GP representative position on this Board	**BR**	**In progress** See also 17/08/09 above. Communications inviting expressions of interested have been sent out. One expression of interest has been received and is currently being followed up.

GB 17/10/11	**RISK AND GOVERNANCE REPORT** Meetings with Public Health to be captured together with the action plan so that the risk rating for those risks relating to the 0-19 service can be considered.	**CM**	**In progress**. Meeting took place 5.10.2017 and a further follow up meeting with BMBC took place on 7.12.2017. Progress Plan received by CCG on from BMBC. Action plan was shared with Primary Care Development Workstream in December 2017 to consider impact on the CCG's risk register. The risk rating currently remains unchanged.
GB 17/10/13	**INTEGRATED PERFORMANCE REPORT** Figures for the Medicine Waste work to be tabled at the November 2017 meeting.	**RN**	**In progress** – information will be available December 2017/January 2018.
GB 17/10/16	**COMMITTEE REPORTS AND MINUTES** All Members to respond to Internal Audit re GBAF.	**ALL**	**Complete** Survey closed on 8.12.2017. 14 responses were received.

NHS
Barnsley Clinical Commissioning Group

Putting Barnsley People First

GOVERNING BODY

11 January 2018

REPORT OF THE CHIEF OFFICER

PART 1A – SUMMARY REPORT

1.	**THIS PAPER IS FOR**
	Decision [ ] *Approval* [ ] *Assurance* [ ] *Information* [X]
2.	**REPORT OF**

	Name	*Designation*
Executive Lead	Lesley Smith	Chief Officer
Author	Lesley Smith	Chief Officer

3.	**EXECUTIVE SUMMARY**
	This report provides an update on the following issues: • Disclosure UK : Call to Action • South Yorkshire Accountable Care System Update • Further Success in National Awards • Update on Commissioning Intentions 2018/19
4.	**THE GOVERNING BODY IS ASKED TO:**
	Note the report
5.	**APPENDICES**
	Appendix A - Disclosure UK Appendix B - ACS CEO Report

Agenda time allocation for report:	10 mins

PART 1B – SUPPORTING INFORMATION

1.	Links to the Governing Body Assurance Framework	Risk ref(s)
	This report provides assurance against the following risks on the Governing Body Assurance Framework:	1,2,4,5,6
2.	**Links to CCG's Corporate Objectives**	**Y/N**
	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 £.	√
3.	**Governance Arrangements Checklist**	
3.1	**Financial Implications**	
	Has a financial evaluation form been completed, signed off by the Finance Lead / CFO, and appended to this report?	*NA*
	Are any financial implications detailed in the report?	*NA*
3.2	**Consultation and Engagement**	
	Has Comms & Engagement Checklist been completed?	*NA*
	Is actual or proposed engagement activity set out in the report?	*NA*
3.3	**Equality and Diversity**	
	Has an Equality Impact Assessment been completed and appended to this report?	*NA*
3.4	**Information Governance**	
	Have potential IG issues been identified in discussion with the IG Lead and included in the report?	*NA*
	Has a Privacy Impact Assessment been completed where appropriate (see IG Lead for details)	*NA*
3.5	**Environmental Sustainability**	
	Are any significant (positive or negative) impacts on the environment discussed in the report?	*NA*
3.6	**Human Resources**	
	Are any significant HR implications identified through discussion with the HR Business Partner discussed in the report?	*NA*

PART 2 – DETAILED REPORT

1.	**DISCLOSURE UK: CALL TO ACTION**
	Governing Body members are asked to note the latest Call to Action, attached at Appendix A in relation to Disclosure UK. The guidance will be shared widely across the CCG.
2.	**SOUTH YORKSHIRE ACCOUNTABLE CARE SYSTEM UPDATE**
	The latest update in relation to progress with the development of an Accountable Care System across South Yorkshire and Bassetlaw is attached as Appendix B for Members' information.
3.	**FURTHER SUCCESS IN NATIONAL AWARDS**
	Further to our recent success in the HSJ wards the CCG has also been successful at the Health Business Awards, securing the CCG award for sustainable improvement and for commissioning of children's mental health services. In addition our Medicines Management Team are also to be congratulated on winning two further awards at the 2017 National Prescribing Safety Awards. • The Best Monitoring High Risk Medication award; and • The Effective Implementation Award
4.	**CONTRACTING ROUND 2018/19 and SOUTH YORKSHIRE AND BASSETLAW COMMISSIONING INTENTIONS**
	The CCG will not be undertaking a detailed contract negotiation process for 2018/19, recognising contracts are in place until 31 March 2019. However we will undertake a contract refresh to take account of our in year commissioning decisions and planned changes for 2018/19. On this basis contracting / commissioning intentions for 2018/19 were shared with our main providers on18 December 2017 and reflect previous Governing Body commissioning decisions, including: • commissioning changes from 2017/18 such as the introduction of new respiratory services and the new intermediate care service • Newly procured MSK services for 2018/19 • Implementation of the recommendations from the HASU Business Case as well as recognition of our local providers' commitment to sustainable stroke services, welcoming Barnsley Hospital Foundation Trust's approach to working jointly with South West Yorkshire Partnership Foundation Trust to deliver sustainable, integrated and value for money services • Development of a new specification and subsequent procurement of services to improve access to psychological therapies (IAPT) • Commitment to working with partners to develop integrated care across Barnsley. The Accountable Care Shadow Delivery Board (ACSDB) will provide leadership to the development of improvement priorities to ensure improved outcomes for the people of Barnsley. Priority areas for 2018/19 include:

	○ Frailty services ○ CVD The CCG is also undertaking further reviews of services delivered across the borough to ensure borough wide services and value for money is achieved, this supports the work of the ACSDB and may result in further in year changes within the contracts held.

GB/Pu/18/01/08.1

To

• NHS Trust Provider CEOs
• NHS Acute Trust Medical Directors
• CCG Accountable Officers and Clinical Leaders

CC: Royal Colleges, BMA and the GMC

NHS England
Skipton House
80 London Road
London
SE1 6LH
England.ConflictsOfInterest@nhs.net
www.england.nhs.net

Phone: 01138 250 733

22 December 2017

Dear Colleague

In June 2016 the Association of British Pharmaceutical Industry (ABPI) launched *Disclosure UK*, a searchable online database showing payments and benefits in kind made to NHS staff and organisations by the pharmaceutical industry for key collaborations including: speaking at and chairing meetings and symposia, training services, and participation in advisory board meetings.

All pharmaceutical companies abiding by the ABPI Code of Practice must disclose payments made each year to UK healthcare professionals through Disclosure UK. When doctors, nurses and pharmacists give consent, this data is then published on an individual, named basis. Where individual consent is not provided, an aggregate figure is disclosed.

2016 data shows that the pharmaceutical industry spent a total of £454.5m working with NHS health experts and organisations. The majority of this (£338.1m) was for research and development activity – primarily clinical trials. 65% of healthcare professionals gave their consent for this data to be published on an individual basis; which is only a 10% increase from 2015. The initiative only achieves its purpose when the data is fully comprehensive. It is for this reason that NHS England and the ABPI share a joint, public ambition to reach 100% coverage as rapidly as possible. 2017 is now the critical year to demonstrate that this voluntary approach works, but this depends on how close we come to the 100% goal.

Our call to action:

Disclosure UK provides a valuable opportunity for healthcare professionals to further demonstrate their integrity in the eyes of patients and the public, which is why we have included reference to it in the NHS England guidance on managing conflicts of interest. In line with this guidance, we want you to help us make sure that 100% of individuals collaborating with the pharmaceutical industry take this opportunity to give their consent to disclose payments or benefits in kind they have received by ensuring that this guidance is effectively embedded and communicated within your

institution.

In support of this, the following context may be useful:

The disclosure process

Disclosure data is published annually in June, one year in arrears. Data for 2017 collaborations will be public on *Disclosure UK* in June 2018. Responsibility for submitting data to the website lies with the pharmaceutical companies. All healthcare professionals need to do is agree when pharmaceutical companies ask for their consent to publication.

The information published on the *Disclosure UK* website includes:

- Healthcare professional's name
- Healthcare professional's principal practicing address
- The payment amount or equivalent benefit in kind in four categories: registration fees; travel and accommodation, fees for service/consultancy, related expenses for fees for service/consultancy
- Pharmaceutical company name

The ABPI only receives individual level data from companies where they have consent from healthcare professionals. This is the data which appears on the live database. Healthcare professionals are able to log on to a secure website to view the data that will be published before it goes live, and raise any questions about the data before it is made public (the annual publication timeline is provided in annex A).

In the event that the 2017 voluntary process does not give rise to a substantial reduction in the number of doctors withholding their consent, then the NHS will take action to introduce alternative measures to ensure full disclosure.

Public support for Disclosure UK

A number of organisations including NHS England, the Academy of Medical Royal Colleges, the General Medical Council and the National Institute for Health and Care Excellence have made public statements in support of *Disclosure UK*. Further details and links to public statements are provided in annex B.

Communication and engagement support

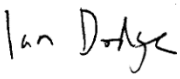
The ABPI has published an engagement and communications toolkit which many NHS trusts received via their communication teams this summer. The toolkit includes a suite of materials designed to explain what *Disclosure UK* is and how it works including an introductory PowerPoint presentation, leaflets and posters.

We would advocate that you make the most of these resources when engaging with colleagues about *Disclosure UK* and promote the disclosure website www.disclosureuk.org.uk to enable colleagues to search for information themselves.

The ABPI is very willing to present on *Disclosure UK* to any relevant Board and Committees where you would find this useful.

For more communication and engagement support from the ABPI email info@disclosureuk.org.uk.

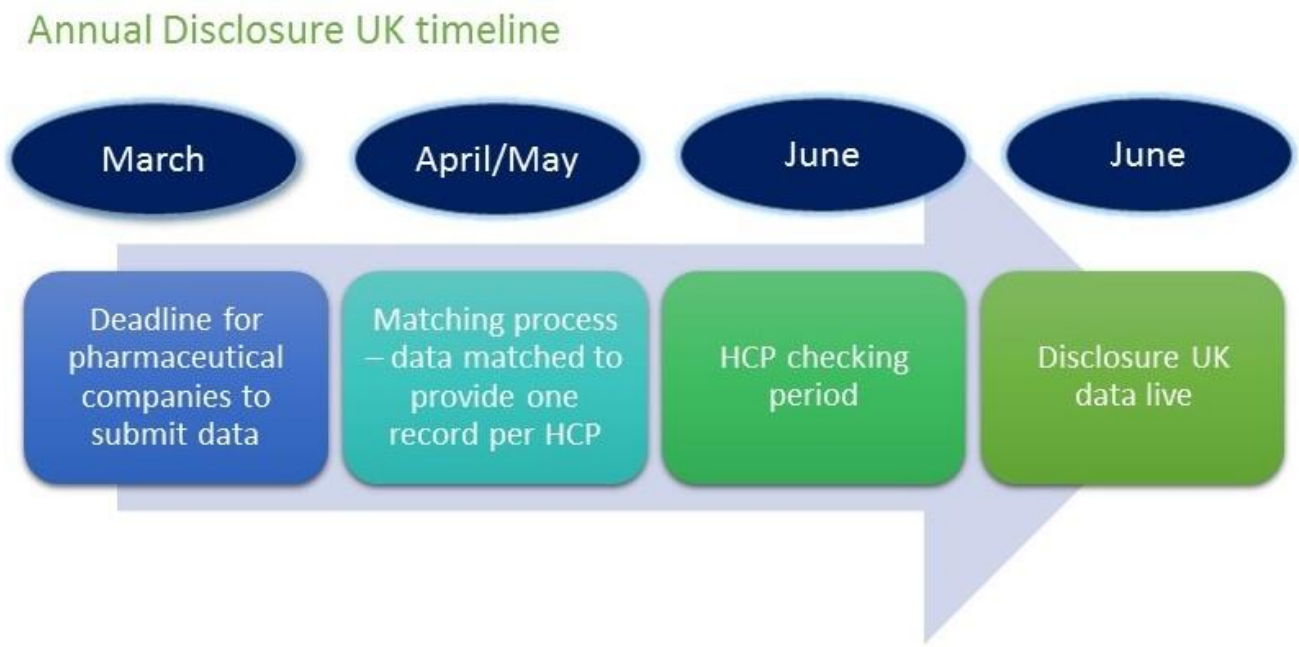
Yours faithfully



Ian Dodge, National Director, Strategy and Innovation, NHS England

Mike Thompson, Chief Executive, The Association of the British Pharmaceutical Industry

Annex A: Annual timeline for publication of Disclosure UK data:



Annex B: Public statements in support of Disclosure UK

- In June 2017, the NHS England guidance on managing conflicts of interest came into force, explicitly endorsing the *Disclosure UK* initiative:

  "…organisations should seek to ensure that staff who are subject to wider transparency initiatives such as the ABPI Disclosure UK scheme are aware of and comply with them…"

- The Academy of Medical Royal Colleges supports the NHS England guidelines on declaring conflicts of interest and released a statement in June 2017 relating to *Disclosure UK*, stating that:

  "Ultimately we would expect one hundred percent take up because patients should know the basis on which their doctor is making a recommended treatment."

- The GMC issued a joint statement from the Chief Executives of statutory regulators of health and care professionals around handling conflicts of interest in September 2017 which is explicitly supportive of the principle that healthcare professionals should be open about any conflict of interest they face and ensure that their professional judgement is not compromised by personal, financial or commercial interests, incentives, targets or similar measures.

- In addition, NICE is currently reviewing consultation responses to its draft conflicts of interest guidance in which it also proposes to endorse *Disclosure UK*:

  "We strongly encourage individuals to give their consent for payments they receive from the pharmaceutical industry to be disclosed as part of the ABPI Disclosure UK initiative…"

Paper B

GB/Pu/18/01/08.2

ACS CEO Report

SOUTH YORKSHIRE AND BASSETLAW
ACCOUNTABLE CARE SYSTEM
COLLABORATIVE PARTNERSHIP BOARD

8 December 2017

Author(s)	**Sir Andrew Cash, ACS Lead and Chief Executive, Sheffield Teaching Hospitals NHS Foundation Trust**
Sponsor	

Is your report for Approval / Consideration / Noting

For noting and discussion

Links to the STP (please tick)

- ☑ **Reduce inequalities**
- ☑ **Join up health and care**
- ☑ **Invest and grow primary and community care**
- ☑ **Treat the whole person, mental and physical**
- ☑ **Standardise acute hospital care**
- ☑ **Simplify urgent and emergency care**
- ☑ **Develop our workforce**
- ☑ **Use the best technology**
- ☑ **Create financial sustainability**
- ☑ **Work with patients and the public to do this**

Are there any resource implications (including Financial, Staffing etc)?

N/A

Summary of key issues

This monthly paper from the ACS CEO provides an:

- Update on the work of the ACS CEO over the last month
- Update on a number of key priorities not covered elsewhere on the agenda

Recommendations

The Collaborative Partnership Board is asked to note and discuss the update.

Accountable Care System CEO Report

SOUTH YORKSHIRE AND BASSETLAW
ACCOUNTABLE CARE SYSTEM

8 December 2017

1. Purpose

This monthly paper from the ACS CEO provides an:

- Update on the work of the ACS CEO over the last month
- Update on a number of key priorities not covered elsewhere on the agenda

2. Report - December 2017

2.1 Developing governance and resourcing to support the ACS strategic priorities

Chief Executive of the King's Fund, Chris Ham has been supporting the ACS to explore future governance arrangements and resourcing the priority areas of work. In addition to a discussion with the ACS senior management team in November, he also joined a workshop with the Audit Chairs from partner organisations and ACS Governance Group on 1 December. The workshop looked at:

- our collective ACS priorities for 2018/19 and leadership requirements
- the implications for staffing and resourcing priority areas of work
- the underpinning governance we will need to have in place for the ACS in 2018/19, the need for governance to support collective decision making and the implications of this for governance in member organisations.

The outputs of the workshop will inform the ongoing work of the governance group between now and March and feed in to the ACS strategy workshop planned for January. This final workshop with Chris Ham will be open to members of the Collaborative Partnership Board along with directors of commissioning and finance.

2.2 Budget announcement

In the Autumn budget statement, the Government 'exceptionally' (outside of the usual budget allocations) increased the Department of Health's budget with £2.8 billion additional resource funding over the next three years, with the Treasury committed to £3.5 billion of capital between 2017/18 and 2022/23 - largely to support STP transformation schemes.

For us this includes two schemes:

- Barnsley Hospital Children's Emergency Department and Assessment Unit scheme to support the rapid assessment and treatment of children, and;
- Doncaster Urgent and Emergency Care scheme to expand, redesign and improve emergency care

This is in addition to the previous announcement that £10 million has been set aside to support:

- The expansion of hyper-acute stroke services at Sheffield Teaching Hospitals
- The buying of a new CT scanner and capacity expansion at Doncaster and Bassetlaw Teaching Hospitals - again to improve stroke as well as cancer care

Showing a commitment to service transformation, these funds will help to support us as we develop as a system. Business cases for all schemes will now be developed and need to be approved before any of the transformation funding is released.

2.3 Sharing good practice in the ACS

A number of NHS partners came together under the Accountable Care System (ACS) banner on 16 November to share learning and best practice for the benefit of patients throughout South Yorkshire and Bassetlaw.

The event 'AHPs in South Yorkshire and Bassetlaw Working Together' was held at Doncaster Royal Infirmary, featuring speakers from all acute and mental health trusts and commissioners in the area, as well as delegates from NHS Improvement, NHS England and Sheffield Hallam University.

Throughout the day, attending AHPs were given the opportunity to hear about wider STP plans within the area, related commissioning intentions as well as the national themes and developments within the wider NHS.

National Lead for AHPs, Suzanne Rastrick, who attended the conference, also joined ACS Medical Director Dr Des Breen and health and university colleagues for an informal discussion looking at what is already happening in the region and what future educational opportunities might look like.

Dr Des Breen also shared the learning from the ACS this month, presenting on clinical engagement on a national webinar for the British Medical Association.

2.4 Staff Partnership Forum

Representatives from the region's unions met with the ACS team in late October for an update on the ACS and to formalise working arrangements for the future.

As well as agreeing terms of reference and a commitment to regular updates and opportunities for involvement in workstreams, the hospital services work was particularly highlighted.

Representatives were keen to have conversations in their organisations so that they could input into developments and also raised how local 'place' conversations could play an important role. Key messages from the discussion have been shared with communications leads across the ACS and also with staff side representatives for wide circulation.

2.5 HSJ Awards

Congratulations to colleagues who were shortlisted and recognised in this year's HSJ Awards which celebrate and promote the successes, achievements and best practice across the NHS. Many congratulations to:

- Sheffield Teaching Hospitals NHS Foundation Trust for winning the HSJ Award for Improving Environmental and Social Sustainability

- NHS Barnsley Clinical Commissioning Group which was highly commended in the Clinical Commissioning Group of the Year category - narrowly missing out on the top spot which went to our Yorkshire and Humber neighbours at Hull CCG
- NHS Rotherham Clinical Commissioning Group which was highly commended in the Supported Self Care category for their great work on social prescribing.

3. Recommendations

The Collaborative Partnership Board is asked to note and discuss the update.

Date 5 December 2017

NHS
Barnsley Clinical Commissioning Group
Putting Barnsley People First

GOVERNING BODY

11 January 2018

COMMISSIONING OF CHILDREN'S HEALTH SERVICES QUARTERLY UPDATE

1.	**THIS PAPER IS FOR**						
	Decision		*Approval*		*Assurance*		*Information*	*x*
2.	**REPORT OF**						

	Name	*Designation*
Executive Lead	Brigid Reid	Chief Nurse
Author	Patrick Otway	Head of Commissioning (Mental Health, Children's and Maternity and Specialised Services)

3.	**EXECUTIVE SUMMARY**
	This report aims to update the Governing Body on the work that has been undertaken since the October 2017 update in relation to the commissioning of Children's Health Services in Barnsley. Key issues in relation to the commissioning of Children's Health Services in Barnsley are highlighted and are focused upon the continued implementation of the Future in Mind Barnsley Local Transformation Plan re Emotional Well Being, CAMHS performance and children's ASD services. Additional information is provided in relation to Child Sexual Exploitation (CSE) and Special Educational Needs and Disability (SEND) work.
4.	**THE GOVERNING BODY IS ASKED TO:**
	• Note the progress made and the risks highlighted
5.	**APPENDICES**
	• **Appendix 1**: CETR Policy (Draft) – for comment • **Appendix 2:** Oasis 'Our Voice Matters, Innit' Manifesto

Agenda time allocation for report:	10 minutes

SUPPORTING INFORMATION

1.	Links to the Governing Body Assurance Framework	Risk ref(s)
	This report provides assurance against the following risks on the Governing Body Assurance Framework:	1.1, 1.4, 1.5, 4.1, 5.1
2.	**Links to CCG's Corporate Objectives**	**Y/N**
	To have the highest quality of governance and processes to support its business	Y
	To commission high quality health care that meets the needs of individuals and groups	Y
	Wherever it makes safe clinical sense to bring care closer to home	Y
	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	Y
	To develop services through real partnerships with mutual accountability and strong governance that improve health and health care and effectively use the Barnsley £.	Y
3.	**Governance Arrangements Checklist**	
3.1	**Financial Implications**	
	Has a financial evaluation form been completed, signed off by the Finance Lead / CFO, and appended to this report?	*N*
	Are any financial implications detailed in the report?	*NA*
3.2	**Consultation and Engagement**	
	Has Comms & Engagement Checklist been completed?	*N*
	Is actual or proposed engagement activity set out in the report?	*NA*
3.3	**Equality and Diversity**	
	Has an Equality Impact Assessment been completed and appended to this report?	*NA*
3.4	**Information Governance**	
	Have potential IG issues been identified in discussion with the IG Lead and included in the report?	*NA*
	Has a Privacy Impact Assessment been completed where appropriate (see IG Lead for details)	*NA*
3.5	**Environmental Sustainability**	
	Are any significant (positive or negative) impacts on the environment discussed in the report?	*NA*
3.6	**Human Resources**	
	Are any significant HR implications identified through discussion with the HR Business Partner discussed in the report?	*NA*

1.	**INTRODUCTION**
	Subsequent to the arrangements described in previous papers to the Governing Body the following updates are provided: • CAMHS performance • Children's ASD services • Children and Young Peoples work stream of the Transforming Care Plan (TCP) • Education, Health & Care Plans (EHCP) • Child Sexual Exploitation (CSE)
2.	**ISSUES**
2.1	**CAMHS** For the 12 month rolling period November 2016 – October 2017 CAMHS received 1,506 referrals, 30% of which (443) were deemed as requiring further information or signposting elsewhere. The average wait to first assessment (CHOICE) continues to remain under 3 weeks (currently 2 weeks) but there are still long waits being experienced, particularly on the Complex Behaviour and ASD pathways. The overall average wait in October 2017 was 252 days, although the Eating Disorder service and Early Intervention Psychosis services are consistently achieving the nationally recommended access and waiting time standards. There is still no nationally recommended access and waiting time standards for any other mental health services, although Barnsley CAMHS are working towards a target of 126 days (equivalent to the acute, physical healthcare standard i.e. 18 weeks referral to treatment). Further work is being undertaken with the service regarding the care of the Complex Behaviour cohort of patients who de facto have enduring episodes of care to effectively review ongoing patients whilst creating capacity for new ones.
2.2	**Future in Mind** The schools-led emotional health and wellbeing support service was relaunched in October 2017 as MindSpace and the manager of MindSpace promoted the service at the November BEST event. The MindSpace young people friendly website is nearing completion and its launch date is imminent. A publication of the Department of Health and Department of Education entitled 'Transforming Children and Young People's Mental Health Provision: a Green Paper' was published in December 2017 and is out for consultation until 2nd March 2018. The recommendations contained within the Green Paper very closely reflect the work that is progressing in Barnsley as part of implementing Future in Mind. (You can read the full green paper here: https://www.gov.uk/government/consultations/transforming-children-and-young-peoples-mental-health-provision-a-green-paper and respond to the consultation here https://engage.dh.gov.uk/youngmentalhealth/).

	CHILYPEP (Children and Young People's Empowerment Project) continue to facilitate the Barnsley Oasis (Opening up Awareness and Support and Influencing Services) young people's participation group and have been nominated for a national award in relation to the development and support of the Young Commissioners in Barnsley and Sheffield. The Future in Mind Local Transformation Plan (LTP) has now been refreshed and the refreshed plan can be found at the following link: http://www.barnsleyccg.nhs.uk/CCG%20Downloads/strategies%20policies%20and%20plans/2017/Future%20in%20Mind%20Barnsley%20Transformation%20Plan%202015-2020%20Refresh%20-%20October%202017.pdf The fourth Future in Mind Stakeholder event held on 18th October 2017 focused on the hard work of the OASIS group (contained within the refreshed LTP) and the significant, positive impact that adopting the THRIVE approach in almost 40% of Barnsley's primary schools is having on the lives of children and their families within the Borough. The fifth Future in Mind Stakeholder event is to be held in April 2018.
2.3	**Children's ASD services** As reported previously the ASD Strategy Steering Group has now been re-established and partners are working closely together to reduce both the length of time waiting for the diagnosis process to begin and to improve the post-diagnosis support offered. ASD service providers are reviewing the ASD pathways to identify if current resources could be utilised more efficiently and a small resource (approximately £33,000) is to be transferred from SWYPFT to BHNFT (who deliver the over 5's ASD pathway) to reduce the waiting times from the current 24 months. Partners will continue to work together to further reduce the average waiting times on both ASD pathways.
2.4	**Transforming Care Plan** Barnsley form part of the 'CKWB TCP' footprint (Calderdale, Kirklees, Wakefield and Barnsley Transforming Care Plan) which is aimed at improving the quality of lives for those children and young people who have either a Learning Disability or Autism Spectrum Disorder or both. As part of the TCP a children and young people's work stream has been established to deliver the key elements of NHS England's requirements. Within the CKWB footprint there are three key milestones that partners are currently working together to develop: I. The development of an 'at risk of admission register' II. The development of a CETR (Care, Education and Treatment Review) policy (*see appendices*) III. The establishment of parent / carer forums to influence decision-making
2.5	**Child Sexual Exploitation (CSE)** The CSE sub group of the Safeguarding Children Board recently undertook an audit to determine if CSE is being identified and managed appropriately.

	Reassuringly the audit illustrated good partnership working, sharing of relevant intelligence and appropriate completion or risk assessments. A formal strategy and action plan remains under development for Operation Make Safe (improving awareness amongst the hospitality industry, late night refreshment venues and taxi drivers).
2.6	**Care of Children with Complex Health Care Needs** There are new changes to the team for the Special Educational Needs and Disability Review Team. Susan Day, Team Manager, has now left the service and a new team arrangement is being put in place. Susan's expert knowledge and support was central to the hard work by the team to get to the position the team are now in with regards to conversions. All conversions from statements to Education, Health and Care (EHC) plans continue to be in line for completion by March 2018. The joint OFSTED and CQC inspection is expected imminently and we continue to prepare for it jointly across agencies. A Self Evaluation Form (SEF) has been completed across Health, Social Care and Education. This self-assessment process has allowed us to identify our weaknesses and gaps, as well as our strengths as a complete organisation and work is ongoing in this area. If a parent / carer or child / young person disagree with a decision around an EHCP there is a very clearly defined process in place which allows them to appeal. This process is an education process and is mainly focused on the education provision and not health and social care. This is due to change in the New Year when "The single route of redress national trial will expand the powers of the First-tier Tribunal SEND" to enable it to make non-binding recommendations on the health and social care aspects of Education, Health and Care (EHC) plans alongside the educational aspects. This is intended to reinforce the person centred nature of the Children's and Families Act 2014 by enabling the Tribunal to take a more holistic view of the child or young person's needs. This will naturally raise new challenges for health services and is being looked at and need to be fully aware of the expectations of health services. The DCO will be attending an information / training day on this in January.
3.	**RISKS TO THE CLINICAL COMMISSIONING GROUP**
	Risk to realising benefits, or reducing risk, in relation to waiting times to access treatment from CAMHS due to any delay in implementing the priorities within the local transformation plan and local delivery of nationally funded remediation of time to treatment action plan.
4.	**CONCLUSION**
	The CCG continues to pursue improved outcomes for vulnerable children and young people and is ensuring that all associated supporting work is progressed to deliver sustainable services to achieve this.

NHS Greater Huddersfield Clinical Commissioning Group
NHS Wakefield Clinical Commissioning Group
NHS North Kirklees Clinical Commissioning Group
NHS Barnsley Clinical Commissioning Group
NHS Calderdale Clinical Commissioning Group

Transforming Care Partnership
For people with learning disabilities and/or autism in Calderdale, Kirklees, Wakefield and Barnsley

BARNSLEY Metropolitan Borough Council
Kirklees COUNCIL
wakefield
Calderdale Council

GB/Pu/18/01/10.1

Calderdale, Kirklees, Wakefield and Barnsley (CKWB) Local Area Care and Treatment Review Policy

Contents

1. Introduction and Purpose
- 1.1 Context
- 1.2 National Policy
- 1.3 Local Approved Mental Health Professional Policy for people with Learning Disabilities and/or Autism or both
- 1.4 Service Model locally to Barnsley
- 1.5 PERSONAL
- 1.6 Standards in Practice

2. Proactive Monitoring and Support - Risk Registers
- 2.1 Learning Disability Risk Register
- 2.2 Autism Risk Register
- 2.3 Children's Risk Register

3. When to hold a Care and Treatment Review
- 3.1 When not to hold a Care and Treatment Review
- 3.2 When to make a referral for a Care and Treatment Review to the TCP hub
- 3.3 Types of Care and Treatment Reviews
- 3.4 Complaints and Redress

4. Alternatives to Admission – Suggested Interventions

5. Admission to Hospital:
- 5.1 Mental Health Act Assessment and working with the Approved Mental Health Professional (AMHP)
- 5.2 Selecting and funding the hospital bed
- 5.3 Post-admission follow up and working with the hospital treating team
- 5.4 Discharge planning

6. Roles and Responsibilities of all Stakeholders and working arrangements

6.1 Clinical Commissioning Group Commissioner
6.2 Experts by Experience
6.3 Clinical Experts
6.4 Approved Mental Health Professionals
6.5 Intensive Support Team or Intensive Home Based Treatment Team
6.6 Local Authority social workers and managers
6.7 Police Multi-Agency Hub in Central Police Station
6.8 Court Diversion and Liaison
6.9 Case Managers in Relevant Clinical Commissioning Group (CCG)
6.10 Specialised Commissioning Team Case Managers
6.11 Providers – community or hospital
6.12 Courts
6.13 Tribunals
6.14 Section 117 Panel
6.15 New General Data Protection Regulation (GDPR)

7. Care and Treatment Review Follow up of Action Plans and Reporting:

7.1 Lead Professional coordination of implementation of the action plan
7.2 Reporting to Responsible CCG commissioner
7.3 Tracking CTRs and planning next one

8. Appendices

8.1 CTR flow chart of increasing risk
8.2 South West Yorkshire Partnership NHS Foundation Trust Risk Register Protocol
8.3 Local Emergency Area Protocol
8.4 Working with the Ministry of Justice

1. Introduction and Purpose

1.1 Context

Care and Treatment Reviews (CTRs) were brought in to address the complex challenges of discharging people with learning disabilities and/or autism from long stays in hospital, after the national issue was highlighted by the Winterbourne View scandal in the Serious Case Review of 2012. CTRs became core business in October 2015 with the publication of Homes Not Hospital Report (ref), Building the Right Support National Service Model (ref) and the Care and Treatment Review National Policy 2017 (ref). The Transforming Care Project was launched to change the way community services were designed, commissioned, and delivered to facilitate more effective appropriate support outside of hospital settings. This is linked to a significant bed closure programme across England, which is expected to be achieved by March 2019. It is expected that Care and Treatment Reviews will continue to be a tool available to professionals beyond 2019.

Transforming Care for Children and Young People

An area wide Transforming Care Plan partnership involving Kirklees, Calderdale, Wakefield and Barnsley has recently established a Children and Young people's workstream. This work stream will look to implement recommendations from the Lenahan review, 'Building the right support' and NHS England Guidance 'Developing support and services for children and young people with a learning disability, autism or both'.

The nine principles outlined in the NHS England guidance will be embedded across the partnership led by the Children and Young People work stream. The work stream comprises of CAMHS transformation plan commissioning leads and representation from local authorities including Special Educational Needs and Disability (SEND) leads across the region.

The children and young people Transforming Care Programme will dovetail and complement local CAMHS transformation plan priorities and reporting arrangements and augment existing joint Children and Families Act arrangements for each area.

Therefore, it has been decided not to produce a standalone Transforming Care Strategy or Plan, but to integrate required actions into existing plans. Each local area has undertaken a self-assessment against Transforming Care Plan priorities and principles. Identified gaps form the basis of local action plans and milestone reporting requirements. NHS England is overseeing implementation of the Transforming Care Plan and regular highlight reporting takes place against agreed work stream actions. See Appendix F.

We have made good progress in terms of needs assessment, planning and projection for groups of children and young people affected and also in implementing the Care, Education and Treatment Reviews process and reviews across the footprint for children and young people.

Recent feedback from NHS England has highlighted the following positive aspects in relation to our local Transforming Care Plan for children and young people:

1. We have an identified Children and Young People's Lead for Transforming Care and a comprehensive, multi-agency work stream to focus on the Children's agenda across the footprint.
2. Kirklees have lower numbers of under 18s in-patient admissions than the national average.
3. Discharges of children and young people are timely.

Also highlighted were areas of future focus:

a) Develop the 'Dynamic Support Register' and 'At Risk of Admission to Hospital Register' for children and young people.
b) The views of young people, parents and carers within the local area should be represented at the Transforming Care Plan Partnership Board.

These areas are incorporated into this refresh and will be monitored through the work stream and quarterly reporting to NHS England.

1.2 National Policy

This local policy needs to be read in conjunction with the new National Policy and the CTR code and tool kit – guide for commissioner's published March 2017.
https://www.england.nhs.uk/wp-content/uploads/2017/03/ctr-code-toolkit.pdf

The National Policy was refreshed in March 2017 and clarified the requirements for completion of Care Education and Treatment Reviews (CETRs) for children in Child and Adolescent Mental Health Services (CAMHS) hospitals or at risk of hospital admission. It clarified the inclusion of people with Autism in the Policy and a clear link to Care Programme Approach (CPA). It added best practice guidance for CTRs for other groups of people like prisoners, and outlined new standards of practice. It also brought in a new Key Lines of Enquiry (KLOE) approach to make the reporting similar to the Care Quality Commission (CQC). There are more resources to support experts by experience (see Section 6.2) and person specifications and recruitment guidelines for experts.

The eight principles and standards for CTRs and CETRs are the same. CTRs relate to those aged 18 and over, whereas CETRs apply to those up to 18 years of age and includes education to better reflect the essential role that education plays in the lives of children and young people.

The words 'people' or 'person' used in this policy refers to children, young people and adults.

Whilst the standards are similar to those for adults, there are some specific additions in relation to children and young people, to assist those planning, supporting, and undertaking CETRs and will normally involve more people in the process that an adult CTR. For example local agencies such as education, CAMHS, health and social care and anyone else involved who can contribute ot the CETR.

Parent carers have a central role in the process as they will usually be making decisions for children under the age of 16. The child should also be involved if the parent is happy for them to take part. If a young person (age 16/17) is unable to consent, the best interest's process need to be followed.

An easy read version of the Care and Treatment Review: Policy and Guidance can be accessed via this link:

1.3 PERSONAL

The guidance identified that the CTR process should be:

Person Centred and family centred
Evidence-based
Rights led
Seeing the whole person
Open, independent and challenging
Nothing about us, without us
Action focussed
Living life in the community

These 8 key principles form the basis of this policy and guide the approach that needs to be taken by chairs, experts and participants in the CTRs locally. For a summary on what these principles mean see section 1 of the Care and Treatment Review Code and Tool Kit 2017.
https://www.england.nhs.uk/learning-disabilities/ctr/commissioners

1.4 Standards in Practice

The new standards in practice are defined in the CTR Code and Tool Kit 2017, the document published at the same time as the CTR Policy 2017. The standards set criteria and operational practice standards under the headings of the PERSONAL principles.

These give direction on a range of areas, such as:

- Preparing the CTR
- Consent and involving the person and family
- Evidence gathering and checking against clinical guidance
- Upholding Human Rights
- All types of legal advocacy

- Timing, invitees, multi-agency roles
- Administration, recording, feeding back and following up
- Link to Care Programme Approach (CPA) and care coordination
- The panel roles

The challenges requiring consideration relating to the hospital stay are required to cover:

- raising concerns and delays
- action planning
- candour
- gap analysis
- risk management
- community service design
- environments
- discharge planning.

All professionals participating in CTRs locally should reference the standards in practice that apply to their role.

1.5 Local Approved Mental Health Professional (AMHP) Policy for people with Learning Disabilities and/or Autism

Care and Treatment Review policy, guidance and the Transforming Care Project significantly affect the Approved Mental Health Practitioner (AMHP) role, and psychiatric practice.

Due to the emphasis on multi-agency approaches to prevent admission to hospital, the Care and Treatment Review policy needs to embed AMHP operational policy within it and give guidance to AMHPs on how to include this good practice into considerations when a Mental Health Act assessment referral has been made. This will be discussed later in the policy.

1.6 Service Models – Local Delivery

The shared service model to support the Care and Treatment Review process and Transforming Care are in place and developing.

The Care and Treatment Reviews are commissioner lead. Several commissioners are involved in chairing reviews – learning disability, mental health and CAMHS commissioners.

These are convened at a Transforming Care Partnership level via the Programme Hub in Huddersfield. This is the point of contact for referrals for CTRs.

Section 117 Panel

Section 117 of the Mental Health Act, is often referred to as 'section 117 aftercare'. The law gives those people who have been kept in hospital under the Mental Health Act to right to get free help and support after they leave hospital.

At a multi-agency senior management level, a Section117 Panel considers the complex individuals coming out of hospital to agree NHS/ LA responsibilities and take accountability for ratifying the discharge community service specifications (care plan) and funding applications.

The following identifies any local differences in the four areas covered under this policy:

1.6.1 Barnsley

Recently a multi-agency hub has been set up in the police station with links to the Court Liaison and Diversion service in the custody suite. This enables closer multi-agency links to be made, on order to be able to work proactively with people presenting in police custody or courts to divert them from the Criminal Justice system and possible long-term hospital stays.

1.6.2 Wakefield

Add any specific local detail as required.

1.6.3 Kirklees

Add any specific local detail as required.

1.6.4 Calderdale

Add any specific local detail as required.

2 Proactive Monitoring and Support - Risk Registers

2.1 Wider Service Model

The Care and Treatment Review process sits within a wider service context, where community services are moving to a Citizenship model of support. The new CTR Policy indicates that services should be aware of working proactively with people with learning disabilities, autism or both in the community who may be at risk of inpatient admission and losing their place in the community. A stronger commissioning approach will be taken locally to understanding this population in order to generate responsive commissioning of community services to create a whole system approach of preventing admissions, following a dynamic risk stratification processes. The National CTR Policy 2017 specifically directs that a register of those people at risk of admission will be developed locally and highlights indicators for risk of admission from the evidence base and the information that needs to contained in referrals and on the register.

2.2 Learning Disability Risk Register

Locally the learning disability risk of admission register has been delegated by the TCP to South West Yorkshire Partnership NHS Foundation Trust (SWYPFT) Learning Disability Service. Referrals for the register are sent through the established referral processes. (Appendix 2 Risk Register Flowchart).

2.3 Autism Risk Register

A separate register is required for people with Autism who do not have a learning disability. Due to absence of a commissioned service pathway in the South West Yorkshire Partnership NHS Foundation Trust (SWYPFT), this register currently will be held in the Joint Commissioning Team, Barnsley Metropolitan Borough Council, but follows the same operational process and format.

2.4 Children's Risk Register

This register is under development in response to the new CETR guidance. This Policy will be updated when this register is available.

3 When to hold a Care and Treatment Review, and when not to.

3.1 When to hold a Care and Treatment Review:

A CTR should take place in addition to the above processes, to add value to complex case management, where usual working practices have failed to achieve discharge, or admission to a psychiatric hospital seems likely.

CTRs are not intended to replace existing good practice and established working processes, such as Care Programme Approach (CPA) meetings, multi-disciplinary meetings, multi-agency conferencing (Multi-Agency Public Protection Arrangements (MAPPA), Multi-Agency Risk Assessment Conference (MARAC), Safeguarding, Vulnerable Adult Risk Management (VARM) and day to day close collaborative working and risk management. These working approaches are routed in effective multi-agency working, risk assessment and risk management.

3.2 When not to hold a Care and Treatment Review:

Specifically, a CTR is not required when a person with learning disability or autism or both is:

- Admitted to general acute hospital, unless detained there under the Mental Health Act
- Admitted to acute psychiatric hospital as part of a crisis plan
- Where discharge planning is taking place and progressing.

- When a person is stepping down to lower level of hospital security or transferring to a more appropriate hospital.
- When a person is sentenced via the criminal justice system under part 3 of the Mental Health Act an access assessment is the gateway to secure hospital beds, and should consider all options. A CTR should then take place post-admission. However, there may be individual cases in regard to children and young people where this is not the case.
- When the situation is very urgent, and a Mental Health Act assessment is required urgently to reduce immediate risk. (see Local area emergency protocol Appendix 3)

3.3 Types of Care and Treatment Reviews:

3.3.1 Pre-admission, Readmission or Community CTRs and When to Request

Pre-admission CTRs must be held with community professionals if the people involved believe hospital admission is likely. The aim is to examine whether admission needs to happen or whether alternative solutions can be put in place. To be effective a full CTR needs convening with a panel, to add value to other multi-agency work already completed in the case. Therefore, professionals involved need to be making careful judgements based on risk about the timing of referring for a CTR so that it is possible to convene before the person deteriorates to a stage where they require a Mental Health Act assessment.

If it is not possible to convene a full CTR due to time limits, an emergency meeting following the Emergency Protocol (Appendix 2) must be held in person or by telephone to ensure all possible alternatives to admission are considered. This needs to be conducted in full collaboration with the Approved Mental Health Professional (AMHP), and if the risk assessment indicates that it is safe to delay a Mental Health Act assessment in order to be able meet or speak. If this route is followed, a post-admission CTR must be convened within 4 weeks for adults, and 2 weeks for a child in order to give clarity over the treatment plan and anticipated discharge at the outset.

A referral should be made by through the lead professional in the case who understands the increasing risks or unmet need, and can identify which areas of escalating risks are likely to lead to admission. It is critical at this stage that the responsible commissioner takes a decision over whether the situation can be resolved using existing resources, or whether a community CTR is necessary to facilitate a more effective and inclusive discussion of the issues and potentially identify a range of possible alternatives to meet the needs of the person.

3.3.2 Post-admission CTRs

This is required to review the circumstances of admission and establish if admission was the most appropriate course of action, looking at alternatives to hospital treatment or to establish expected outcomes, timescales, and ensure planning for discharge is underway.

Post-admission CTRs should be convened 4 or 2 weeks post-admission via the Criminal Justice system by the Responsible Commissioner if the bed has been funded by the relevant Clinical Commissioning Group. Alternatively the Responsible CCG commissioner should attend post-admission CTRs for people admitted to secure hospitals via the court or prison to ensure they are treated at the most appropriate and least restrictive level of hospital security.

3.3.3 In-patient CTRs

These will occur every 6 months for adults in local CCG funded beds, every 3 months for children in Child and Adolescent Mental Health Services (CAMHS) beds and 12 months for adults in secure beds, whilst the person remains an in-patient.

The CTR should focus on the reasons for an extended stay, identifying barriers to progressing to discharge, and whether the most appropriate treatment is being provided. A collaborative, and solution focussed approach needs to be taken to overcoming barriers, action planning, agreeing responsibilities, timelines and monitoring.

It is essential the appropriate responsible commissioner and local authority representative attend CAMHS and secure hospital CTRs convened by Yorkshire and Humber Specialist Commissioning in order to inform proactive pathway and discharge planning, and present alternatives to extending the hospital stay.

For working with patients who are subject to Ministry of Justice restriction orders, see Appendix 4 ‘Working with the Ministry of Justice’.

If a CTR is required before the regular planned 6 monthly CTR, lead professionals in the case from the hospital team or community team involved can make a referral through the above route. The responsible commissioner needs to take a decision whether the situation is urgent and if it requires an unplanned CTR to be convened, or whether the situation can be managed via other processes and wait until the date of the next planned CTR.

3.4 When to make a referral for a Care and Treatment Review to the Transforming Care Partnership Team

The Calderdale, Kirklees, Wakefield and Barnsley Transforming Care Partnership have a programme team in Greater Huddersfield CCG. All referrals for community based or in-patient CTRs needs to be made to the business coordinator within this team – judith.hall6@nhs.net

Any stakeholder can make a request for a CTR, at any point.

3.5 Complaints or Redress process somewhere in this policy?

CTRs are required to ensure that the person (and their parent carers) remain at the heart of any review.

Hopefully this will usually result in mutual agreement about the most appropriate course of action.

However this may not be the outcome where:

- The person is detained under the Mental Health Act
- Disagreement exists about the efficacy and robustness of the CTR process
- And/or where the agreed actions arising are not implemented fully and /or appropriately

Any complaint needs to be either directed through the Responsible Commissioner, or in the case of the Mental Health Act through that tribunal process.

4 Alternatives to Admission – Suggested Interventions:

Below is a list of interventions that have been used singularly or in multiple combinations successfully in the Barnsley area with people to avoid hospital admission:

- Increasing the intensity of support in the current accommodation
- Increasing the intensity and type of multi-disciplinary support
- Increasing the intensity of support and interventions for the family / carer
- Increasing the intensity of multi-agency working and collaboration
- Increasing the skills of the provider through training and supervision
- Identifying and assessing sensory needs
- Reviewing the appropriateness of services, including housing.
- Reviewing medication and accuracy of diagnosis
- Reviewing the support style
- Adding restrictions in the community through legal frameworks
- Remove interventions or medication that may be causing harm
- Identify new needs and gaps in need or provision previously missed
- Research case history to improve assessment of risks and needs
- Listening and acting upon the wishes and feelings of the person and family
- Undertaking an ecological assessment to identify any environmental impacts upon current presentation

5 Roles and Responsibilities of all Stakeholders and working arrangements

All roles and responsibilities are outlined in more detail the 'Care and Treatment Review Code and Toolkit 2017 – a guide for commissioners, panel members and providers'.
https://www.england.nhs.uk/learning-disabilities/ctr/commissioners

All stakeholders engaging with the CTR process should make themselves aware of the guidance on their role in toolkit. There are full role descriptors for panel experts, commissioner checklist for setting up and running CTRs, plus a list of key evidence required at a CTR, sample agenda and provider checklist.

All professionals should demonstrate candour when discussing the person's care and treatment.

5.1 Clinical Commissioning Group Responsible Commissioner

The role of the Responsible Commissioner is to decide if a CTR should be held following a request/referral, by establishing if the situation can be resolved using existing resource. If a CTR is to go ahead, the commissioner convenes the CTR with an expert panel via the Transforming Care Partnership hub as soon as possible, including all lead professionals from agencies involved now and, if known, to be in the future.

At the beginning of the process the responsible commissioner shares a pen picture including communication needs of the person and ensures any necessary Capacity Assessment and Best Interests Decision for the CTR is undertaken, and checks that the panel and all the people involved with the CTR, including the person the CTR has been set up to discuss, are suitably prepared for the CTR, before commencing.

The responsible commissioner must ensure the person is safe and all safeguarding requirements to protect vulnerable and at risk people are in place, taking necessary action if there are any concerns. They must ensure that the CTR findings are based on evidence gathered and assurance provided. Recording of the CTR must be in accordance with the national policy guidance 2017, and must include the views of all panel members, with clearly named individuals linked to the action plan. The plan must be uploaded onto the relevant health and social care databases and distributed to all stakeholders, with systems in place to follow up the identified actions, with the relevant detail contained to be able to appropriately report outcomes to NHS England via the relevant trackers.

5.2 Experts by Experience (EbyE)

The EbyE will have lived experience of being either directly involved in the care and support of an individual with Learning Disability, Autism or both Or they will be a person with a Learning Disability, Autism or both.

Their role is to ensure that the CETR process:

- Keeps the needs of the person at the centre.
- Is co-produced with the family and person at every stage.
- The family are aware and understand what is being said and what is happening.

Barnsley Joint Commissioning Team have a service level agreement with Inclusion North to supply Experts by Experience (EbE) who are CTR trained. EbE are allocated in response to a referral form completed by the Responsible Commissioner who requests the skills needed, and any EbE previously involved in the case. If CTRs are outside of the Yorkshire and Humber area, Inclusion North can also seek EbE in the Midlands and East region and North West region through links with other Experts By Experience charities and reimbursing them via our SLA.

5.3 Clinical Experts

A Clinical Expert is someone qualified to work in health care. This might be a nurse, psychologist or psychiatrist. The Clinical Expert should be able to bring a strong critique of the current care, treatment and pathway plans, identify gaps, inappropriate interventions and promote use of best practice from NICE guidelines for people with learning disabilities and autism. When care is not in line with the evidence base, recommendation actions should be recommended to change this. Where the person's care and treatment has been detrimental and discharge has been delayed as a result, a Safeguarding referral should be considered and/or raising concerns to the Care Quality Commission

The current arrangements for Clinical Experts are to use reciprocal arrangements from other nearby CCGs or NHS England staff that is at no cost. Under current funding arrangements there is no allocated budget for this work. Therefore sometimes this means that no expert can be found.

In exceptional circumstances, funding for a Clinical Expert may be found if a case can be made. The recommended fee is £300 per day, equivalent to Care Quality Commission inspection rates.

5.4 The Panel

Members must:

- Be Disclosure and Barring Service (DBS) checked, and the chair must be assured that all members have received the appropriate level of training and support to participate. Confirmation must also be sought of any potential conflict of interest for any members.
- Meet the person separately.
- Ensure the family and person has verbal feedback on the day.
- Ensure rights are being upheld in accordance with the relevant legislation.

- Check if the person has an advocate – Independent Mental Capacity Advocate (IMCA), Independent Mental Health Advocate (IMHA), or legal representative if needed.
- Ensure that a complete and thorough review of physical health care has been undertaken.
- Ensure all diagnoses have a strong evidence base.
- Agree rationale for continued admission and treatment.
- The panel to review the person's living environment in person if appropriate.
- Access incident and safeguarding reports, risk assessments.
- Seek evidence to support risk assessment for now and in the future, with positive risk taking taken into account and demonstrated.
- Agree an expected length of stay.
- Examine progress against expected outcomes and length of stay.
- Agree actions to expedite the process where the panel believe there is a lack of progress.
- Recommend discharge or transfer if there is little prospect of the person achieving expected outcomes within the existing service.
- Bring challenge, scrutiny and second opinion to the provider's care and treatment by questioning aspects of care and treatment, and ensure they are satisfied that care and treatment continues to need to be provided in a hospital setting.
- Use their expertise to understand whether the person could be supported in a community setting, review the person's community service specification and/or make recommendations as to the most appropriate community service design.
- Ensure the person has been as involved as much as possible with the completion of the community service specification and seek evidence to support that the person is being involved in the community.
- Must have the previous CTR to follow up on previous actions.

5.5 Relevant Clinical Commissioning Group Case Mangers and Specialised Commissioning Team Case Managers

Case managers monitor, review, and reassess, hospital placements on behalf of the relevant CCG to ensure value for money principles are maintained in terms of the delivery of timely, effective and most appropriate treatment delivery to minimise the length of stay in hospital.

The relevant CCG and Specialist Commissioning Case manager must work collaboratively to agree action plans in CTRs that ensure progress to discharge is being made in accordance with the CTR panel and experts involved the case, and to ensure the most appropriate use of NHS funds.

5.6 Care co-ordinators and Providers – Community or Hospital

The preparation for the CTR is delegated from the relevant CCG commissioning to the community or hospital provider or care coordinator.

There are a range of tasks that must be completed before a CTR can take place, in order for it to be as effective as possible.

This includes preparing the person for the CTR using the 'My Care and Treatment Review' and 'My CTR planner' documents from the NHS England website.
https://www.england.nhs.uk/learning-disabilities/ctr/commissioners

This includes:

- Supporting the person to review the last CTR report and Care Programme Approach. .
- The provider must ensure consent is provided by the person to the CTR or assess capacity.
- Ensure that a best interest process is undertaken if the individual is unable to consent to the CTR taking place.
- Ensure the person has invited all the people who are important to them.
- Identifying reasonable adjustments that need to be made to ensure the person's participation.
- Give family and the person updates on progress against the action plan after the CTR.

They must prepare for the panel to review the care and treatment by:

- Ensure essential documents are collated and ready for the CTR panel and that they are accessible to the person using checklist in National CTR policy 2017.
- Ensure the CTR panel has access to all data e.g. electronic log-ins.
- Ensure NICE guidelines can be accessed if necessary.
- Ensure action plan from CTR is embedded in to Care Programme Approach plan.
- Ensure all members of the team are supported to share updates with candour.

5.7 Approved Mental Health Professionals

The role of the Approved Mental Health Professionals (AMHP) is to coordinate a Mental Health Act assessment, ensure that a correct legal process has been followed, and balance risk with the person's right to the least restrictive treatment setting, ensuring that all other community alternatives have been exhausted before detention is considered. The consideration of alternatives to detention will usually be via a community CTR or emergency meeting, if time is limited.

It is important that the AMHP is fully aware of Chapter 20 of Mental Health Act Code of Practice that covers the threshold for admission for people with a learning disability or autism. The code advises the AMHP and professionals involved in a Mental Health Act assessment of the factors to consider.

The CTR process does not prevent a Mental Health Act assessment being completed, but offers a best practice process for application to people with learning disabilities or autism who are at high risk of admission to psychiatric care.

There is an expectation locally, that AMHPs dealing with a Mental Health Act assessment referral for a person with a learning disability and/or autism seek to include CTRs, or emergency meetings into the process of their assessment where ever possible. This may include delaying the decision to detain for several days so that any identified actions can take place in the short term. This may include the AMHP making a referral for a CTR if this has not happened in the case.

5.8 Intensive Support Team (IST) or Intensive Home-Based Treatment Team (IHBTT)

The role of the IST and IHBTT is to provide high intensity support during a time of crisis for people with learning disabilities or people with mental health problems. A referral to either team should be made if the lead professional believes intensive support may stabilise the person in the community.

These teams have a key role in CTRs to provider evidence of success or failure of their support to inform decisions to admit to hospital or remain in community.

Involvement of intensive support should be considered before a CTR is called and may advise on alternative ongoing multi-disciplinary support that may stabilise the person further.

5.9 Local Authority social workers and managers

Social workers from the Local Authority have a pivotal role in community CTRs to review existing services for the person, looking at other sources of community support.

Social workers also have a critical role in developing thorough assessments of need and risk, based on the multi-disciplinary and multi-agency information available from the hospital providers to inform discharge plans as part of the in-patient CTR process.

They have a key role in community service specification design with the hospital and multi-agencies involved, including drawing together plans regarding how this may be commissioned and funded, including identification of and liaison with suitable providers.

In addition, social workers will provide key long-term case management to stabilise highly complex people in the community who have been discharged from hospital, or support prevention of admission, in collaboration with others.

5.10 Police Multi-Agency Hub in Central Police Station (Barnsley Locality)

The new multi-agency hub in Barnsley police station provides a new link between the Criminal Justice System and learning disability professionals. It will increase to the speed to which multi-agency crisis and contingency plans for repeat offenders with a learning disability (LD) and autism can be implemented across the police, courts, NHS and local authority, by identifying and intervening when people present in custody.

The multi-agency hub police officers have a key role to play in community CTRs to support alternatives to long term hospital detentions via the court.

5.11 Court Diversion and Liaison (Barnsley Locality)

The newly developed NHS Mental Health team based in the custody suite of Barnsley police station provide an important link between the police and courts and wider NHS, local authority and community services. Their central function is to be able to effectively refer and sign post people with learning disabilities and autism to more appropriate services, who have begun to be caught up in the Criminal Justice System, as a result of their behaviour.

The team members will provide key information to community CTRs where professionals are seeking to avoid a person becoming detained in a long-term section of the Mental Health Act via the court. It is important that this team are given a direct referrals route to key local authority and NHS teams in order for a speedy response to be agreed during the custody episode.

Other areas to provide details of alternatives for 5.11 and 5.12

5.12 Courts

In order to ensure the best possible solution for the person achieved, and to promote effective treatment or prevention of unnecessary hospital admission, professionals involved with a person should liaise proactively with the courts and collaborate with all legal professionals. Lead professionals should inform the CTR of possible alternatives to admission at all stages of the court processes pre-admission.

5.13 Tribunals and Hospital Manager's Reviews

If the person's circumstances are being given additional scrutiny by the Tribunal or Hospital Manager's, the hospital provider or community care co-ordinator/social worker should ensure that the Tribunal is provided with a copy of the CTR report, in order that they can consider the outcome.

The person's Mental Health Act solicitor should have a copy of the CTR report.

5.14 Section 117 Panel

The multi-agency section 117 aftercare panel considers and ratifies funding sources for all community discharges from long stay hospital settings.

This is an important forum for CTR action plans and community service specifications to be sent to gain agreements in principle of discharge plans.

5.16 The new General Data Protection Regulation (GDPR) (from 25/05/18)

The principles are similar to those in the DPA, with added detail at certain points and new accountability requirements for those who have day-to-day responsibility for data protection and maintaining personal data and processing activities.

The new regulations have significantly more legal liability where a breach occurs.

6 Admission to Hospital

6.1 Mental Health Act Assessment and working with the Approved Mental Health Professional (AMHP)

If a community CTR has been held, or an emergency meeting or teleconference, and all parties have agreed that hospital admission is appropriate, the CTR chair will ensure referral for a Mental Health Act assessment if detention is thought to be necessary is undertaken The discussions and findings of the CTR will be an important source of information to support the AMHP in the decision-making processes in order to make a clear rationale for hospital treatment and indicate outcomes of the admission.

If the AMHP does not consider that detention is appropriate or warranted, then this must be communicated back to the Chair urgently, for discussions to take place regarding the potential alternative options to meet the need and risk, and, if necessary re-convene the CTR to agree options.

6.2 Selecting and funding the hospital bed

The Responsible Commissioner for the CTR will work closely with the AMHP leading the Mental Health Act assessment to identify the most appropriate bed to support effective and timely treatment, in line with the findings of the CTR, if the AMHP supports admission.

This may be via the block purchased beds (with the exception of Calderdale CCG) with the Horizon Centre, assessment and treatment service, in Wakefield, or it may be within local Mental Health Acute wards under the Green Light Protocol, or it may be spot purchased autism specific hospital service, or locked rehabilitation hospital. For a child or young person, this must be referred to Specialised Commissioning, Yorkshire and the Humber to identify a CAMHS bed.

All these hospital providers will ideally assess the person before admission if the situation is not urgent.

Preferred hospital provider procurement for locked rehabilitation hospital provision is taking place regionally and will inform this process in the future.

6.3 Post-admission follow-up and working with the hospital treating team

If a community CTR did not take place, following admission a full CTR must be take place within 4 weeks. This is to agree the treatment plan and path to discharge.

In order to facilitate discharge in a timely manner, community professionals must stay involved or be allocated as soon as possible from the Local Authority social worker team, Intensive Support Team and community psychiatric service.

6.4 Discharge planning

The Responsible Commissioner continues to have a role in overseeing discharge and facilitating discharge planning meetings.

If the outcomes for treatment cannot be achieved in the hospital settings, discharge should be considered. A Ministry of Justice Restriction Order should not be thought of as a barrier to discharge, but discussions with the Ministry of Justice should begin as soon as it is identified that the person is ready.

Before involving providers, all parties involved need to agree a detailed community service specification design.

Providers with the skills to deliver the community service specification should be involved at the earliest opportunity.

7 Care and Treatment Review Follow up of Action Plans and Reporting

7.1 Lead Professional co-ordination of implementation of the action plan

The lead professional in the case – social work case manager, care coordinator, or relevant CCG case manager, are delegated the responsibility to ensuring implementation of the action and embedding into Care Programme Approach meetings. This lead professional is responsible for reporting to the Responsible Commissioner any barriers to delivering the action plan or delays in progress.

7.2 Reporting to Responsible CCG commissioner

Upon receiving updates regarding progress, the Responsible Commissioner has several duties.

The person must have an estimated date of discharge for reporting to NHS England. This date may not be shared with the person if they lack capacity to engage in the discussion or if to do so will cause unnecessary distress.

If progress towards discharge is slow, delayed, or the professionals involved face challenges agreeing or designing the community service specification, the responsible commissioner can bring in a community service specification expert to help draw up plans.

Where progress is not being made, this needs escalating to the contract manager in the relevant CCG if this is believed to be a performance issues relating to the provider.

The responsible commissioner can also request additional CTRs or other meeting such as Multi-Disciplinary Team (MDT) or Care Programme Approach (CPA) to review the action plan before the next scheduled CTR.

7.3 Tracking CTRs and planning next one

The Responsible Commissioner must set the next 6 monthly in-patient CTR, when the CTR report for the CTR is generated.

All Community CTRs and in-patient CTRs must be recorded on the NHS England regional trackers in a timely fashion. Emergency meetings and other multi-agencies meetings do not need tracking.

CETRs

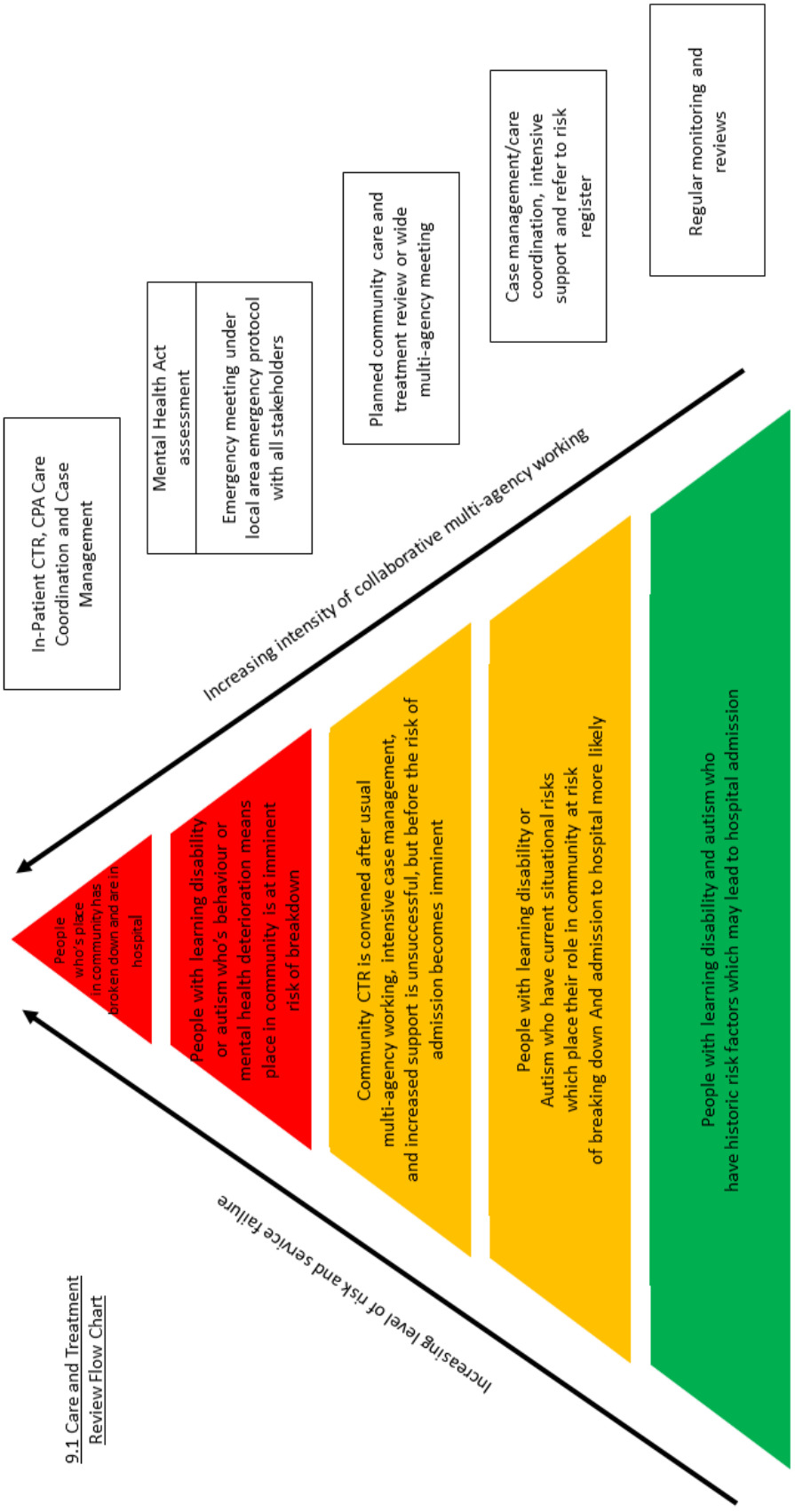
On important consideration relates to CETRs which need to take place prior to 38 and 52 week special educational residential placements

The ‘Responsible Commissioner’ will investigate the request and make a decision as to whether a CETR is appropriate.

CETRs should be undertaken before an access assessment to a Tier 4 placement – hospital/secure. Community CETRs need to be undertaken before the child and family go into crisis, when the outcome is most likely to be hospitalisation

Early intervention and person-centred intensive community support should be agreed at community CETR to keep the young person living within their own family and community

8 Appendix 1 CTR Flowchart



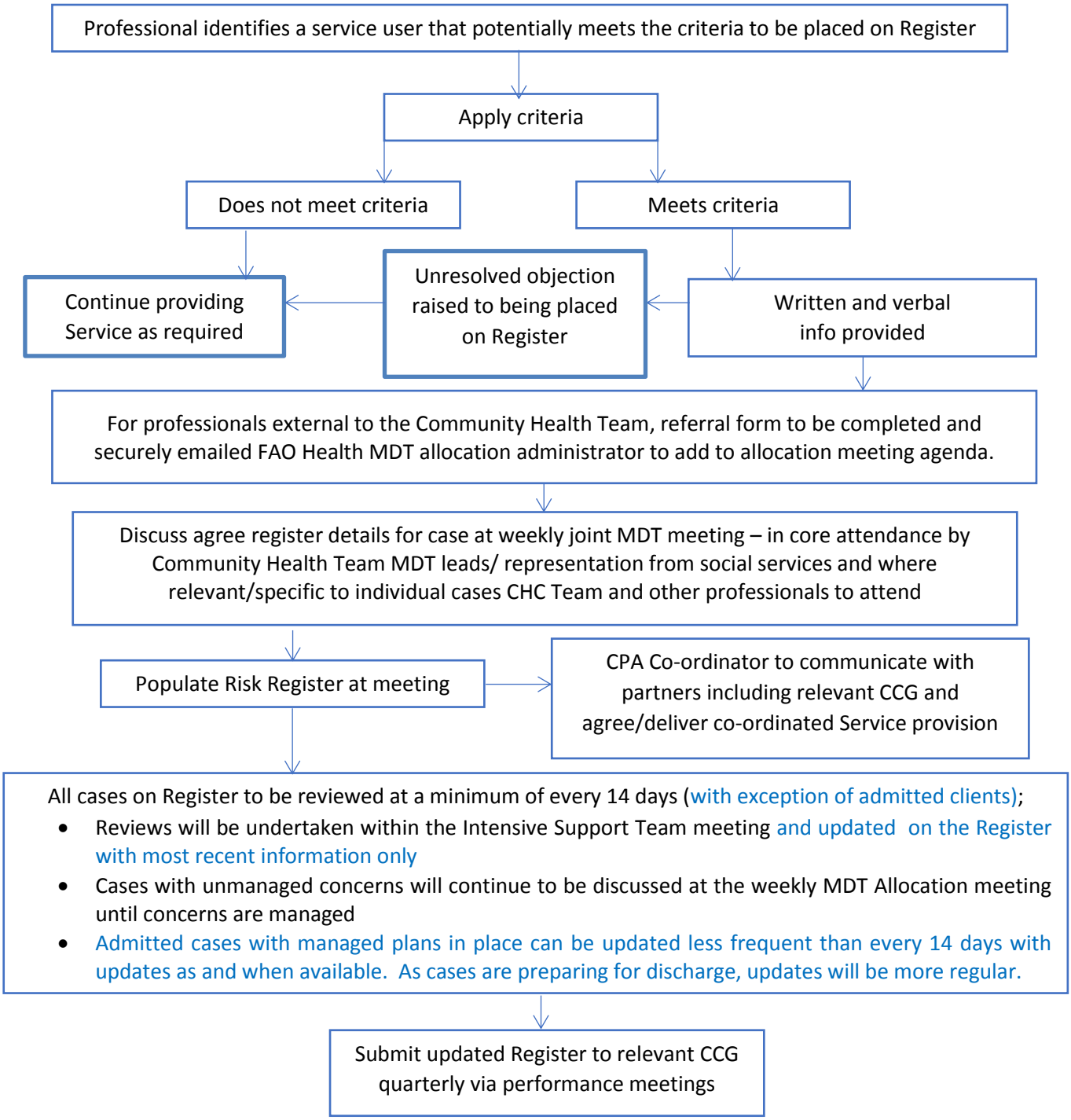
9.1 Care and Treatment Review Flow Chart

8.2 Appendix 2 South West Yorkshire Partnership NHS Foundation Trust Risk Register

3.8 Placing process

The process for placing people on the At Risk of Admission Register is shown below:

NB. This process runs alongside existing clinical/integrated/care pathways in place.



8.3 Appendix 3 Local Area Emergency Protocol

Introduction

In circumstances where an admission is unplanned, urgent or someone is in 'crisis' it is recognised that a CTR may be, on a practical level, very difficult to set up due to short time scales, level of risk and the need for urgent action. The aim of the Local Area Emergency Protocol is to provide the responsible commissioner with a set of prompts and questions both to prevent people with learning disabilities being admitted unnecessarily into inpatient learning disability and mental health hospital beds and, where there is a clearly supported clinical indication for admission to ensure that there is clarity about the intended outcomes and timescales.

It is also intended to help identify barriers to supporting the individual to remain in the community and to make clear and constructive recommendations as to how these could be overcome by working together and using resources creatively. The format of the 'Local Area Emergency Protocol' is most likely to be a secure teleconference to allow people to participate at short notice, although it can be a face to face meeting and must make every effort to involve the person with learning disabilities or their representative/advocate and family to gain their views on their preferred options for treatment and support and what could help to avoid admission into hospital.

This protocol describes when this response is needed, and suggests who should attend and what discussions should take place. Locally it expected that agencies will follow this protocol to support prioritising of their time and resource to respond both flexibly and at short notice to a request for a meeting.

For NHS England specialist commissioned services, a referral for an ACCESS assessment may happen alongside this protocol if it is felt that the individual may need admission to secure services or CAMHS.

Anyone involved in the care of a person with learning disabilities, autism or both can raise concerns about an individual who is at risk of being admitted to hospital unnecessarily. This ordinarily should lead to a community CTR being arranged. This protocol is to be used where there is neither prior knowledge of the escalating risk of admission, nor the time to set up or hold a CTR. The lead responsible commissioner will be responsible for ensuring that a Local Area Emergency Protocol meeting is organised and chaired.

Roles of people involved in emergency meeting:

- The person being considered for admission - give a first-hand account of issues and what would help. Listening to the individual is essential and should be prioritised and facilitated Family member/s to give additional information. As above, listening to the family views, ideas and wishes should also be prioritised and facilitated.
- Psychiatrist to provide feedback on assessed clinical needs and risks. Role in Mental Health Act processes.
- Community Learning Disability Nurse Coordinating role, provider of clinical information (May be Care Programme Approach Care Coordinator)

- Social worker Care manager, involvement in assessment and care planning. (May be Care Programme Approach Care Coordinator)
- IMHA/IMCA/Independent advocate as appropriate- to advocate for the individual concerned.
- Responsible Commissioner to provide support to fund alternatives to institutional care.
- GP to ensure effective support around health needs as required.

It is important for all involved to sign up to a 'no blame' principle, in order to give individuals or services the confidence to speak up should they face difficulties fulfilling their contracted role/s. The chair should bring people together for a conversation using the following steps:

1. The chair is made known to people and the current situation is shared.
2. Understanding the person. The needs and wishes of the person are identified including hearing from the individual and if appropriate the family, relevant carers, or clinicians.
3. The current risks are identified.
4. Care and treatment needs and options considered
5. Current resources and potential resources available are identified.
6. Decision made and support plan agreed, responsible people follow up identified.

The following questions will help to focus the discussions:

1. Gather a pen picture. 'Understanding me?'
2. What are my and my family's / carers' views of the current situation?
3. What are my symptoms? How is my physical health? Does any of this mean I need to be in hospital? Have I had an annual health check and do I have a health action plan?
4. What are the current issues and risks and how can I stay safe and keep others around me safe?
5. What's working well / what doesn't work? (Everyone's views, including what has helped me before).
6. What support has been/can be put in place so I that can stay in the community?
7. What treatment am I currently receiving including medication, therapy, diet and care? Does this need reviewing? Is it helping?
8. Can the care and treatment I need be given in a community setting?
9. What additional support is needed to keep me/others safe in the community?
10. What resources are available/can be created or used in a different way to support me?
11. What additional support is needed for my family/ carers? Has there been a carers assessment?
12. Do I have advocacy to support me to understand my care and treatment?
13. What is the reason for considering inpatient admission?
14. What would the outcomes be for me from an admission?
15. What would the impact of admission be on me and others around me? (For example, moving away from home and the people I know, to a new environment).

The outcomes of this conference call should be recorded and uploaded on to health and social care databases and lead to an updated Care Programme Approach care plan and risk assessment (or Education Health and Care Plan for a child or young person.)

8.4 Appendix 4 - Working with the Ministry of Justice

Guidance on conditional discharge provided by Ministry of Justice (NOMS), Mental Health Casework Section (MHCS)

The Secretary of State has the power to conditionally discharge a restricted patient under section 42(2) of the Mental Health Act 1983 (The Act). (The independent First Tier Tribunal (Mental Health) may also discharge under section 73 of the Act.) The MHCS section of the Ministry of Justice also consider discharge (section 19 transfers and section 17 leave) on behalf of the Secretary of State.

The Secretary of State may discharge a restricted patient by means of a warrant if s/he considers that the mental disorder is no longer of a nature or degree to warrant continued detention in hospital. It is usual for discharge to be subject to carefully considered conditions. These normally relate to where the discharged patient should live; compliance with supervision by a clinician and social supervisor; and to any other reasonable conditions considered appropriate for each case. For example, it might be thought necessary for an individual to not being able to live near a school due to previous offences against children, or having to comply with regular therapeutic interventions such as medication, or psychosocial interventions. Sometimes it might be thought appropriate to apply more stringent conditions, such as a 'no contact' condition with a victim, or an exclusion zone. Such conditions will only be applied after very careful consideration of individual circumstances, case law, Victim Liaison Officer (VLO) consultation and of the patient's human rights.

Discharge is via 2 routes: directly via the Mental Health Case Work section or via Tribunal. The former is less resource intensive and stressful for the patient if the Ministry of Justice are happy to support this route.

Mental Health Casework Section may take any of the following into account when considering discharge

The below issues should be addressed by the responsible clinician in any request for discharge, or when MHCS and the clinician are working together to consider Section 19 transfers or Section 17 leave requests, with a view to future discharge. The Responsible Clinician can delegate this liaison to any member of the team supporting the person but remains accountable.

- The diagnosis/es
- Circumstances of the index offence and other offending
- The patient's mental state at the time of the index offence
- The background, family history and development of the patient
- The symptoms of the mental disorder and whether/how these were linked to the index offence
- Historic risk factors
- Progress in hospital, including the completion of any interventions designed to reduce risk
- Future possible triggers or relapse indicators
- How the risks have been removed/reduced over time

- What risks remain
- How these residual risks will be mitigated and managed safely in the community
- Progress on leave
- Appropriateness of the proposed care plan – the responsible clinician should propose conditions
- Victim issues – the Responsible Clinician and Social Worker should liaise with the Victim Contact Service where appropriate in the first instance
    - If the patient has been discharged before then recalled to hospital, the Mental Health Casework section would look for how this might be avoided in the future
- Appropriate conditions to ensure, as far possible, that the patient presents no undue risk to others (or himself)
- Adequate and suitable accommodation, taking into account the potential level of risk presented by the patient.

This information is often drafted in the form of a report, but can be collated by all members of the professionals working with the person.

Supporting documentation

All types of relevant documentation, such as Care Programme Approach minutes, Annual Statutory Reports, reports on the use of community leave and psychological reports, where relevant, can be helpful in supporting the decision-making process and should be submitted early on as supporting documentation. This can be done through continuous liaison with the allocated case worker in the Ministry of Justice, sharing documents regularly with verbal updates by telephone to allow the case work team to understand the person in detail.

Doing this can prevent unnecessary delays in the process if this information is sought by the relevant case worker. It should be noted that:

- The above list is not exhaustive and other information may be requested, and other factors may be taken into account depending on the circumstances of the particular patient.
    - The Mental Health Casework section is not prescriptive with regard to specific interventions being undertaken but how the patient has engaged with treatment available to reduce/manage his/her risks.
    - When making risk assessments in general, and deciding upon conditional discharge specifically, the Mental Health Casework section takes many factors into account. does not make clinical judgements, but reasonable and objective decisions based on the evidence presented. The Mental Health Casework section will rarely get involved in the preparation of a care plan; but for complex and/or high profile cases, may attend care plan (or Multi-Agency Public Protection Arrangements) meeting if deemed appropriate.

  The onus is on the professionals involved to share as much information as possible and enable the Mental Health Casework section to make reasonable and objective decisions.

Our Voice Matters, Innit

GB/Pu/18/01/08

Manifesto

OASIS

OPENING UP AWARENESS & SUPPORT AND INFLUENCING SERVICES

#NotJustMe

RAISING THE VOICE AND AWARENESS OF YOUTH MENTAL HEALTH

CHILYPEP

CHILDREN AND YOUNG PEOPLE'S EMPOWERMENT PROJECT

Horizon Community College

NHS Barnsley Clinical Commissioning Group

Making Our Voices Heard: call to action and change

In Barnsley, the OASIS group (Opening up Awareness and Support, and Influencing Services) have been using creative consultations to talk other children and young people about mental health and emotional wellbeing, to find out what they need and what problems they face.

Now we want to raise our voices to tell others what we've found out!

The Our Voice Matters, Innit? manifesto draws on our key findings and shows some of the issues and difficulties children and young people are dealing with in Barnsley, and more importantly, what has worked well for them!

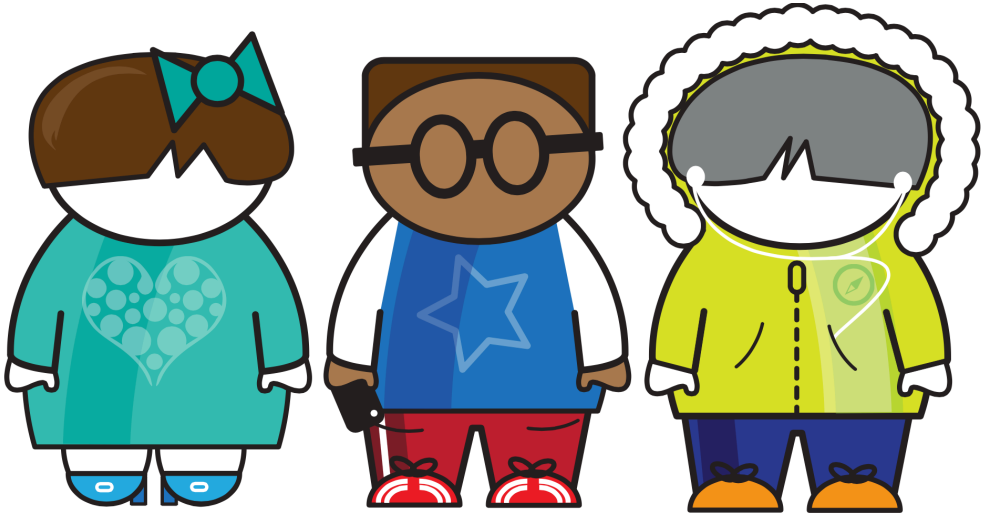
It is our Call to Action and Change, with 8 Key Recommendations, that we hope will inspire children, young people, families, communities, professionals and politicians to focus more attention on improving the emotional wellbeing and mental health of young people.

We want to see everyone in Barnsley work togetether to reduce stigma and isolation. To ensure that supporting young people's resilience, emotional wellbeing, and mental health are everyone's priority.

These stories illustrate the key problems young people face and how they can be improved by Barnsley's services and the wider community.

We hope that they will inspire everyone to think about what they can do to respond to the recommendations - as individuals, members of organisations and communities, and as service providers, commissioners and policy makers.

We believe that by responding to our Call to Action and Change, together we can truly transform services and support for young people today, and create a 'r8 Mental Health Friendly Barnsley' now and for the future!



The OASIS group are facilitated by Chilypep and funded by Barnsley Clinical Commissioning Group as part of the Barnsley Future in Mind Local Area Transformation Plan.

Unite Us: put in place peer support programmes for young people

How would you support someone close to you?

Name: Shelly
Gender: Non binary
Age: 15
Sexuality: Pansexual

I go to a youth group that has a peer-mentoring project for young people in the community. It's really good because other young people who all have similar experiences and understanding run it.

A teacher at school told me about the youth group and the peer-mentoring project. I needed some support and this is something that worked for me.

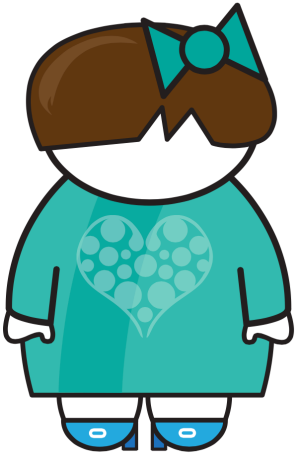
Peer support **unites us**. It gives young people a chance to come together and talk about our issues openly with each other. We make new friends at the group, have a right laugh and build our self-esteem and confidence at the same time.

I've built a great relationship with my mentor and I know the other mentors well. The group provides me with regular activities and a break from home, away from my caring responsibilities. I even get access to a quiet space to catch up on my school work in a relaxing place.

Providing emotional care for my mum who has mental illness is important and I'm glad to be there for her but sometimes I need time for me, which I recognise now. My mentor has shown me different healthy coping mechanisms, which actually work, and I feel more positive about my future and passing my exams at school.

The peer mentors are going to train new young people to become mentors and I think I'd be a good person to help others in the future. I think peer-mentoring projects would be good in different settings. They would support young people moving from primary to secondary school and then into higher education.

It would be great to see this kind of support in other places like mental health in-patient hospitals and supported accommodation. If young people work together it will **UNITE US.**



The majority of young people talked about the value of friendships, naming their friends as a key source of support. Young people involved in groups said that by meeting people of a similar age, with similar experiences, their confidence had improved as well as their general wellbeing. This highlights the need for peer support in relation to mental health and it is recommended that peer support models be developed, as well as therapeutic group work activities, to support young people's emotional wellbeing and mental health.

Left Unsaid: raise awareness of mental health in schools and colleges

What is your attitude towards mental health?

Name: Junior
Gender: Male
Age: 17
Sexuality: Heterosexual

I've had anxiety since I was really young. I didn't realise for a long time that what I was experiencing was a mental illness because I only understood the physical symptoms I had and there wasn't any information I could get about what anxiety is and how it can affect people.

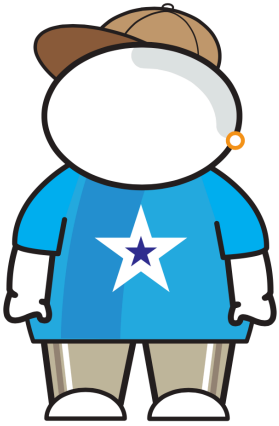
I had a lot of ongoing physical health checks before a doctor explained that what I was going through was in fact, anxiety.

Up 'til that point I didn't even know what anxiety was. I started to understand my illness more when I got counselling support. I couldn't help but feel that other young people might be feeling the same as me and not know why they felt the way they did or understand just like I did.

With anxiety and mental illness it's what is **LEFT UNSAID** that is a huge issue. I remember seeing a campaign poster displayed around the secondary school I went to that the year above me worked on. It was the first time I'd seen anything about mental health openly mentioned like that. We also had a mental health service that came into my school to do an assembly around mental health.

I think that if talking about your emotional wellbeing and feelings from an early age was taught in every primary school and then again at secondary and college age I would have felt less alone and isolated from others whilst growing up.

I always felt that they didn't understand me. Looking back now, other young people could have understood and felt the same and I may have been able to connect to them and get support for mental illness if things weren't **LEFT UNSAID.**



Whilst approximately 50% of those we spoke to had heard about mental health within schools, this was not routinely implemented across all settings. It is therefore recommended that there be more of a focus on mental health education within schools and colleges. This could include assemblies around mental health, workshops, peer-led sessions and talks from external organisations/ mental health providers, and those with lived experience of mental ill health. Young people said they would want this to start in primary school. This would enable young people to understand more about managing their emotions and signs of mental ill health and where to go for support earlier on and prevent issues from escalating at a later age.

Stuck in an 'Ole: improve signposting and information

Would you know where to go for help?

Name: Chrissie
Gender: female
Age: 19
Sexuality: Heterosexual

I'm at college part time but I also work one day a week. I needed some support around depression after I recently lost my dad to cancer and found it hard to cope. I didn't know who to turn to or where to start...

My mum encouraged me to see my GP when I was 18 years old and my GP referred me to a mental health service. It was all quite daunting and scary.

I didn't know what was going to happen next, I was told I would be contacted by the service to book an appointment. I didn't get a phone call and it had been a few days since the doctor referred me to the service and I was starting to feel more worried. I already felt **STUCK IN AN 'OLE** and I'd actually talked to a professional about how I felt and somehow I still felt stuck. I then got a letter for my first appointment one week after visiting the GP. The letter was addressed to me with a date and time and address of where I needed to go for my appointment inside.

I didn't know anything about the service which makes it intimidating but I hoped I could get help from them to make me feel better. My head is still spinning with questions, like, what is the person called that I am going to see? Will they understand what I'm going through? I don't know anything about them. It's making me feel anxious.

What about if someone sees me walking into the building that I know from college, will they judge me? If only the service had called me or sent a text explaining who I was going to see and given me a way to get in touch with them to ask them what treatment they could offer me.

It would be even better if they could meet me outside of the mental health service building in a space I felt comfortable going to. Help us help others to no longer feel **STUCK IN AN 'OLE.**

Whilst some of the young people did refer to mental health provision and services available locally, the majority of these already had experience of such services; there was less awareness about services amongst the general population. This highlights the need to raise awareness more widely amongst the general population of which services and support are available to young people who may be in need of mental health support. Young people said they would like to see the development of an 'online directory' of services so they could know where to go to for support and what is available to them. They would also like to know more about their rights in relation to mental health and the services available to them, and for services to be more flexible about meeting young people away from clinical settings.

Picture This: involve young people in service design and evaluation

Am I not the expert in my own experience?

Name: Jack
Gender: Male
Age: 16
Sexuality: Heterosexual

I guess my family can be a bit complicated sometimes. My dad lives in Thailand so me and my little brother, who is 3, live with my mum. Mum has to work a lot so it's up to me to look after my brother most of the time.

I don't hang out with my friends as much as I used to because I don't go to school any more. I didn't like it anyway. After school finished I spent a lot of time at home with my brother. I started to feel different and didn't know why. Then I was diagnosed with depression and anxiety. I wanted to get help.

I was referred to counselling but the counsellor didn't really get me and that made me frustrated. I didn't think it was helpful so I stopped going.

But then I got involved with what's called the Service User Involvement Group that the counselling service ran once a month. It's where every-one who has had counselling can talk about what it was like and things they'd like to be different. It was only once a month so I managed to make it to every session and still look after my brother.

The group made me feel like I had a voice that was being taken seriously and after a while I even started co-chairing the meetings.

Together the Service User Involvement Group made a young person friendly waiting room with young volunteers from the local college so that it seemed less clinical and more open and approachable for other young people like me. I was able to change counsellor with the same service and now I've built a great relationship with them. The counsellor looked at using different therapies to the ones I'd tried before and that made me feel better.

It really helped me get better when I realized that I could be a part of something that changed things for the better. **PICTURE THIS**...all you have to do is ask and involve us!

Young people showed a desire to be involved in shaping the services and support they received, coming up with many wonderful ideas in relation to service design throughout the consultations. Young people are the experts in their own experiences and in the services and support they would like to receive and it is recommended that there be opportunities for young people to influence service design at all levels to ensure that services best meet the needs of the young people using them.

This could include involving young people in the recruitment of staff, in the design of new services, and in evaluating and reviewing services. Young people said they wanted to be able to have a choice in the interventions they received and wanted to have more of a range of services and support available to them. It is recommended that commissioners and services work with young people to develop a range of interventions to suit individual needs, based on the views of young people.

Create a 'r8 Mental Health Friendly Barnsley': put in place training around mental health for professionals, and communities supporting young people

Are you ready to challenge your perceptions?

Name: Conor
Gender: Male
Age: 21
Sexuality: Asexual

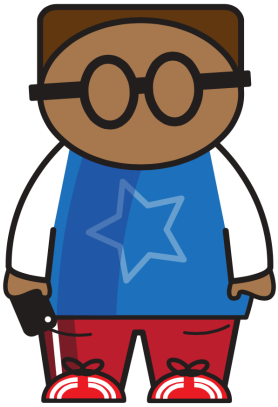
I live with my uncle now because my parents passed away after an accident a few years ago. I haven't really been coping well.

My uncle tries to understand and help but he doesn't get it. My school had no idea about what to do for students struggling with mental health and gave me no support. My friends at school tried to understand but didn't always know what to say or how to help. Most of the time I just didn't want to be around people.

My uncle got in touch with the local youth service and now I've started regularly going to the sessions there, The youth worker there gets it, he makes me feel understood and that helps.
I've made some new friends at the Youth Centre who also have mental health problems, they really understand and I know I can talk to them. I've been referred for counselling and I think the counselors are very supportive but they don't have all the answers.

I've noticed that the differences between the services and support I get from both professionals and friends/family depends on how much they know about and have experienced ill mental health.

Now I want all professionals, schools, colleges and youth workers to have mental health training. I also think parents, families, and other professionals like social workers and benefit workers should be trained around mental health. I think it's really important for everyone to have a greater understanding of mental health problems and the impact it can have on someone. There could be wellbeing events with taster sessions and awareness raising in the town centre to get people talking about mental health. I know that together we can create a **R8 MENTAL HEALTH FRIENDLY BARNSLEY!**



The majority of the young people we spoke to said they would go to friends, family, youth workers, or school or college for support. It is therefore recommended that there be more training and support in place for these workers so that they can feel confident to support young people around their mental health. This could include a training offer for youth workers and schools staff, as well as more awareness aimed at parents around engaging their children in conversations around mental health. As friends were an often named source of support we would recommend working with young people around 'how you could support a friend' to enable them to feel confident in having conversations around mental health and supporting their friends to get the right support.

Keep it Real: support young people to manage stress and pressure

How would you handle the pressure?

Name: Marie
Gender: female
Age: 16
Sexuality: I don't like labels

I have only just turned 16. I get a lot of pressure from my parents to do well in my exams this year.

Both my parents are doctors and they've always wanted me to be a GP too. My mum just had a baby too so I now have a sister and I'm not an only child anymore. I'm doing okay at school but I've had to work so hard on my revision and homework and I'm not sure I can keep it up.

I used to really like school but now all I can think about is how I have to do well in my exams.

I used to play football for my local team but stopped going to the training and kick-abouts because I just had too much work to do. I know the team really want me to go back and play but I just can't fit everything in.

I worry that I'm not getting as much exercise now though. I feel like I need to look a certain way, like my friends who seem perfect. I think they think I'm not pretty enough to hang out with them.

That's why I stopped eating regularly and my parents referred me to an eating disorder service, but I know they are worried that getting help in the medical sector will affect my future job prospects and maybe be a barrier to me becoming a doctor.

I think it sounds like I may have low self-esteem and anxiety. I need more emotional support from my parents but since they had the baby I know they're really busy and I feel like they don't have time for me as much.

So much stress and pressure is building up and all I want is to learn how to get support, know who might be able to help me and look after my own mental health without feeling like I'm doing the wrong thing. If only we could all build awareness around services, support and self-help coping strategies and mechanisms to **KEEP IT REAL** with young people who are struggling with school and peer pressure.

Pressure came up consistently as the main issue impacting on young people's mental health. A large majority of young people spoke about educational pressures, including exams, and pressure to achieve. Young people also felt wider societal pressures, such as pressure from the media to 'be a certain way', pressures around their identity and their futures, and peer pressure and discrimination. Whilst it might not be possible to eliminate the pressures young people face it is recommended that young people be supported to develop coping strategies to deal with the pressures they face and to prevent this from having a negative and lasting impact on their mental health.

Take Time: build relationships with young people

Have you got time for me?

Name: Jade
Gender: Non-binary
Age: 17
Sexuality: I like what I like

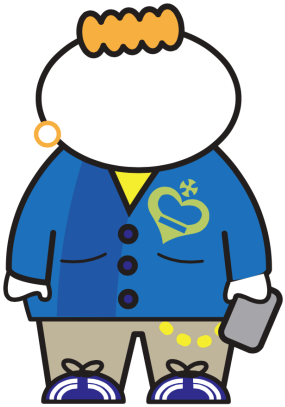
I feel like because I am non-binary, acceptance of my identity has created a lot of stigma amongst my family, and the village in which I live.

No one seems to understand being non binary and I feel pushed away from a community I wish supported me. I spoke to my GP as I was feeling displaced from society and everyone around me. The GP was okay I guess, they referred me to a mental health service but it didn't work for me because the worker had a spiritual approach - it may work for some but not for me.

I then got referred to the college counsellor, in my first session I was told it was one of 5 more sessions I would have with them and my homework was to think of something that makes me smile. Some days I couldn't think of anything. After my 6 sessions were up I was in no better place and was referred to the adult mental health team. In my first appointment I was told I was too young for the service, yet again I was reminded how displaced I felt, not only within the community but also within services and accessing support.

I was told that the Children and Adolescent Mental Health Service may better meet my needs. This time, in my first session I asked how many sessions I would have with them. The worker was really cool and kind and answered by asking me how long a piece of string was. This straight away made me feel at ease and made me smile. I smiled because I felt welcomed and felt able to open up. I was also signposted to the LGBT (lesbian, gay, bisexual and transgender) forum which opened me up to a community of likeminded people and additional support.

For a long time I felt I didn't fit. I began to feel more accepted and a sense of belonging with support from my counselor. **TAKE TIME** to build relationships with us or to get the right support package, not limited time in a certain number of sessions.



Relationships came out as a really important factor in young people feeling comfortable to be able to speak out about their mental health, as well as in how well they engaged with services. Young people said they did not want to have to keep repeating their story, but would instead like to build up a relationship with a worker who could support them consistently over a period of time. They said they wanted to have access to a range of interventions to support their wellbeing, including more informal interventions, and for services to be flexible in meeting their needs.

Knowledge isn't Understanding: give us tools to make it easier for young people to navigate services, and ensure they receive timely, appropriate support

Could you do things differenty?

Name: Lola
Gender: Female
Age: 14
Sexuality: Heterosexual

I used to secretly self-harm regularly as I thought it was helping me cope. I had no previous history of poor mental health and was seen as an A* Student with no problems through everyone else's eyes.

My eyes tell a different story. I opened up to a teacher one day at school as I felt really upset and I trusted the teacher. The teacher explained confidentiality to me and mentioned if I was to say something that causes me or anyone else harm they may have to take it further. I trusted the teacher, I desperately wanted someone to help me. Although I self-harmed secretly, deep down I wanted someone to know.

I used confidential phone lines but every time I felt I was getting somewhere I was told I could only stay on the phone to them for 35 minutes. I could call back but wasn't guaranteed it would be the same person I just spoke with.

I was referred to the Children and Adolescent Mental Health Service and despite a long waiting list, I was asked to sit in the waiting room that was very clinical, dark, and daunting and straight away made me feel anxious. I told the worker that the waiting room made me feel like that and they said they would take this to their Service User Group. Then 6 months later the service user group had painted the waiting room in neutral colours and made it young person friendly with bean bags and comfy cushions. I found my own ways of coping in the meantime by accessing online support but I was exposed to a lot of negative websites in the process. I'd prefer more interactive interventions and creative group work but I didn't know those things were available before I met my worker at the mental health service, so I just looked online.

KNOWLEDGE ISN'T UNDERSTANDING!

It can be very difficult to navigate services and support, particularly when you are experiencing mental ill health. In addition to ensuring young people know about where to go to for support, and what their rights are, we need to ensure that young people are at the centre of services and are able to receive timely and appropriate support. Waiting lists came up several times throughout the consultation as a barrier for young people, and they said they would like to get help early on to prevent their mental health from getting worse before it can get better. Young people said they wanted to have services available to them 24/7 and wanted to see more online support for young people. They wanted the spaces they went to, to feel 'less clinical' and more 'young person friendly'.

For more information visit
www.chilypep.org.uk/oasis

NHS
Barnsley Clinical Commissioning Group

Putting Barnsley People First

GOVERNING BODY

11 January 2018

RISK AND GOVERNANCE EXCEPTION REPORT

PART 1A – SUMMARY REPORT

1.	**THIS PAPER IS FOR**						
	Decision		*Approval*	✓	*Assurance*	✓	*Information*	

2.	**REPORT OF**		
		Name	*Designation*
	Executive Lead	Richard Walker	Head of Governance & Assurance
	Author	Kay Morgan	Governance & Assurance Manager

3. EXECUTIVE SUMMARY

Introduction
The Governing Body receives the full Assurance Framework (GBAF) on a quarterly basis and full Risk Register twice a year with exception reports brought to intervening meetings. In accordance with timescales this report presents to the Governing Body an extract of the red risks on both the GBAF and the Corporate Risk Register.

Governing Body Assurance Framework
The Governing Body Assurance Framework (GBAF) facilitates the Governing Body in assuring the delivery of the CCG's annual strategic objectives. The GBAF is reported to every meeting of the Governing Body as part of the Risk & Governance Exception Report. There is one risk on the GBAF rated as 'red' extreme risk (reference 7.1), regarding Patient Safety. Appendix 1 provides a summary of the GBAF for members' consideration, and Appendix 2 details risk 7.1.

Corporate Risk Register
The *Corporate Risk Register* is a mechanism to effectively manage the current risks to the organisation. This report provides the Governing Body with an extract of 'red' extreme risks from the Corporate Risk Register (Appendix 2).

Red (extreme) risks
There are currently seven 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 13/3 (rated score 20 'extreme') - BHNFT's under performance against the target that 95% of A&E patients are treated or discharged within 4 hours
- Ref CCG 14/10 (rated score 16 'extreme') – Risks resulting from the lack of GPs in Barnsley compared with the national average
- Ref CCG 14/15 (rated score 15 'extreme') – Potential impact on quality & patient safety of incomplete D1 discharge letters
- Ref CCG 15/07 (rated score 15 'extreme') – Quality & patient safety risks relating to Yorkshire Ambulance Service (YAS) under achieving against the Category A response standard of 75% within 8 minutes
- Ref CCG 15/14a (rated score 16 'extreme') - In relation to the 0-19 pathway reprocurement by Public Health, if there is any reduction in service (or failure to improve outcomes) there is a risk that there is a risk that the service quality and safeguarding provided for the 0-19 population will be adversely affected
- Ref CCG 15/14b (rated score 16 'extreme') - In relation to the 0-19 pathway reprocurement by Public Health, if there is any reduction in service (or failure to improve outcomes) there is a risk that there will be a negative impact on primary care workforce and capacity
- Ref CCG 15/14c (rated score 16 'extreme') - In relation to the 0-19 pathway reprocurement by Public Health, if there is any reduction in service (or failure to improve outcomes) there is a risk that the CCG will suffer reputational damage, given the public's natural assumption that the NHS (CCG) has direct agency over the 0-19 pathway.

Additions / Removals

Following review by Officers, Finance & Performance Committee recommends that two risks from the Risk Register be closed, as follows:

1. The risk 13/22 "Variation in performance – capacity within the CCG to support and improve quality in primary care." The rationale is that:
   - The Primary Care Quality Improvement Tool was approved at the December 2017 Governing Body meeting and will now be populated in January 2018.
   - All recommendations from Internal Audit have been actioned and processes are in place to report assurance to the Quality & Patient Safety Committee.
   - There is good engagement with Practice Managers (see below)
   - Primary Care team in place and Primary Care Development Workstream well established..

2. Risk 14/3 "If the CCG fails to secure Practice Manager engagement there is a risk that the Primary Care development project will fail to deliver transformation." The rationale is that there is good engagement with Practice Managers, as evidenced by good practice engagement re the demand management programme, and 12 Practice Managers have supported development of the PDA.

	Emergency Planning Resilience and Response (EPRR) Self-Assessment and Assurance Process 2017-18 At its meeting in September 2017 the Governing Body reviewed and signed off the CCG's EPRR self-assessment and statement of compliance for submission by the Accountable Emergency Officer (Head of Planning, Delivery, and Performance) to the NHS England Local Health Resilience Partnership secretariat. This fed into regional and national assurance processes in October 2017. Following the assurance process the LHRP confirmed the CCG's self-assessment and compliance rating as 'substantial.'
4.	**THE GOVERNING BODY IS ASKED TO:**
	GBAF: • Review the GBAF for 2017/18, and consider whether the risks on the GBAF are appropriately described and scored, and whether there is sufficient assurance that they are being effectively managed as at 11 January 2018 • Identify any positive assurances relevant to the risks on the GBAF *Risk Register:* • Review the Corporate Risk Register to confirm all risks are appropriately scored and described. • Approve the removal of risk reference 13/22 and 14/3 from the Risk Register. • Identify any potential new risks. *EPRR Assurance Process 2017/18* • Note that following the assurance process the LHRP has confirmed the CCG's self-assessment and compliance rating as 'substantial.'
5.	**APPENDICES**
	• Appendix 1 – GBAF 2017/18 (summary) • Appendix 2 - GBAF 2017/18 (risk 7.1) • Appendix 2 - Corporate Risk Register (red risks).

Agenda time allocation for report:	10 minutes

1.	Links to the Governing Body Assurance Framework	Risk ref(s)
	This report provides assurance against the following risks on the Governing Body Assurance Framework:	All
2.	**Links to CCG's Corporate Objectives**	**Y/N**
	To have the highest quality of governance and processes to support its business	Y
	To commission high quality health care that meets the needs of individuals and groups	Y
	Wherever it makes safe clinical sense to bring care closer to home	Y
	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	Y
	To develop services through real partnerships with mutual accountability and strong governance that improve health and health care and effectively use the Barnsley £.	Y
3.	**Governance Arrangements Checklist**	
3.1	**Financial Implications**	
	Has a financial evaluation form been completed, signed off by the Finance Lead / CFO, and appended to this report?	*NA*
	Are any financial implications detailed in the report?	*NA*
3.2	**Consultation and Engagement**	
	Has Comms & Engagement Checklist been completed?	*NA*
	Is actual or proposed engagement activity set out in the report?	*NA*
3.3	**Equality and Diversity**	
	Has an Equality Impact Assessment been completed and appended to this report?	*NA*
3.4	**Information Governance**	
	Have potential IG issues been identified in discussion with the IG Lead and included in the report?	*NA*
	Has a Privacy Impact Assessment been completed where appropriate (see IG Lead for details)	*NA*
3.5	**Environmental Sustainability**	
	Are any significant (positive or negative) impacts on the environment discussed in the report?	*NA*
3.6	**Human Resources**	
	Are any significant HR implications identified through discussion with the HR Business Partner discussed in the report?	*NA*

Barnsley Clinical Commissioning Group

Barnsley CCG: Summary of Governing Body Assurance Framework 2017-18

Introduction

The Governing Body Assurance Framework aims to identify the principal or strategic risks to the delivery of the CGG's strategic objectives and key operational priorities. 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 priorities, 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.

Priority Area	Principal Threats To Delivery	Risk Owner	Initial score	Current score	Risk app.	Current gaps in control / assce
URGENT & EMERGENCY CARE • Front door clinical streaming • Improved patient flow • Free up hospital beds • Urgent Treatment Centres • More GP appointments evenings & weekends • Increased clinical assessment of calls to NHS 111.	If partners locally and across the ACS do not engage constructively together, to develop a model for urgent care at a South Yorkshire and Bassetlaw and Barnsley level, in line with best practice and national guidance there is a risk that urgent care services are unable to meet the growing demand, constitution standards for urgent care are not achieved and the quality of patient care is negatively impacted	FPC	15	12	12	Non delivery of A&E 4 hour wait
PRIMARY CARE Delivery of 'GP Forward View' and 'Forward View - Next Steps for Primary Care' to: a) deliver investment into Primary Care b) improve Infrastructure c) ensure recruitment/retention/development of workforce d) Address workload issues using 10 high impact actions e) Improve access particularly during the working week, more bookable appointments at evening and weekends.	There is a risk to the delivery of Primary Care priorities if the following threat(s) are not successfully managed and mitigated by the CCG: • Engagement with primary care workforce • Workforce and capacity shortage, recruitment and retention • Under development of opportunities of primary care at scale, including new models of care • Not having quality monitoring arrangements embedded in practice • Inadequate investment in primary care • Independent contractor status of General Practice.	PCCC	12	12	12	0-19 pathway; lack of GPs; primary and community workforce shortages

GB/Pu/18/01/11.1

Barnsley CCG: Summary of Governing Body Assurance Framework 2017-18

Priority Area	Principal Threats To Delivery	Risk Owner	Initial score	Current score	Risk app.	Current gaps in control / assce
CANCER • Reduced Inequalities • Better cancer survival • Speed up and improve diagnosis • Faster test results • Access to the most modern cancer treatment in all parts of the country • Improve Patient Experience • Deliver Survivorship Program (LWABC) • Commissioning for Value	1. Risk to delivery of the 62 day wait NHS Constitution standard if clear pathways from cancer diagnosis to treatment are not developed and shared by partners 2. Risk to delivery of early diagnosis if: (a) the CCG does not effectively promote to the people of Barnsley the national screening programme (b) Practices do not consistently apply NICE guidance for cancer diagnosis and referral. 3. Risk that, if the CCG does not have a clear local strategy for delivering cancer priorities, the CCG may not get access to cancer transformation funding which would impact negatively on securing improvements to services for people Living With and Beyond Cancer (LWABC). 4. Risk that the incidence of cancer is not reduced, and of poorer outcomes post treatment, if steps to promote healthy lifestyles for Barnsley people are not successful.	FPC	12	12	12	
MENTAL HEALTH • Increase the number of children and young people receiving evidence-based treatment to improve their emotional health and wellbeing • Improve access to psychological therapies (IAPT) from 15% of the local population suffering from depression to 25% by 2020 and improve the IAPT recovery rate to achieve national targets as a minimum; Improve pre and post mental health crisis care support • Crisis care: extend the Liaison Mental Health service in A&E to include children and young people; Implement the Police and Crime Act 2017; Reduce the numbers of suicides in Barnsley to the national average as a minimum	If the CCG and its partners are unable to manage and mitigate the potential barriers to improving mental health services - lack of workforce capacity, limited financial resources, and legacy 'backlogs' - there is a risk that the CCG's ambitions for these services will not be achieved.	FPC & QPSC	12	12	12	

Barnsley CCG: Summary of Governing Body Assurance Framework 2017-18

Priority Area	Principal Threats To Delivery	Risk Owner	Initial score	Current score	Risk app.	Current gaps in control / assce
• Improve perinatal mental health • Develop robust pathways for adults with ASD / ADHD						
STP & ACCOUNTABLE CARE *System Level*: There is a shared view that in order to transform services to the degree required to achieve excellent and sustainable services in the future, we need a single shared vision and plan in each Place and across South Yorkshire and Bassetlaw. Partners from across health and social care in each Place have come together to develop a single shared vision and plan as part of an Accountable Care System. *Place level*: development of Accountable Care Partnership which brings Barnsley service providers and commissioners together to plan and deliver care for our population and make best use of the Barnsley £ *CCG contributions to system wide working & enabling work streams*: Leadership and programme support.	If the CCG and its partners in Barnsley are unable to maintain partner buy-in and agreement; AND / OR if individual organisational barriers and statutory duties prevent partners from remaining focussed on the journey towards accountable care; there is a risk that the ambition for the people of Barnsley to see one NHS and care system and truly integrated services will not be achieved.	ACPB	9	9	12	
EFFICIENCY PLANS • Free up hospital beds • Best value out of medicines and pharmacy • Reduce avoidable demand • Reduce unwarranted variation in clinical quality and efficiency • Cut the costs of corporate services and administration • Financial accountability and discipline for all trusts and CCGs	If the CCG does not develop a robust QIPP plan supported by effective delivery & monitoring arrangements, there is a risk that the required QIPP savings will not be achieved, resulting in a failure to achieve statutory financial duties and non-compliance with NHSE business rules.	F&PC	12	12	12	
	If the CCG does not develop a robust Demand Management Programme and PDA scheme supported by effective delivery & monitoring arrangements, there is a risk that anticipated QIPP savings will not be achieved, and that inequalities in the quality and accessibility to healthcare services across Barnsley will remain.	F&PC	12	12	12	Reduction in procedures as a consequence of the scheme.

Barnsley CCG: Summary of Governing Body Assurance Framework 2017-18

Priority Area	Principal Threats To Delivery	Risk Owner	Initial score	Current score	Risk app.	Current gaps in control / assce
	Specific threats include: • Provider adherence to policies. • Practices may disengage if not meeting the required targets are met, particularly if the expected reductions are not achievable in-year. Consequentially, the PDA may not fully deliver the return on investment • Map of Medicine (MoM) are withdrawing their tool from 31 March 2018; this removes a tool to support adherence to CCG policies and may cause practices to disengage from the tool in the interim period whilst a replacement is sourced.					(Now anticipated to fall into 2018-19)
PATIENT SAFETY • Reduced HCAI in Providers beyond MRSA bacteraemia and C.Difficile • Improved maternity safety by delivery of Better Births within the STP • Ensuring Providers implement Learning from deaths via mandated Death Reviews • Reduced medication errors in Providers	1. Maternity reconfiguration is dependent on STP providers cooperating and likely to be strongly contested by the public. 2. Providers have a significant challenge to change culture for Learning from Deaths to be meaningfully adopted	QPSC	15	15	12	Provider processes for learning from deaths tbc; D1 discharge summaries

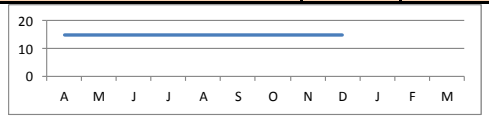
03/01/2018

NHS Barnsley CCG Governing Body Assurance Framework 2017-18

PRIORITY AREA 7: PATIENT SAFETY	Delivery supports these CCG objectives:		PRINCIPAL THREATS TO DELIVERY
• Reduced HCAI in Providers beyond MRSA bacteraemia and C.Difficile • Improved maternity safety by delivery of Better Births within the STP • Ensuring Providers implement Learning from deaths via mandated Death Reviews • Reduced medication errors in Providers	Highest quality governance	✓	1. Maternity reconfiguration is dependent on STP providers cooperating and likely to be strongly contested by the public. 2. Providers have a significant challenge to change culture for Learning from Deaths to be meaningfully adopted
	High quality health care	✓	
	Care closer to home	✓	
	Safe & sustainable local services	✓	
	Strong partnerships, effective use of £	✓	
	Links to SYB STP MOU		

Committee Providing Assurance	QPSC	*Executive Lead*	BR	*Clinical Lead*	MG / SK

Risk rating	Likelihood	Consequence	Total
Initial	3	5	15
Current	3	5	15
Appetite	3	4	12
Approach	Treat		



Date reviewed Dec-17

Rationale: Whilst all the work has national momentum driving it historically all aspects have proved hard to do therefore we must consider that the risk of not achieving is possible; given the nature of the risks the consequence will always be in the catastrophic category

Key controls to mitigate threat:	Sources of assurance	Rec'd?
Provider reports relating to HCAIs, SIs, medication errors received and reviewed by the CCG	Quality & Patient Safety Committee (Q&PSC) oversees QA of provider SIs	Ongoing
CCG on Barnsley Health Protection Board (HPB) which reports to Health & Well Being Board (H&WBB) and minutes seen at Q&PSC	Minutes of all relevant committees seen at Q&PSC	Ongoing
Clinical Quality Board (CQB) for each Provider reports to Q&PSC	CQB reports and relevant CQC inspection reports taken to Q&PSC	Ongoing
Process to resolve risk 14/15 with Area Prescribing Committee (APC) which reports to Q&PSC	Monitored via Q&PSC	Ongoing
Q&PSC report to the Governing Body	Q&PSC Highlights Report and Annual Assurance Report	Ongoing
CCG represented on both Safeguarding Boards which report to the H&WBB	Proceedings summarised at Q&PSC via Patient Safety reports, would be escalated to GB by exception. Minutes of safeguarding boards publicly available via BMBC website.	Ongoing
CCG participates in the South Yorkshire & Bassetlaw Quality Surveillance Group (QSG)	Verbal updates to QPSC	Ongoing

Gaps in assurance	Positive assurances received
Primary Care SEAs are not mandated to come to the CCG and those that do are of variable quality	Review of BHNFT position re Better Births in Summer 2016 indicated that all aspects within BHNFT's gift (i.e. outwith STP decisions) could be positively evidenced and subsequent Dashboard data reflects this being sustained

Gaps in control	Actions being taken to address gaps in control / assurance
Provider processes from Learning from Deaths process yet to be confirmed, CCG seeking positive evidence of the support and communication of bereaved families and carers	This will be pursued by CQBs, SWYPFT went live 30/9/17 Process shared at October CQB
(risk ref 14/15) Potential for harm to patients due to scant or absent information re why medication changes have been made on D1 discharge letters, or resulting from medication reconciliation work not being done robustly.	A Trust re-audit was reported to the APC in March 2016 which did not show any improvement and a Quality Review Meeting was held on 18/08/16 with the CCG, NHSE and the Trust. The Trust have since explored a variety of options for improving the process, including re-design of the D1 form. The June 2017 re-audit was deferred to facilitate a collaborative primary and secondary care audit but this will now not be progressed due to technical difficulties. The Trust have advised that they are introducing an electronic prescribing software system in 17/18. A primary care re-audit using the original criteria is being undertaken and is planned to complete by end of Dec 2017.
March 2017 Audit of Quality Monitoring of Primary Care Providers only able to offer limited assurance	All 7 recommendations in the audit report have now been addressed. A Primary care Quality Improvement Group is now in place and a Quality Improvement Tool has been developed to facilitate the provision of targeted support to primary care to enhance quality.
Nov 2017: BHNFT have experienced 2 MRSA bacteraemias since April 2017 (1 contaminate).	PIR to advise re learning.

RISK REGISTER – December 2017

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)	7	Monthly
Likely	4	Major	4	Amber	High Risk	(8- 12)	19	3 mthly
Possible	3	Moderate	3	Yellow	Moderate Risk	(4 -6)	7	6 mthly
Unlikely	2	Minor	2	Green	Low Risk	(1-3)	3	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 13/3	1,3, 5,6, 8	If the system, via the A&E Delivery Board fails to deliver and sustain improvement in BHNFT's performance against the target that 95% of A&E patients are treated or discharged within 4 hours there is a risk that the Trust will not meet the level of performance required to achieve its Sustainability and Transformation Funding and also that the CCG will fail to deliver the NHS	4	5	20	Health Community whole system wide response lead by the CCG Health Community whole system wide response lead by the CCG A&E Delivery Board established A&E Improvement Plan Daily Reporting Winter & Bank Holiday Planning arrangements IHEART Barnsley established and operational offering out of hours GP appointments on evenings and Saturdays	JW (Finance & Performance Committee)	Risk Assessment	5	4	**20**	12/17	**December 2017** Performance against the 4 hour standard was not achieved in December. **November 2017** Performance against the 4 hour standard has improved in November. Performance as at 20 November was 95.47% for the month.	01/18

			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**
		constitution standard and there will be a reduction in the Quality Premium payable to the CCG.				Strengthened GP Streaming adjacent to ED in place. BHF commenced provision of service in September 2017 in ED but with a GP providing the service and from December 2017 in new separate primary care area adjacent to ED. IHEART 365 service established, bringing together extended access and OOH GP services.								
15/14(b)	4	In relation to the 0-19 pathway reprocurement by Public Health, if there is any reduction in service (or failure to improve outcomes) there is a risk that there will be a negative impact on primary care workforce and capacity.	4	4	**16**	As for risk 15/14(a) Monitoring at practice level delivery of 0-19 KPIs in relation to practice contracts, utilizing identified escalation routes when core service KPIs are not delivered in real time. A Governing Body Development Session on 27 April 2017 with service leads agreed to establish a co-production Group with CCG involvement to work on service model	MG (Primary Care Commissioning Committee)	Governing Body	4	4	**16**	12/17	**December 2017** Meeting held recently with Public Health and progress is being made. The risk to was discussed at Primary Care Committee meeting. No change to risk rating at this stage.	01/18

			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 Practice Managers Group are being regularly updated with the 0-19 pathway							**November 2017** A meeting has been held with CCG representatives and representatives from Public Health which identified actions to initiate future cohesive working between the 0-19 Service and primary care. An Action Plan from BMBC was received on 25 October 2017 detailing the progress. BMBC have been asked to firm up next two meeting dates. The Action Plan will now be shared with the Primary Care Workstream (PCWS) for them to consider	

			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**
													whether the actions mitigate the risks recorded in the CCG's Risk Register .	
15/14(a)	5, 6	In relation to the 0-19 pathway reprocurement by Public Health, if there is any reduction in service (or failure to improve outcomes) there is a risk that the service quality and safeguarding provided for the 0-19 population will be adversely affected.	3	4	**12**	Membership of Children & Young people's Trust Oversight through Children & Young People's Trust ECG Promoting dialogue and shared ownership as commissioners with Public Health The Practice Managers Group are being regularly updated with the 0-19 pathway	BR (Quality & Patient Safety Committee)	Governing Body	4	4	**16**	11/17	**December 2017** GB Leads reported continued good progress. **November 2017** *See 15/14(b) above*	03/18
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:	**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	MG (Primary Care Commissioning Committee)	Governing Body	**4**	**4**	**16**	12/17	**December 2017** Consideration to be given to a rewording of this risk as discussed at PCC. To rescore once Quality dashboard available	01/18

			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**
		(a) Some practices may not be viable, (b) Take up of PDA or other initiatives could be inconsistent (c) The people of Barnsley will receive poorer quality healthcare services (d) Patients services could be further away from their home.				with the Medical School to enhance attractiveness of Barnsley to students The CCG continues to invest in primary care capacity. The PDA enables practices to invest in the sustainability of their workforce. The innovation Fund saw £0.25m invested in developing new, more efficient and flexible ways of working. The successful PMCF has enabled additional capacity to be made available outside normal hours via the I heart Barnsley Hubs. The CCG is also creating 4 GP fellowships in partnership with SWYPFT. The Workforce Summit Plan**.** GP Forward View							**November 2017** Position remains the same **October 2017** Position remains the same **September 2017** Position remains the same	
14/15	1, 5, 6	There are two main risks: 1. Scant or absent information relating to why medication changes have been	4	4	**16**	Ongoing discharge medication risks escalated to BCCG Chief Officer and Chief Executive of BHNFT resulted in 2 quality risk meetings (August and November 2016)	MG (Quality & Patient Safety Committee)	Risk Assessment & audit of discharge letters	3	5	**15**	12/17	**December 2017** Re-audit currently being undertaken	01/18

			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**
		made. Poor communication of medication changes , even if changes are appropriately made for therapeutic/safety reasons, creates a patient safety risk when post discharge medicines reconciliation is being undertaken by the GP practice. The risk being that the GP practice may either accept inappropriate changes when all the patients' risk factors have not been accounted for by the hospital clinicians or an error has been made or not accept clinically important changes as not confident about the reasons for the change. 2.				Area Prescribing Committee (APC) monitor concerns and will report 2017 audit to the Quality & Patient Safety Committee A working Group (with reps from Practice managers Group & BHNFT) looking at D1 Discharge Summary Letters.							**November 2017** At Area Prescribing Committee 11.10.17 it was agreed that separate audits will be undertaken. Primary Care will re-audit using the same criteria as the previous audit (except day cases). BHNFT are working on the scope and timelines of the audit and expect to deliver the audit no later than the end of the financial year. **September 2017** The audit criteria to be agreed with BHNFT on 13 September 2017	

			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**
		Clinically significant safety alerts, such as contraindicated combinations of medication, are being frequently triggered by primary care prescribing systems during post discharge medicines reconciliation when adding medicines to the Patients Primary Care Record. This indicates that either the hospital is not reconciling medicines using the GP Practice Summary Care Record or that the reconciliation is not sufficiently robust.											and audit to start immediately.	
CCG 15/07	1,5, 6	If improvement in Yorkshire Ambulance Service (YAS) performance against the Category A response standard (75% within 8 minutes	4	5	**20**	July 2016 Regular consideration of YAS incident reporting by QPSC and GB to understand the frequency and severity of incidents associated with ambulance response.	BR (Quality & Patient Safety Committee)	Risk Assessment	3	5	**15**	12/17	**December 2017** No additional information to alter the risk.	02/18

			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**
		for Barnsley residents) is not secured and sustained, there is a risk that the quality and safety of care for some patients could be adversely affected.											**November 2017** No additional information to alter the risk. **September 2017** No additional information to alter the risk **July 2017** In two reviewed incidents no evidence of system pressure compromising safety (both attributed to human safety factors) **June 2017** No additional information to alter the risk	

			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**
15/14(c)	1	In relation to the 0-19 pathway reprocurement by Public Health, if there is any reduction in service (or failure to improve outcomes) there is a risk that the CCG will suffer reputational damage, given the public's natural assumption that the NHS (CCG) has direct agency over the 0-19 pathway.	3	3	**9**	Identified GB members to work with 0-19 Service Lead on improved GP access to, and better communicate with, 0-19 practitioners.	BR (Equality and Engagement Committee)	Governing Body	4	4	**16**	12/17	**December 2017** GB Leads reported continued good progress. **November 2017** *See 15/14(b) above*	03/18

NHS
Barnsley Clinical Commissioning Group
Putting Barnsley People First

GOVERNING BODY

11 January 2018

INTEGRATED PERFORMANCE REPORT

PART 1A – SUMMARY REPORT

1.	**THIS PAPER IS FOR**						
	Decision		*Approval*		*Assurance*	✓	*Information*	✓
2.	**REPORT OF**						

	Name	*Designation*
Executive Lead	Roxanna Naylor / Jamie Wike	Acting Chief Finance Officer / Head of Planning, Delivery and Performance
Author	Roxanna Naylor/ Jamie Wike	Acting Chief Finance Officer/ Head of Planning, Delivery and Performance

3.	**EXECUTIVE SUMMARY**
3.1	The Finance and Performance reports aim to provide an overview of the performance of NHS Barnsley Clinical Commissioning Group (BCCG) up to the end of November 2017.
3.2	The reports provide details of the latest performance against key performance indicators and an overview of the financial performance of the CCG up to 30 November 2017, together with forecasts for the year end.
3.3	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 oversight of performance and finance and provide assurance to Governing Body.
3.3	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 local priorities and financial performance.
3.4	Key performance indicators issues which are highlighted within the exception report are: • The 4 hour standard for patients waiting in A&E (Commissioner and Barnsley Hospital)

	Based upon the latest available data, other key performance measures in relation to RTT & Diagnostic waiting times (Oct), Cancer (Oct) and IAPT (Nov) are all being achieved.
3.5	For information, also attached to this report at Appendix 2 is a paper provided by the lead commissioner for 999 describing changes to the way performance and quality are measured.
3.6	The finance report attached at Appendix 3 provides an assessment of the current financial performance of the CCG up to 30 November, together with head line messages and forecasts for the year end.
3.7	The CCG continues to forecast to achieve all financial duties and planning guidance requirements, with an in-year balanced budget position. The forecast position, after risk assessment has deteriorated from the position reported in Month 7 due to Category M clawback and No Cheaper Stock Obtainable (NCSO) drugs now being included within the forecast position, rather than being reported through Risks and Mitigations. The month 8 forecast overspend is £1,266k this is offset by a net mitigation of £2,052k, which provides headroom of £786k. This headroom will cover any further risk associated with contract activity overtrading, particularly during the winter period. Further information on the CCG's financial performance targets is set out in section 2 of Appendix 3. Appendix 3 also includes a forecast assessment of the CCG's efficiency programme. The position as at 30 November is that schemes whilst planned schemes have not delivered in line with expectation, other budget reductions have contributed to the efficiency programme to allow the target of £11.5m to be achieved.
4.	**THE GOVERNING BODY IS ASKED TO:**
	Note the contents of the report including: • 2017/18 performance to date and the changes described in the paper attached at Appendix 2 • continued projected delivery of all financial duties, predicated on the assumptions outlined in this paper • the update on the CCG's efficiency programme and delivery of the £11.5m target.
5.	**APPENDICES**
	• Appendix 1 – Barnsley CCG Monthly Performance Report to November 2017 • Appendix 2 - Improving ambulance services: Changes to the way performance and quality are measured • Appendix 3 – Finance Report 2017/18 – Month 8

Agenda time allocation for report:	10 minutes

PART 1B – SUPPORTING INFORMATION

1.	Links to the Governing Body Assurance Framework	Risk ref(s)
	This report provides assurance against the following risks on the Governing Body Assurance Framework:	1.1, 1.3, 1.4, 3.1 and 4.1
2.	**Links to CCG's Corporate Objectives**	**Y/N**
	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 £.	✓
3.	**Governance Arrangements Checklist**	
3.1	**Financial Implications**	
	Has a financial evaluation form been completed, signed off by the Finance Lead / CFO, and appended to this report?	NA
	Are any financial implications detailed in the report?	Section 3
3.2	**Consultation and Engagement**	
	Has Comms & Engagement Checklist been completed?	NA
	Is actual or proposed engagement activity set out in the report?	NA
3.3	**Equality and Diversity**	
	Has an Equality Impact Assessment been completed and appended to this report?	NA
3.4	**Information Governance**	
	Have potential IG issues been identified in discussion with the IG Lead and included in the report?	NA
	Has a Privacy Impact Assessment been completed where appropriate (see IG Lead for details)	NA
3.5	**Environmental Sustainability**	
	Are any significant (positive or negative) impacts on the environment discussed in the report?	NA
3.6	**Human Resources**	
	Are any significant HR implications identified through discussion with the HR Business Partner discussed in the report?	NA

NHS
Barnsley Clinical Commissioning Group

NHS Barnsley Clinical Commissioning Group
Performance Report for Governing Body

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 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

Barnsley Clinical Commissioning Group

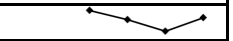
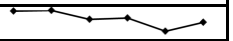
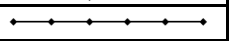
Exception Report 2017/18

Key Performance Indicators by Exception				
Indicator	**Target**	**Actual Period**	**Actual YTD**	**Period Performance**
% 4 hour A&E waiting times - seen within 4 hours - CCG (Monthly)	95.00%	91.58%	91.51%	In November, 91.58% (CCG) of patients were seen and treated within 4 hours. Year to date performance for Barnsley CCG for 2017/18 is 91.51%, missing target by 3.49%. The A&E delivery Board is continuing to oversee the implemention of the A&E improvement plan. Plans for Winter are also underway with detailed capacity plans in place to meet expected demand across acute, community, primary and social care. The new Primary Care Streaming Model with increased GP capacity went live week commencing 4 December 2017 and is seeing increased numbers of patients.
% 4 hour A&E waiting times - seen within 4 hours (Type 1 BHNFT) (Monthly)	95.00%	92.19%	91.74%	In November, 92.19% (BHNFT) of patients were seen and treated within 4 hours. Year to date performance for BHNFT for 2017/18 is 91.74% - below the required 90% associated with STF funding. Local data shows that December performance as at 27 December was 85.63%. With Q3 at 88.55%, and YTD 91.11%

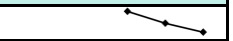
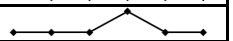
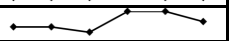
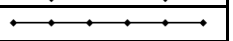
NHS
Barnsley Clinical Commissioning Group

Governing Body Report 2017/18

Performance					
Outcomes	**Target**	**Actual Period**	**Actual YTD**	**Period**	**Trend**
Improved Access to Psychological Services-IAPT: People entering treatment against level of need	1.25%	1.41%	1.30%	Nov-17	
Improved Access to Psychological Services-IAPT: People who complete treatment, moving to recovery	50.00%	52.15%	-	Nov-17	
Estimated diagnosis rate for people with dementia	66.70%	74.37%	73.91%	Nov-17	
Unplanned hospitalisation for chronic ambulatory care sensitive conditions - Yearly	1236	1248	-	YTD 2016/17	
Unplanned hospitalisation for chronic ambulatory care sensitive conditions - Current Provisional	1236	1255	July 2016 to June 2017 (Provisional)		
Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s - Yearly	344	279	-	YTD 2016/17	
Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s - Current Provisional	344	267	July 2016 to June 2017 (Provisional)		
Emergency admissions for acute conditions that should not usually require hospital admission - Yearly	1675	1671	-	YTD 2016/17	
Emergency admissions for acute conditions that should not usually require hospital admission - Current Provisional	1675	1642	July 2016 to June 2017 (Provisional)		
Emergency admissions for children with Lower Respiratory Tract Infections (LRTI) - Yearly	607	481	-	YTD 2016/17	
Emergency admissions for children with Lower Respiratory Tract Infections (LRTI) - Current Provisional	607	505	July 2016 to June 2017 (Provisional)		
% Patient experience of primary care - GP Services	84.93%	83.47%	-	Jul-17	
% Patient experience of primary care - GP Out of Hours services	66.96%	67.00%	-	Jul-17	
% 4 hour A&E waiting times - seen within 4 hours - CCG (Monthly)	95.00%	91.58%	91.51%	Nov-17	
% Patients on incomplete non-emergency pathways waiting no more than 18 weeks (Commissioner)	92.00%	92.43%	92.08%	Oct-17	
Number of 52 week Referral to Treatment Pathways Incomplete (Commissioner)	0	0	7	Oct-17	
% Patients waiting for diagnostic test waiting > than 6 wks from referral (Commissioner)	1.00%	0.89%	0.75%	Oct-17	
Cancer - % Patients seen within 2wks referred urgently by a GP	93.00%	95.87%	95.41%	Oct-17	
Cancer - % Patients referred with breast symptoms seen within 2 wks of referral	93.00%	100.00%	94.52%	Oct-17	
Cancer - % Patients seen within 31 days from referral to treatment	96.00%	99.26%	98.16%	Oct-17	
Cancer - % Patients seen within 31 days for subsequent treatment (Surgery)	94.00%	100.00%	99.38%	Oct-17	
Cancer - % Patients seen within 31 days for subsequent treatment (Drugs)	98.00%	100.00%	100.00%	Oct-17	
Cancer - % Patients seen within 31 days for subsequent treatment (Radiotherapy)	94.00%	100.00%	95.16%	Oct-17	
Cancer - % Patients seen within 62 days of referral from GP	85.00%	90.16%	89.81%	Oct-17	
Cancer - % Patients seen from referral within 62 days (Screening Service: Breast, Bowel & Cervical)	90.00%	87.50%	93.22%	Oct-17	
Cancer - % Patients being seen within 62 days (ref. Consultant)	85.00%	84.62%	83.10%	Oct-17	
Proportion of people on Care Programme Approach (CPA) who were followed upwithin 7 days of discharge	100.00%	98.15%	96.15%	Q2 17/18	
Urgent operations cancelled for a second time	0	0	0	Aug-17	
Ambulance handover delays of over 30 mins	0	147	1909	Nov-17	

Ambulance handover delays of over 1 hour	0	12	207	Nov-17	
Satisfaction with accessing primary care	85.00%	67.96%	-	Jul-17	
% Patient experience of primary care - GP Services	84.93%	83.47%	-	Jul-17	
Trolley waits in A&E -zero waits from decision to admit to admissions over 12 hours - BHNFT (Month)	0	0	0	Nov-17	
Improvement in health related quality of life for people with a long term mental health condition	0.53	0.44	-	YTD 2016/17	
Proportion of people waiting 18 weeks or less from referral to first IAPT treatment appointment	95.00%	99.46%	-	Nov-17	
Proportion of people waiting 6 weeks or less from referral to first IAPT treatment appointment	75.00%	81.75%	-	Nov-17	
Cancelled operations rebooked within 28 days	0	0	0	Aug-17	

Quality

Outcomes	Target	Actual Period	Actual YTD	Period	Trend
Patient experience of hospital care	77.3	75.8	-	YTD 2015/16	
Incidence of healthcare associated infection (HCAI) - MRSA (Commissioner)	0	0	2	Nov-17	
Incidence of healthcare associated infection (HCAI) - MRSA (Provider) - BHFT	0	0	1	Nov-17	
Incidence of healthcare associated infection (HCAI) - C.Diff (Commissioner)	3	4	35	Nov-17	
Incidence of healthcare associated infection (HCAI) - C.Diff (Provider) - BHFT	1	1	5	Nov-17	
Number of mixed sex accomodation breaches (Commissioner)	0	0	0	Oct-17	

Improving ambulance services: Changes to the way performance and quality are measured

1 December 2017

1. Purpose

The purpose of this paper is to update the Clinical Commissioning Group (CCG) Governing Body on the recent national work undertaken to improve ambulance service performance and develop a consistent framework for measurement of performance.

2. Executive summary

Following an extensive review of the way ambulance services in England assess 999 calls and allocate a response, in July 2017 the Secretary of State for Health approved a number of changes to the way ambulance services prioritise their work and their performance is measured. The changes made are designed to ensure:

- The sickest patients receive the fastest response
- Patients get the response they need first time, and in a timeframe that is appropriate for their condition
- Resources are spread more equally amongst all patients contacting the ambulance service and waits are reduced
- That people living in rural areas receive a more equitable response

These changes started being measured by the Yorkshire Ambulance Service (YAS) from 1 September 2017.

3. Background

Since the 1974, ambulance services across the UK have been assessed on their ability to achieve time based response times and meet various clinical quality indicators. This was borne out of a belief that the quicker someone was seen and/or taken to hospital the better the outcome. Over time a number of factors have changed that thinking:

- The training, clinical education and development of the ambulance workforce has improved meaning greater capability to treat on scene rather than convey to hospital.
- Patients would prefer to be treated on scene where this is appropriate and clinically safe.
- Clinical effectiveness has improved. Whilst some people dialling 999 will still need immediate treatment, for example to stem blood loss and others with

serious conditions will need treatment in an acute care setting e.g. stroke patients others some can be managed safely and to a high standard of care without conveyance to hospital.
- The nature of the reasons people dial 999 for has changed over time due to the aging UK population and the availability of alternative services e.g. NHS 111. Many 999 calls now relate to urgent care for people with long term conditions rather than life threatening emergencies.

In addition, emergency ambulance providers have themselves found the historic service standards have distorted behaviour. This can include:

- Dispatching resources to a 999 call, on blue lights and sirens, before it has been determined what the problem is, and whether an ambulance is actually required.
- Dispatching multiple ambulance vehicles to the same patient, on blue lights and sirens, and then standing down the vehicles least likely to arrive first.
- Diverting ambulance vehicles from one call to another repeatedly, so that ambulance clinicians are chasing time standards rather than focussing on patients care needs.
- Using a 'fast response car' to 'stop the clock', when this unit may provide little clinical value to the patient (e.g. stroke patient), who then has to wait a long time for a conveying ambulance to arrive.
- Patients receiving very long waits for lower priority (green) calls that nevertheless need assessment and conveyance to hospital, and some of which concern time sensitive problems

4. Development process

As part of the review of urgent and emergency care led by Sir Bruce Keogh, http://www.nhs.uk/NHSEngland/keogh-review/Documents/UECR.Ph1Report.FV.pdf a service improvement programme called the Ambulance Response Programme (ARP) was designed around three overarching improvement objectives:

- Prioritising the sickest patients to ensure they receive the fastest response.
- Driving clinically and operationally efficient behaviours, so the patient receives the response they need first time and in a clinically appropriate timeframe.
- Reducing long waits by ensuring resources are distributed more equitably amongst patients

The ARP established a number of working groups that looked at:

4.1 Despatch on Disposition (DoD)

Ambulance trusts felt that the existing national target of 60 seconds to triage and dispatch a resource wasn't enough time to do this effectively. Pilots were established within a small number of ambulance trusts to allow them longer to determine the nature of the call before deciding to despatch a response. The changes were piloted and evaluated and gradually expanded to a larger number of ambulance services. The objectives were:

- Better responses to Red1 incidents: faster dispatch to the most critical calls.
- Ensure resources more available (through less multiple dispatches to single incidents) to respond to life threatening immediate calls.
- Dispatch of the most clinically appropriate resource (single-crew, double-crew, local responder) to patients by taking a little more time to triage the call.
- Increase 'Hear & Treat' during the call – no ambulance is dispatched if inappropriate.
- Increase 'See & Treat' on scene with no conveyance from scene of incident.
- Improve speed of conveyance for patients for whom time of conveyance is critical e.g. cardiac and stroke patients.

4.2 Coding changes

ARP also looked at how 999 calls were coded once received. The coding determines the priority of response. Traditionally calls were allocated a response code: red, amber or green and an associated response timeframe.

The working group found the coding model used was no longer for purpose with many calls being coded 'higher' than was necessary. Work was undertaken to review the data and reach consensus as to which codes (presenting clinical conditions) could be moved safely to a different response category. These codes were tested with an external reference group, including patient representatives and other stakeholders.

5.0 Evaluation of pilots

The ARP development work was overseen by a group of leaders (including commissioners) working in the field and was monitored for safety and evaluated on a regular basis.

Early on NHS England identified Sheffield university as an academic partner to conduct a thorough evaluation. The University of Sheffield published their final report in July 2017 and it can be found at:
https://www.england.nhs.uk/wp-content/uploads/2017/07/ARPReport_Final.pdf
In summary, the main findings of the ARP are that:

- Giving call handlers more time to assess a call is beneficial
- The most urgent emergency calls do not receive a slower response when call handlers have this extra time available
- The ambulance service becomes more efficient, and there are less long waits for an ambulance to arrive
- Patients in rural areas get a response more like urban areas
- In over 14 million 999 calls analysed no patient came to harm as a result of the ARP
- Ambulance staff acknowledge that the changes are beneficial to patients and to staff. They said:

    - Additional time for call assessment is a positive step;
    - Workload management is clearer for the people who allocate and send ambulance vehicles. This helps them to prioritise the sickest patients;
    - Ambulance crews in rapid response cars feel they are sent to more appropriate patients;
    - There are fewer “stand downs”, where vehicles are cancelled before arrival;
    - Fewer stand downs are better for public safety as there are fewer ambulance vehicles travelling at high speeds on the roads.
    - ambulance services are better able to manage their workload, and are less vulnerable to peaks in demand.
    - Staff recognise that the changes are designed to be more focused on patients than simply chasing a time target. This leads to staff being more satisfied that they are doing the right thing for patients.

6.0 New ambulance performance and clinical quality measures

On 13th July 2017 the Secretary of State for Health accepted five recommendations:

- That DoD is adopted as a permanent change in England.
- That all ambulance services adopt the three pre-triage questions. The early identification of potential cardiac arrest patients should be introduced as a new ambulance performance indicator.
- That the new clinical prioritisation set is adopted permanently in England.
- That the current ambulance performance indicators are replaced, and that a 90th centile response time standard is adopted in England.
- That a new updated and expanded programme of Clinical Quality Indicators (CQIs) be introduced in England.

999 calls will be prioritised into one of four new categories:

–Category 1 (Purple) – Life threatening
–Category 2 (Amber) – Emergency

–Category 3 (Yellow) – Urgent
–Category 4 (Green) – Less Urgent

ARP sets the bar at 90%, rather than 75%, so 9 in 10 patients have to hit the target in order to meet the standard. Measurement will be around the mean, rather than median response times, so every single patient counts towards the time target.

A time standard will apply to every patient to whom a vehicle is sent. Apart from the most urgent cases (Cat 1), when a patient needs to be transported only the arrival of the conveying ambulance will 'stop the clock'. This aims to reduce long waits for both a response and a transporting vehicle.

NHS England will also be introducing a new set of Ambulance Quality Indicators (AQIs) to measure the time between the 999 call and receiving life-saving treatment for heart attack and stroke, as well as cardiac arrest survival. These will be followed by new measures for patients with sepsis, and people who have fallen and are still on the floor.

New AQIs will include reporting of data across the patient pathway as ambulance Trusts begin to utilise national outcome databases. Reporting will move to a quarterly schedule to better monitor trends ahead of full publication in April 2018 due to the preparatory work required for a new stroke indicator. The STEMI and Cardiac Arrest outcome data, which are unchanged, will be available ahead of this.

The new quality indicators include revised and standardised definitions for "Hear and Treat" and "See and Treat" which will impact on reporting of these two interventions.

The revised quality indicators are being adopted by ambulance trusts as they move to the ARP system during the period July to November 2017. During this period there will be two sets of national standards in place and ambulance services will report on those associated with their operating system; ARP or non-ARP. These two sets are not comparable.

7.0 Next steps

a. Nationally, the ARP work will continue under the auspices of the Ambulance Integration Programme (AIP) which has commissioner representation. New Ambulance System Indicators have been published https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2013/04/20170811-Ambulance-System-Indicators.docx and a full suite of ambulance reporting can be found at https://www.england.nhs.uk/statistics/statistical-work-areas/ambulance-quality-indicators/

b. NHS England has updated the NHS Constitution to accommodate the changes to the way ambulance performance is measured https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/642390/NHS_constitution_addendum_September_2017.pdf and confirmed that ambulance trusts must not have financial sanctions directly applied in 2017-19 for non-delivery of the new performance standards.

c. YAS have indicated to commissioners that they are in the process of undertaking an impact assessment of the new changes. YAS commissioners have similarly indicated that they wish to receive a trajectory for performance for 2018-19 against all the new categories.

d. Commissioners and YAS remain in dialogue regarding agreement of a contract variation embedding the new standards into the YAS 999 contract.

e. Nationally, ambulance commissioners will continue to encourage NHS England to review the four national ambulance currencies to bring them into line with the new standards.

f. At a Y&H level performance against the new measures will be monitored, as now, through the 999 Contract Management Board which has representation from the coordinating commissioner and Sustainability and Transformation Partnership (STP)/ Accountable Care System (ACS) sub regions. Y&H CCGs are sent performance updates on a weekly basis with a more detailed report being made available monthly.

g. Over the next few months further engagement with Y&H CCGs/STPs/ACS will be undertaken regarding the ARP changes. This will happen at two levels:

h. YAS and a 999 coordinating commissioner representative will attend will attend STP/ACS meetings to discuss the changes.

i. A workshop for CCG Business Intelligence leads/ CCG Directors of Performance will be held in each of the STP/ACS sub regions in January/February 2018 to discuss in detail the ARP changes and to inform the narrative within CCG Governing Body Board reports. These workshops will be supported by Y&H CCGs, YAS, Embed Health Consortium and North of England Commissioning Support.

8.0 Action for Governing Body/Recommendations

The x Governing Body is asked to note the positive outcomes of the ambulance response programme and the changes to reporting from 1 September 2017.

Appendix 1 – Ambulance Performance Indicators (Abridged)

Category	Percentage of calls in this category	National Standard	When does the clock start?	What stops the clock?
Category 1	8%	7 minutes mean response time 15 minutes 90th centile response time	The earliest of: •The problem is identified •An ambulance response is dispatched •30 seconds from the call being connected	The first ambulance service-dispatched emergency responder arrives at the scene of the incident (There is an additional Category 1 transport standard to ensure that these patients also receive early ambulance transportation)
Category 2	48%	18 minutes mean response time 40 minutes 90th centile response time	The earliest of: •The problem is identified •An ambulance response is dispatched •240 seconds from the call being connected	If a patient is transported by an emergency vehicle, only the arrival of the transporting vehicle stops the clock. If the patient does not need transport the first ambulance service-dispatched emergency responder arrives at the scene of the incident
Category 3	34%	120 minutes 90th centile response time	The earliest of: •The problem is identified •An ambulance response is dispatched •240 seconds from the call being connected	If a patient is transported by an emergency vehicle, only the arrival of the transporting vehicle stops the clock. If the patient does not need transport the first ambulance service-dispatched emergency responder arrives at the scene of the incident
Category 4	10%	180 minutes 90th centile response time	The earliest of: •The problem is identified •An ambulance response is dispatched •240 seconds from the call being connected	Category 4T: If a patient is transported by an emergency vehicle, only the arrival of the transporting vehicle stops the clock

Coding categories explained:

Identifier	Clock start	Response measure	Definition	Comment
Category 1 Purple	Problem identified Allocation 30 seconds	Mean (7 mins) 90th Percentile (15 mins)	Time critical life-threatening event needing immediate intervention and/or resuscitation. Example – Cardiac or respiratory arrest; airway obstruction; ineffective breathing; unconscious with abnormal or noisy breathing; hanging. Mortality rates high, a difference of one minute in response time is likely to affect outcome and there is evidence to support the fastest response.	Sub-category of C1T (transport) will be monitored with a view to a future standard regarding transport.

Identifier	Clock start	Response measure	Definition	Comment
Category 2 Amber	Allocation MPDS Code 240 seconds	Mean (18 mins) 90th Percentile (40 mins)	Potentially serious conditions (ABCD problem) that may require rapid assessment, urgent on-scene intervention and/or urgent transport. Example – Probable MI, serious injury, stroke, sepsis, major burns, fits, unconscious with normal breathing. Mortality rates are lower; there is evidence to support early dispatch.	

Identifier	Clock start	Response measure	Definition	Comment
Category 3 yellow	Allocation MPDS Code 240 seconds	90th Percentile (120 mins)	Urgent problem (not immediately life-threatening) that needs treatment to relieve suffering (e.g. pain control) and transport or assessment and management at scene with referral where needed within a clinically appropriate timeframe. Example – serious injury modalities without systemic compromise; burns (not major); non-emergency late pregnancy/childbirth problems; uncomplicated diabetic hyper/hypoglycaemia; not immediately at risk drug overdoses; non-emergency injuries; abdominal pain. Mortality rates are very low or zero; there is evidence to support alternative pathways of care.	

Identifier	Clock start	Response measure	Definition	Comment
Category 4T (Transport) GreenT Category 4H (Hear & Treat) GreenT	Allocation MPDS Code 240 seconds	90th Percentile (180 mins)	Problems that are not urgent but need assessment (face to face or telephone) and possibly transport within a clinically appropriate timeframe. **C4T** – 999 or 111 calls that may require a face to face ambulance clinician assessment, or requests for transport by health care professionals. **C4H** – Calls that do not require an ambulance response but do require onward referral or attendance of non-ambulance provider in line with locally agreed plans or dispositions, or can be closed with advice (hear and treat).	

NHS
Barnsley Clinical Commissioning Group
Putting Barnsley People First

NHS Barnsley Clinical Commissioning Group

Finance Report 2017/18

Month 8

1 Headline Messages and contents

Headline Messages	Contents	
• The CCG continues to forecast achievement of financial duties and planning guidance requirements, with an in-year balanced budget position. Further information on the CCG's financial performance targets is provided in section 2. • The CCG's Efficiency Programme Management Office (PMO) monitor and review delivery of the CCG's £11.5m efficiency programme. In the year-to-date (YTD), the CCG is reporting achievement of £10.6m against plan; however, it is important to note that NHS BSA Prescribing data in only available to Month 6 and therefore the £4.2m YTD position reported by the Head of Medicines Optimisation has not yet been fully confirmed through actual prescribing data. Internal validation is however undertaken by the Head of Medicines Optimisation to validate the reported position. The forecast position shows full achievement against the £11.5m target. • Barnsley Hospital NHS Foundation Trust (BHNFT) contract activity data has been received for Month 7 (flex) and is showing a forecast overtrade of £5.5m. This forecast is based on an assumption that non elective activity continues to be above plan during the winter months to yearend and that overtrades on elective and daycase activity continue. Work continues on reviewing activity, particularly in areas such as daycase and elective where there has been a significant reduction in the numbers of outpatient attendances. • Other Acute contract activity to Month 7 (flex) is showing a forecast underspend position across all providers of £1.9m. Variances are across a variety of delivery points and specialities, with activity at private providers continuing to decrease in Trauma and Orthopaedics. All contracts will continue to be monitored to ensure further potential risks are reported. • Month 6 data has now been received for Primary Care prescribing budgets from NHS BSA and is showing a total forecast overspend of £296k against budget. The shift in position from Month 7 is due to Cat M clawback and NCSO drugs pressures of £2.1m now being part of the forecast position. Underspends continue on practice prescribing (£169k), central drugs (£678k), home oxygen (£53k) and income recharges (£589k, including Flu recharge to NHSE). This will continue to be closely monitored as further data is received and validated. • Risks and mitigations were considered by the Finance and Performance Committee. The current projections in the 'Most Likely' scenario indicate a potential net mitigation of £2,052k that will offset the current forecast overspend of £1,266k in section 3, with 'headroom' of approximately £786k. This headroom will cover any further risk associated with contract activity overtrading, particularly during the winter period.	1 2 3	Headline Messages and Content Financial Performance Targets Monthly Finance Monitoring Statement – Executive Summary

2 Financial Performance Targets

1) Financial Duties

NHS Act Section	Duty	2017/18 Target £'000	2017/18 Forecast Performance £'000	2017/18 Forecast Achievement
223H (1)	Expenditure not to exceed income	411,964	411,964	YES
223I (2)	Capital resource use does not exceed the amount specified in Directions	0	0	YES
223I (3)	Revenue resource use does not exceed the amount specified in Directions	411,412	411,412	YES
223J(1)	Capital resource use on specified matter(s) does not exceed the amount specified in Directions	0	0	YES
223J(2)	Revenue resource use on specified matter(s) does not exceed the amount specified in Directions (Note 1)	405,775	406,340	YES
223J(3)	Revenue administration resource use does not exceed the amount specified in Directions	5,637	5,072	YES

2) Financial targets/NHS England Business Rules requirements

Target/Business Rule Requirement	2017/18 Target	2017/18 Forecast Performance £'000	2017/18 Forecast Achievement
Delivery of in year balanced position	0	0	YES
0.5% Contingency to manage in-year pressures (Note 2)	2,052,000	2,052,000	YES
1% non-recurrent reserve - 50% to remain uncommitted, to act as an NHS system risk reserve. (Note 2)	1,868,005	1,868,005	YES

Comments

The CCG continues to forecast to achieve all financial duties/targets and NHS England (NHSE) Business Rules, this is however predicated on the assumption that there will be no further significant risks to the in-year forecast position above those noted within this report.

Note 1: This figure represents the revenue resource allocated for programme expenditure. It can be exceeded to the extent that it can be compensated for by underspends against the administration resource allocation. The CCG plans to utilise £565k of administration resource to cover additional spending on commissioned services for the population of Barnsley.

Note 2: These figures, both represent 0.5% of CCG resource allocation; however the 1% non recurrent reserve does not include Primary Care Co-Commissioning budgets in the calculation.

3 Monthly Finance Monitoring Statement – Executive Summary

PROGRAMME AND RUNNING COST AREAS	ANNUAL BUDGET RECURRENT £000	ANNUAL BUDGET NON RECURRENT £000	TOTAL ANNUAL BUDGET £000	YTD BUDGET £'000	YTD ACTUAL £'000	YTD VARIANCE OVER / (UNDER) £	FORECAST OUTTURN £000	FORECAST VARIANCE OVER / (UNDER) £000
PROGRAMME EXPENDITURE								
Acute	199,933	568	200,501	133,682	132,558	(1,124)	202,180	1,679
Mental Health	33,226	204	33,430	22,191	22,354	163	33,664	234
Community Health	36,425	211	36,637	24,468	24,475	7	36,639	3
Primary Medical Services (Co-Commissioning)	34,708	0	34,708	23,138	23,125	(12)	34,750	41
Primary Care Other	57,168	174	57,342	38,469	37,650	(819)	57,357	15
Continuing Health Care	16,312	184	16,496	10,997	10,698	(299)	16,510	14
Other Programme Costs	19,268	(273)	18,995	12,648	12,493	(156)	18,749	(247)
TOTAL COMMISSIONING SERVICES (INCLUDING PRIMARY CARE RESERVES)	**397,041**	**1,068**	**398,109**	**265,593**	**263,353**	**(2,240)**	**399,848**	**1,738**
Corporate Costs	2,395	24	2,419	1,612	1,277	(335)	2,115	(304)
Depreciation / Property Charges	673	0	673	449	473	24	712	39
TOTAL CORPORATE COSTS	**3,068**	**24**	**3,092**	**2,061**	**1,750**	**(311)**	**2,827**	**(265)**
TOTAL PROGRAMME COSTS (INCLUDING PRIMARY CARE RESERVES)	**400,109**	**1,092**	**401,201**	**267,654**	**265,103**	**(2,551)**	**402,675**	**1,474**
RUNNING COSTS								
Pay	3,264	28	3,292	2,197	1,900	(297)	3,179	(113)
Non Pay	1,904	272	2,177	1,451	1,271	(179)	2,060	(117)
Income	(181)	0	(181)	(121)	(109)	12	(168)	14
TOTAL RUNNING COSTS	**4,987**	**300**	**5,287**	**3,527**	**3,062**	**(463)**	**5,071**	**(216)**
Other Plans required to deliver Target Efficiency Programme	(7)	0	(7)	7	0	(7)	0	7
CCG Reserves	7	2,714	2,721	(2,758)	0	2,758	2,721	0
NHS England Planning Guidance Reserves	342	1,868	2,210	0	0	0	2,210	0
In Year (Over)/underspend	0	0	0	0	264	264	(1,266)	(1,266)
TOTAL RESERVES/CONTINGENCY (EXCL. PRIMARY CARE RESERVES)	**342**	**4,582**	**4,924**	**(2,751)**	**264**	**3,015**	**3,665**	**(1,259)**
TOTAL EXPENDITURE	**405,437**	**5,975**	**411,412**	**268,430**	**268,430**	**(0)**	**411,412**	**(0)**
Programme	410,333	(4,558)	405,775	264,903	264,903	0	405,775	0
Running Costs	5,487	150	5,637	3,527	3,527	0	5,637	0
RESOURCE ALLOCATIONS	**415,820**	**(4,408)**	**411,412**	**268,430**	**268,430**	**0**	**411,412**	**0**
SURPLUS/(DEFICIT)	**10,384**	**(10,383)**	**(0)**	**0**	**0**	**0**	**0**	**0**

Comments

- Acute expenditure and forecasts reflect month 7 (flex) data. Pressures continue to be experienced at BHNFT with the forecast overtrade of £5.4m; this pressure is offset with activity across other acute providers being below plan and the release of the contract risk reserve.
- Prescribing forecasts are now showing an overspend of £296k against budget due to NCSO and the Cat M clawback of £2.1m now being included within the forecast position. Underspends continue on practice prescribing, central drugs, home oxygen and income recharges. This will continue to be closely monitored as further data is received and validated.
- Other forecasts continue to be broadly in line with budget.

NHS
Barnsley Clinical Commissioning Group
Putting Barnsley People First

GOVERNING BODY

11 January 2018

Quality, Innovation, Productivity and Prevention (QIPP) Programme Reporting

1.	**THIS PAPER IS FOR**						
	Decision		*Approval*		*Assurance*	X	*Information*	X
2.	**REPORT OF**						

	Name	*Designation*
Executive Lead	Jamie Wike	Head of Planning, Delivery and Performance
Author	Jamie Wike	Head of Planning, Delivery and Performance

3.	**EXECUTIVE SUMMARY**
3.1	The QIPP programme reporting dashboard aims to provide the Governing Body with an overview of progress and performance against the schemes within the CCG QIPP/Efficiency Programme. The progress of each scheme has been reviewed by the QIPP Delivery Group and the dashboard has been reviewed by the Finance and Performance Committee.
3.2	The dashboard attached at Appendix 1 is intended to provide the Governing Body with a high level overview of current delivery of the QIPP programme with this covering report providing details of any areas highlighted by the Finance and Performance Committee for the attention of the Governing Body. The schemes and projects included within the dashboard include those which are being delivered in 2017/18 but with savings expected in 2018/19.
3.6	On reviewing the dashboard and discussing progress against CCG QIPP/Efficiency Programme, the Finance and Performance Committee highlighted the following areas for the attention of the Governing Body in order to provide assurance that appropriate action is being taken to mitigate any risks to delivery of the programme: • The need to firm up and agree expected impacts (financial and activity) for those schemes where this has not been finalised. • The PMO were requested to continue follow up on schemes not on track and ensure support is provided to bring projects in line with project plans/timescales. • The requirement to identify opportunities which could be brought forward to deliver further efficiency savings during 2017/18 should contract overtrading continue to be experienced.

4.	**THE GOVERNING BODY IS ASKED TO:**
	• Note the contents of this report and the dashboard attached at Appendix 1.
5.	**APPENDICES**
	• Appendix A – QIPP Reporting and Escalation Dashboard

Agenda time allocation for report:	*10 mins*

PART 1B – SUPPORTING INFORMATION

1.	Links to the Governing Body Assurance Framework	Risk ref(s)
	This report provides assurance against the following risks on the Governing Body Assurance Framework:	6
2.	**Links to CCG's Corporate Objectives**	**Y/N**
	To have the highest quality of governance and processes to support its business	Y
	To commission high quality health care that meets the needs of individuals and groups	Y
	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	Y
	To develop services through real partnerships with mutual accountability and strong governance that improve health and health care and effectively use the Barnsley £.	Y
3.	**Governance Arrangements Checklist**	
3.1	**Financial Implications**	
	Has a financial evaluation form been completed, signed off by the Finance Lead / CFO, and appended to this report?	*NA*
	Are any financial implications detailed in the report?	*NA*
	Whilst no financial evaluation form has been completed and there are no direct financial implication relating to this report, the report and attached dashboard do provide an overview of financial performance against the CCG efficiency plans. The Integrated Performance Report provides further details relating to current reported financial performance against the CCG Efficiency Plan.	
3.2	**Consultation and Engagement**	
	Has Comms & Engagement Checklist been completed?	*NA*
	Is actual or proposed engagement activity set out in the report?	*NA*
3.3	**Equality and Diversity**	
	Has an Equality Impact Assessment been completed and appended to this report?	*NA*
3.4	**Information Governance**	
	Have potential IG issues been identified in discussion with the IG Lead and included in the report?	*NA*
	Has a Privacy Impact Assessment been completed where appropriate (see IG Lead for details)	*NA*
3.5	**Environmental Sustainability**	
	Are any significant (positive or negative) impacts on the environment discussed in the report?	*NA*
3.6	**Human Resources**	
	Are any significant HR implications identified through discussion with the HR Business Partner discussed in the report?	*NA*

Quality Innovation Productivity and Prevention (QIPP) Programme Reporting and Escalation Dashboard

This monthly QIPP programme dashboard is intended to be used to provide an overview of current delivery of the QIPP programme. The dashboard is set out in 2 distinct sections, one to provide assurance on the delivery of QIPP schemes/projects, the second to set out any risks or issues identified by the QIPP delivery Group. The Integrated Performance Report provides a further source of assurance in relation to delivery of the specific areas of the QIPP programme which contribute to the CCG efficiency programme.

QIPP Shemes and Projects

Scheme Status (RAG)

	Project	Objectives	Finance	Commentary
Clinical Thresholds Wave 1				The status for delivery is amber to reflect some challenges around implementation of audit processes of financial savings is currently red to reflect the impact of remodelling work and reduction in expected savings to be achieved in 2017/18.
Map of Medicine				MOM Implemented in all practices and activity levels being monitored and reviewed
Prescribing - Medicines Optimisation				Practices are completing work earlier than planned allowing for earlier reporting of end of year position ahead of phasing targets. Monitoring is taking place of other potential growth pressures in prescribing to identify any risks to the financial savings.
Intermediate Care				Implementation of new model ongoing in line with plans.
GP Out of Hours				Procurement concluded and revised contract value agreed.
Lower Back Acupuncture				Lower back acupuncture has been decommissioned
Care Navigation				Project is on track in line plan
Social Prescribing				Cohort 1 - Core Service is in place and a high level of referrals being received with positive impacts made. Cohort 2 - Implementation delays however work has commenced to support HIU of ED. Specialist advisor has been appointed by the provider. Impact currently being reviewed.

GB/Pu/18/01/13.1

	Project	Objectives	Finance	Commentary
Diabetes *This project is being delivered in 2017/18 however there are no efficiencies identified within the 2017/18 QIPP Plan*				Procurement processes concluded in line with plan. Financial savings may not be relaeased and need to be reviewed following the procurement to inform 2018/19 plans.
Respiratory				Net savings have been revised to take account of delays in mobilisation linked to HR issues. Delivery of objectives is also rated as amber due to these delays.
Clinical Thresholds Wave 2				Agreement to delay implementation resulted in reduction in level of anticipated savings. Delivery of objectives is amber as the new policy is yet to go live
Clinical Thresholds - Compliance with existing policies				Policies in place and monitoring arrangements in place however further work is ongoing to agree expected saving in line with modelling work relating to wave 1.
CVD - Atrial Fibrillation				No anticipated savings in 2017/18. Work is ongoing in line with plan with the pilot practices - 71 additional patients have been identified and treated. Prescribing costs are higher than initially anticipated.
Care Homes				Project being progressed however there have been some slippages. There has been a significant reduction in admissions from Care Homes however the cost of admissions is increasing.
Prescribing - Medicines Ordering, Safety and Waste				Currently on track

RAG - Red = Off track, significant resk to delivery - Amber = Off track but plans to recover - Green = On track

* At this point it has not been possible to validate acute contract and other activity data to assess the delivery of the anticipated activity reduction.

Issues and Risks for Escalation

Overall the key projects are being delivered in line with plan however in some areas the level of savings included in the origibnal plan may not be achieved.

The IPR provides financial details of the YTD position being reported at month 8.

The key risk to delivery of the required efficiency savings as part of the QIPP plan is that delivery of all the projects which are currently identified to achieve savings in 2017/18 will not achieve the required level of net savings.

Taking account of all currently agreed schemes which are rated as green and other mitigating actions, the current forecast is to deliver the £11.5m target. The Programme Management Office (PMO) contine to explore 'Amber', 'Red' rated schemes and schemes in the pipeline to ensure delivery of the £11.5m target and mitigate any contract overtrading above the 0.5% contingency.

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 7 December 2017 at 10.30am in the Boardroom, Hillder House, 49 – 51 Gawber Road, Barnsley S75 2PY.

PRESENT:

Dr Nick Balac (Chair)	- Chair
Dr John Harban	- Elected Member Governing Body - Contracting
Lesley Smith	- Chief Officer
Roxanna Naylor	- Acting Chief Finance Officer
Dr James Holloway	- Elected Member Governing Body
Jamie Wike	- Head of Planning, Delivery & Performance
Dr Madhavi Guntamukkala	- Elected Member Governing Body
Nigel Bell	- Lay Member Governance
Dr Andrew Mills	- Membership Council Member

IN ATTENDANCE:

Leanne Whitehead	- Executive Personal Assistant

APOLOGIES:

Patrick Otway	- Head of Commissioning (MH, Children, Specialised)

Agenda Item		Action & Deadline
FPC17/198	**QUORACY**	
	The meeting was declared quorate.	
FPC17/199	**DECLARATIONS OF INTEREST, SPONSORSHIP, HOSPITALITY AND GIFTS RELEVENT TO THE AGENDA**	
	The Committee noted the declarations of interest report. The Chair, Dr J Harban and Dr A Mills declared there could be a conflict of interest on Item 9 – De-Commissioning of Services for vasectomy and carpal tunnel. It was reported that no decisions were being asked of the Committee and was a discussion only and so the Committee decided that colleagues could remain in the room but not take part in discussion.	
FPC17/200	**MINUTES OF THE PREVIOUS MEETING HELD ON 2 NOVEMBER2017** – Approved.	
FPC17/201	**MATTERS ARISING REPORT**	
	FPC17/178 Matters Arising – Update on Contracting Cycle All staff now in place for the Breathe Service and information packs had been circulated to practices and so far received well. This action was now complete.	

Adopted

	FPC17/123 Update on Contracting Cycle Dr J Harban reported that this action was now complete he had spoken with the Comms team about the breathe service and a piece was done on Look North and within the Friday Roundup. **Agreed Action:** • **Chair asked Committee Secretary to check what information was shared for Breathe.** **The Committee received and noted the report.**	**LW**
FPC17/202	**UPDATE ON RECENT PUBLISHED AND EXPECTED GUIDANCE** – No update to report.	
FPC17/203	**UPDATE ON CONTRACTING CYCLE**	
	The Acting Chief Finance Officer presented the report to the Committee. It was reported that the Breathe Respiratory Service was on track however it is expected that BHNFT will not sign the contract due to a dispute relating to a specific KPI, these had not changed however are now being contested. The Trust do not agree to the 40% reduction target in non-elective activity and the penalty associated with non achievement of this. It was reported that both SWYPFT and BHNFT had confirmed there acceptance of the changes to the contract documentation that was previously circulated. **Agreed Actions:** • **A response was still awaited for BHF on the new contract documentation, this had been chased but no response had yet been received, Dr J Harban suggested writing to BHF's Chair on this matter.** The Committee were asked to note that Thames Ambulance Service (TASL) – PTS Contract had been issued with three contract performance notices on the 6 November 2017. It was noted that a contract performance meeting was held on the 13 November 2017 to discuss the notes and gain assurance on these issues, an action plan had been received and was currently under review by the Finance and Contracting Team. It was noted that there were some ongoing issues relating to Spa Medica and the CCG had spoken with NHS England in regards to this activity and were advised to issue a contract to Spa Medica. It was felt this was against procurement law further advice was being sought and update would follow. It was reported that all current contracts were 2 year contracts for the period 2017-19 and the CCG were proposing a light touch review of activity and finance for 2018/19, letters will be sent to	**RN**

Adopted

	BHNFT and SWYPFT to set out this approach. The Chief Officer noted that a conversation with colleagues at NHS England seemed to suggest negotiations would be reopened with providers. The Chief Officer agreed to follow this up with Alison Knowles at NHS England to confirm the position. Discussion was had on activity within day cases for injections of therapeutic substance especially over the weekend as this should be done as part of MSK for most with the exceptions of hips/back etc. Following the findings of this activity review, clinical input would be required before a decision to de-commission was taken. **Agreed Actions:** • **Acting Chief Finance Officer to find out activity for day case joint injections over the weekends.** • **Clinical input required following these findings.** • **Primary Care to explore joint injections training.** • **Chief Officer to following up previous conversation with Alison Knowles in relation to re-opening contracts, to understand this better.** **The Committee noted the contents of the report including:** • **the update on the Alliance 2017-19 contract** • **the update on 2017/18 Contract Monitoring** • **the contract performance notices for Thames Ambulance Service** • **the update on Non Contracted activity with Spa Medica** • **the update on the 2018/19 contract planning round**	**RN** **RN/JH** **NB** **LS**
FPC17/204	**APPROVAL AND OR UPDATE ON PROCUREMENTS**	
	The Committee received the report on Procurement Updates the report provided an update on: • Barnsley Integrated Diabetes Services: Community Specialist Nurse and Outpatient Provision • Community Musculoskeletal Clinical Triage, Assessment and Treatment Service • Sheffield City Region Health-Led Employment Trial • AQP Vasectomy and AQP Carpal Tunnel and Nerve Conduction Studies **The Committee received and noted the report.**	
FPC17/205	**DE-COMMISSIONING OF SERVICES**	
	Following discussion at item 3 on DOI relevant to the Agenda the Chair, Dr A Mills and Dr J Harban were not to participate in any decisions in relation to vasectomy or carpal tunnel services.	

Accepted

	Discussion was had in relation to services that could potentially be de-commissioned and to work through these options for consideration. Discussion was had around ECG machines which had previously been purchased for practices and was noted that not all were being used. It was noted that more work needed to be completed before letters could be issued in relation to de-commissioning of services. **Agreed Actions:** • **Acting Chief Finance Officer to pick up ECG machines with Catherine Wormstone.** • **Acting Chief Finance Officer to check if CCG agreed to pay license for ECG machines at £120.** **The Committee received and noted the verbal update.**	**RN** **RN**
FPC17/206	**INTEGRATED PERFORMANCE REPORT**	
	<u>Performance</u> The Head of Planning, Delivery and Performance updated members on the performance section of the report with the following areas highlighted with exception: • The 4 hour standard for patients waiting in A&E (Commissioner and Barnsley Hospital) • The number of 52 week referral to treatment pathways (incomplete) It was noted that A&E performance was still above 90% for the year to date and good in comparison to other areas, however performance was volatile with strong performance in September and November but dips in October and from the end of November up to date with December performance at 77%. Discussion was had around the intermediate care beds/ward as this could have caused issues within A&E. It was noted that the new service of primary care streaming in A&E had started on Monday which had seen 50 patients and all were sent home which the Committee found very encouraging. Discussion was had about some additional winter monies that may become available nationally and the Trust had put a request in for an additional ward for 4 months. It was also noted that changes to Ambulance Performance Reporting had taken place as a result of roll out nationally of the Ambulance Response Pilot reporting standards. A paper has been received describing the changes and the impact of these on performance and the way ambulance services respond to 999 calls. It was agreed that this be presented to the Committee in January 2018.	

Adopted

	Agreed Actions: • **Head of Planning, Delivery and Performance to present a paper on changes to Ambulance reporting and performance standards at January meeting** Finance The Acting Chief Finance Officer presented the finance section of the report to Committee highlighting that the CCG continues to forecast to achieve all financial duties and planning guidance requirements, with an in-year balanced budget position. The forecast position, after risk assessment had improved from the position reported in Month 6 due to reductions in acute contract activity and reductions in the cost and numbers of continuing care packages. The month 7 forecast overspend is £694k this is offset by a net mitigation of £852k, which provides headroom of £158k. As previously reported any further risk/contract overtrading will require additional savings to be generated in order to achieve financial duties. The position as at 31 October reported that efficiency schemes whilst planned schemes have not delivered in line with expectation, other budget reductions have contributed to the efficiency programme to allow the target of £11.5m to be achieved. The Committee were asked to be thinking about next year's QIPP target. **The Committee received and noted the report including:** • **2017/18 performance to date and the YAS briefing note attached at Appendix 2** • **continued projected delivery of all financial duties, predicated on the assumptions outlined in this paper** • **the update on the CCG's efficiency programme and delivery of the £11.5m target.** • **the potential requirement that further efficiencies need to be explored to mitigate any financial risk associated with increasing acute contract activity pressures.**	**JW**
FPC17/207	**QIPP PROGRAMME REPORTING**	
	The Head of Planning, Delivery and Performance presented an update on the QIPP Programme to the Committee. It was reported that all projects were progressing and in line where they would expect them to be, the challenge is seeing the finances coming through with the projects reporting red on finances these should start to see some impact. It was noted that the Head of Planning, Delivery and Performance was working with project leads to see more information on the schemes.	

Approved

	Information on demand management was shared with the Committee noting that the 10% reduction in activity target had slipped a little from month 6 to 7 but this would be picked up at relevant locality meetings. It was noted that consultant to consultant referrals were still high. **The Committee were asked to:** • **Note the content of the dashboard and identify any specific actions that the committee agree in relation to the QIPP/Efficiency Programme.** • **Note the current position against the £11.5m target.** • **Note the requirement for further efficiency to be delivered should contract overtrading continue to be experienced.** • **Agree the content of the dashboard and any risks for escalation for presentation to Governing Body**.	
FPC17/208	**ASSURANCE FRAMEWORK**	
	The Head of Planning, Delivery and Performance presented the Assurance Framework to the Committee. It was noted that no changes had been made since the last meeting. **Agreed Actions:** • **The Acting Chief Finance Officer agreed to provide update narrative for priority 6.** **The Committee noted the report and were asked to:** • **Review the risks on the Assurance Framework for which the Finance and Performance Committee is responsible** • **Note and approve the risks assigned to the Committee** • **Review and update where appropriate the risk assessment scores for all Finance and Performance Risks** • **Identify any new risks that present a gap in control or assurance for inclusion on the Assurance Framework** • **Agree actions to reduce impact of high risks** • **Identify any sources of positive assurance to be recorded on the Assurance Framework to reassure the Governing Body that the risk is being appropriately managed.**	**RN**
FPC17/209	**RISK REGISTER**	
	The Head of Planning, Delivery and Performance presented the Risk Register to the Committee. It was reported that there was 1 red risk on the register relating to 4 hour A&E target. It was noted that following recommendation by the Committee the Governing Body had approved inclusion of risk 17/05 on the register in relation to IAPT services. Dr A Mills raised that risk CCG14/3	

Adopted

	seemed to have quite a high score attached to it, which related to practice manager engagement etc and felt that we were getting this engagement. **Agreed Actions:** • **The Head of Planning, Delivery and Performance agreed to ask Catherine Wormstone to look into risk CCG 14/3 and its score.** **The Committee noted the report and were asked to:** • **Review the Finance and Performance Committee Risk Register for completeness and accuracy** • **Note and approve the risks assigned to the Committee** • **Review the risk assessment scores for all Finance and Performance risks** • **Identify any other new risks for inclusion on the Risk Register** • **Agree actions to reduce impact of extreme and high risks** • **Identify any positive assurances relevant to these risks for inclusion on the Assurance Framework**	**JW**
FPC17/210	**MINUTES OF THE BHNFT CONTRACT EXECUTIVE BOARD HELD ON THE 19 OCTOBER 2017** – Noted.	
FPC17/211	**MINUTES OF THE SWYPFT CONTRACT EXECUTIVE BOARD** – No minutes available	
FPC17/212	**MINUTES OF THE CHILDRENS EXECUTIVE COMMISSIONING GROUP HELD ON THE 18 SEPTEMBER 2017** – Noted.	
FPC17/213	**MINUTES OF THE ADULTS JOINT COMMISSIONING GROUP HELD ON THE 11 SEPTEMBER 2017 –** Noted.	
FPC17/214	**MANAGEMENT TEAM DECISIONS WITH FINANCIAL IMPLICATIONS**	
	The Head of Planning, Delivery and Performance presented the report the Committee. The Committee were asked to note that the following decisions to commit expenditure were taken by Management Team during November 2017: • Agreed to pay £400 to fund essential glasses for a child with Irlen Syndrome • Approved £2000 legal fees to Leigh Day Solicitors • Agreed funding to enable IT solutions to BHNFT based Intermediate Care Services – approx. £2500 for short term solution (Lorenzo), then £18,000 set up costs and £12,000 annual costs for long term solution (BHNFT SystmOne) • Approved £840 to repair flagstones behind Board Room fire exit **The Committee received and noted the report.**	

Agreed

FPC17/215	**ANY OTHER BUSINESS** - No items were raised under this heading.	
FPC17/216	**AREAS FOR ESCALATION TO GOVERNING BODY** - There were no areas raised for escalation to the Governing Body.	
FPC17/217	**REFLECTION ON HOW THE MEETINGS BUSINESS WAS CONDUCTED** - There were no further comments received.	
FPC17/218	**DATE AND TIME OF NEXT MEETING**	
	Thursday 4 January 2018 at 10.30 am in the Boardroom at Hillder House, 49 – 51 Gawber Road, Barnsley, S75 2PY.	

Adopted

NHS
Barnsley Clinical Commissioning Group

Putting Barnsley People First

Minutes of the meeting of the Barnsley Clinical Commissioning Group AUDIT COMMITTEE held on Thursday 30 November 2017 at 1.00 pm in Meeting Room 1, Hillder House, 49/51 Gawber Road, Barnsley S75 2PY

PRESENT:

Nigel Bell	Audit Committee Chair – Lay Member for Governance
Dr Madhavi Guntamukkala	Governing Body Member
Marie Hoyle	Practice Manager Member
Chris Millington	Lay Member for Patient and Public Engagement and Primary Care Commissioning

IN ATTENDANCE:

Claire Croft	Counter Fraud Specialist (Up to and including minute reference AC 17/11/07)
Kay Meats	Client Manager, 360 Assurance
Kay Morgan	Governance and Assurance Manager
Roxanna Naylor	Acting Chief Finance Officer
Richard Walker	Head of Governance & Assurance
Amy Warner	KPMG Audit Manager

APOLOGIES

No Apologies

Agenda Item	Note	Action	Deadline
AC 17/11/01	**QUORACY**		
	The meeting was declared quorate.		
AC 17/11/02	**DECLARATIONS OF INTEREST, SPONSORSHIP, GIFTS AND HOSPITALITY**		
	The Committee noted the Declaration of Interests Report. No new declarations of interest were received.		
AC 17/11/03	**MINUTES OF THE PREVIOUS MEETING HELD ON 21 SEPTEMBER 2017**		
	The minutes of the meeting held on 21 September 2017 were verified as a correct record of the proceedings.		

UNADOPTED

Agenda Item	Note	Action	Deadline
	With regard to minute reference AC 17/09/15, the Head of Governance and Assurance confirmed that the CCG's business continuity arrangements had been tested via a communication test message to all staff and a table top 'Business Continuity' exercise.		
AC 17/11/04	**MATTERS ARISING REPORT**		
	The Committee considered the Matters Arising Report and the following main points were noted: **Minute Reference AC 17/09/06 - Internal Audit Progress report** It was confirmed that the Acting Chief Finance Officer and Client Manager had agreed the reallocation of available 5 days within the Audit Plan. This action was now complete. The Audit Plan had been updated accordingly and would be further considered under agenda item 7 Internal Audit Progress Report. The Committee were informed that the Information Governance Manager eMBED would attend a meeting of the Practice Managers Group to present on latest developments with Information Governance. However, the date for this was dependent on when the new information Governance guidance was issued. The Head of Governance and Assurance agreed to include assurance on IT assets from third party providers in the year end third party assurances report. . It was noted that information governance more widely fell under the remit of the Quality and Patient Safety Committee. **Minute Reference AC 17/09/08 – Losses and Special Payment Irrecoverable Debt.** The Committee were informed that a fraud case could not be pursued regarding an irrecoverable debt. Due to a CCG internal error (SBS allocation of invoices), there was no false misrepresentation, no fraud and prosecution was not an option. To provide assurance on the controls in place to prevent reoccurrence of the error, the Acting Chief Finance Officer and Client Manager, 360 Assurance agreed to ascertain how this could be included as part of the review of Financial Systems and Controls.	**RN/KMe**	**25.01.18**

UNAPPROVED

Agenda Item	Note	Action	Deadline
	The Committee noted the Matters Arising Report.		
AC 17/11/05	**ASSURANCE ON COMPLIANCE WITH STANDING ORDERS AND PRIME FINANCIAL POLICIES**		
	The Head of Governance and Assurance introduced his report which provided the Audit Committee with assurance in respect of compliance with the CCG's Standing Orders and Prime Financial Policies. The Committee noted that the single tender waiver appended to the report had been signed off by the Head of Commissioning (MH, Children & Specialised) and Chief Officer.		
	The Audit Committee noted the report.		
AC 17/11/06	**INTERNAL AUDIT PROGRESS REPORT**		
	The Client Manager, 360 Assurance presented the Internal Audit Progress Report to the Committee. The Committee noted the significant assurance provided by the three completed issued internal audit reports. These were Performance Management Arrangements, Patient & Public Engagement and Risk Management.		
	Following discussion the following main points were noted: • The Acting Chief Finance Officer reported that a number of recommendations were shown as overdue, in particular one linked to the finance team was complete and the information/evidence had been sent to internal audit. In response the Client Manager advised that the updating of the Recommendation Tracker was evolving. There was a cut off point for receipt of information to update the Recommendation tracker prior to distribution of Audit Committee papers. The Client Manager was actively chasing long outstanding recommendations in particular ones around the Care Quality Board. • The Committee Chair expressed concern indicating that some recommendations were 2 months overdue. The Committee recognised that completion of actions from one review would cover off actions on other reviews for example the performance management review and Care Quality Board requirements / actions.		

UNADOPTED

Agenda Item	Note	Action	Deadline
	• On a point of clarification, the Acting Chief Finance Officer explained that the terms 'core contract' referred to the main contracts for Barnsley Hospital NHS Foundation Trust and South West Yorkshire Partnership Foundation Trust where services were not part of the Alliance Contract. • In response to a question raised by the Committee Chair, the Client Manager confirmed that the scope of all reviews had been agreed with the relevant executive prior to reporting to Audit Committee. • The Committee Chair highlighted that Appendix A of the report 'Follow up of Previous Recommendations' did not include advisory recommendations. It was agreed that these would be included in the future. • The Client Manager confirmed that the Client Briefing was circulated to Audit Committee Members only. • It was established that the IGT plan/review did not include the CCG preparations for General Data Protection Regulations (GDPR). The Head of Governance & Assurance informed the Committee that under GDPR regulations all organisations were required to have a Data Protection Officer (DPO). However there was currently no definitive guidance on this. Local health and social care organisations were considering arrangements to have a DPO but none were in post as yet. The Practice Manager member commented that on a similar vein Practices were required to have a Freedom to Speak Up Guardian. This was linked to the Practice Whistleblowing Policy. Practices were considering the possibilities for a named Freedom to Speak Up Guardian.		
	The committee noted the Internal Audit Progress Report. **Agreed Action:** **To include reference to the review of Patient & Public Engagement and the significant assurance provided in the Patient and Public Activity Report to the**	**CM**	**14.12.17 (complete)**

UNAPPROVED

Agenda Item	Note	Action	Deadline
	Governing Body. **Going forward advisory recommendations to be included in appendix A – Follow up of previous recommendations, status table.** **To circulate the 360 Assurance Briefing to Management Team.** **To considered a piece of work to review the CCGs preparations for GDPR. To check what internal audit work was being undertaken elsewhere with regard to GDPR**	**KMe** **KMo** **RW / KMe**	**25.01.18** **25.01.18** **25.01.18**
AC 17/11/07	**PROGRESS REPORT OF LOCAL COUNTER FRAUD SPECIALIST**		
	The Counter Fraud Specialist introduced the Counter Fraud, Bribery and Corruption Progress Report to the Audit Committee. It was noted that the role of NHS Protect had changed, with a special health authority, the NHS Counter Fraud Authority (NHSCFA) established.		
	The Practice Manager Member confirmed that the Counter Fraud Training had been provided to Practice Managers. The Counter Fraud Specialist reported the positive feedback received from questionnaires about the Fraud Awareness Month. One response to a questionnaire flagged an area of concern relating to staff undertaking work whilst on sick leave. The Governance and Assurance Manager reported that a member of staff had received a £5.00 as a thank you for completing an external web based survey. The £5.00 voucher was accepted and will be donated to the CCG's Christmas Charity. The following key messages were identified to reinforce with staff via the Fraud Awareness bulletin / Fraudulent Times and CCG staff Comms Bulletin. • The need to report fraud to the Counter Fraud Specialist • not to work whilst of sick leave • Acceptance of Gifts and Hospitality		
	The Committee noted the Progress Report.		

UNAPPROVED

Agenda Item	Note	Action	Deadline
	Agreed Actions: **To update relevant CCG Policies to reflect the change in name from NHS Protect to the NHS Counter Fraud Authority (NHSCFA)**. **To include Fraud 'Do's and don'ts in the CCG Staff briefing.** **To highlight the CCG's Policy around the acceptance of gifts and hospitality and the requirement not to work under any circumstances (including voluntary work) whilst signed off unfit for work by a doctor via the Weekly CCG staff Comms Bulletin and Counter Fraud Newsletter** The Counter Fraud Specialist left the meeting	**RW** **RW** **RW / CC**	**25.01.18** **25.01.18** **25.01.18**
AC 17/11/08	**UPDATE FROM EXTERNAL AUDITORS KPMG**		
	The KPMG Audit Manager presented the Technical Update to the Committee. The Committee's attention was draw to a new appendix in the Report demonstrating KPMG performance against KPIs. It was noted that due to retirement of John Prentice, Rashpal Khangura will take over this role as Engagement Lead for the audit.		
	The Committee noted the KPMG Report.		
AC 17/11/09	**POLICY FOR LOSSES AND SPECIAL PAYMENTS**		
	The Committee received and approved the Policy for Losses and Special Payments subject to the Acting Chief Finance Officer signing off any comments received from the Counter Fraud Specialist.	**RN**	**25.01.18**
AC 17/11/10	**PETTY CASH PROCEDURE**		
	The Committee received and approved the Petty Cash Procedure subject to the Acting Chief Finance Officer signing off any comments received from the Counter Fraud Specialist.	**RN**	**25.01.18**
AC 17/11/11	**AUDIT COMMITTEE TERMS OF REFERENCE**		
	The Committee approved the terms of reference subject		

UNAPPROVED

Agenda Item	Note	Action	Deadline
	to: • Not adding the proposed paragraph 5.9, with a rationale that a review of the CCGs Schedule of Debtors and Creditors was undertaken by the Finance and Performance Committee which is attended by the Audit Committee Chair who will report back relevant issues. The Acting Chief Finance Officer will also highlight any losses and special payments to the Audit Committee. • Amend references from NHS Protect to the NHS Counter Fraud Authority (NHSCFA)	**RW** **RW**	**25.01.18** **25.01.18**
	For Audit Committee information, the Chairman advised that the Remuneration Committee had requested an HR Assurance Report be submitted to the Audit Committee as part of third party assurances at year end.		
AC 17/11/12	**ASSURANCE FRAMEWORK RISK REGISTER – EXCEPTION REPORT**		
	The Head of Governance and Assurance introduced his Assurance Framework Risk Register Exception Report. He reported that risk owners had undertaken a review of all risks on the Assurance Framework resulting in minor tweaks but no substantial changes. The Practice Manager Member drew members attention to the three risks on the Risk register relating to the 0-19 pathway and informed the Committee that a meeting with relevant providers would be held on 7 December 2017 to look at the service responsiveness to need and integration into Primary Care Services. The 0-19 action plan was also being reviewed and all of which may impact on the controls, assurances and scores for the three risks.		
	The Audit Committee: • **Reviewed the Assurance Framework and Risk Register** • **Determined that all risks were being appropriately managed** • **Noted the risks added to the Risk Register** • **Did not identify any potential new risks or risk for removal**		

UNADOPTED

Agenda Item	Note	Action	Deadline
	• **Noted the report**		
AC 17/11/13	**REGISTERS OF INTERESTS, GIFTS HOSPITALITY & SPONSORSHIP AND PROCUREMENT DECISIONS**		
	The Head of Governance and Assurance presented the Registers of Interests, Gifts Hospitality & Sponsorship and Procurement Decisions Report to the Committee. **Register of Interests & Register of Gifts, Hospitality and Sponsorship.** The Committee noted that there were 3 or 4 Practices where the level of detail included on their declarations was being reviewed with the relevant Practice. The HR Department provided reports on new starters and leavers to and from the CCG to ensure that the CCGs Register of Interests was maintained. **Register of Procurement Decisions** It was agreed that the entry relating to Intermediate Care should separately show the managed change process for the service and the procurement exercise for the care homes element. The Acting Chief Finance Officer and Head of Governance and Assurance agreed to meet outside of the meeting to consider how to amend the register accordingly.	**RN / RW**	**25.01.18**
	The Committee noted the report and the assurance that the report provided in respect of Registers of Interests, Gifts Hospitality & Sponsorship and Procurement Decisions.		
AC 17/11/14	**ESCALATION OF ITEMS TO GOVERNING BODY**		
	The following key issues for the Audit Committee meeting were highlighted to raise at the October 2017 Governing Body Meeting: • Audit Committee Terms of Reference (to also include in Risk & Governance Report) • Review of Losses and Special Payments Policy and Petty Cash Procedure		
AC 17/11/15	**REFLECTION ON HOW WELL THE MEETING'S BUSINESS HAS BEEN CONDUCTED**		

UNADOPTED

Agenda Item	Note	Action	Deadline
	Members reflected on the meeting it was noted that the meeting had been well conducted at an appropriate pace.		
AC 17/11/16	**DATE AND TIME OF NEXT MEETING**		
	The next meeting of the Audit Committee will be held on **Thursday 25 January 2017 at 1.00 pm** in Meeting Room 1, Hillder House, 49/51 Gawber Road, Barnsley, S75 2PY.		

UNADOPTED

NHS
Barnsley Clinical Commissioning Group
Putting Barnsley People First

GOVERNING BODY

11 January 2018

Primary Care Commissioning Committee Assurance Report

PART 1A – SUMMARY REPORT

1.	**THIS PAPER IS FOR**						
	Decision		*Approval*		*Assurance*	x	*Information*	
2.	**REPORT OF**						

	Name	*Designation*
Executive Lead	Chris Millington	Lay Member
Author	Richard Walker	Head of Governance & Assurance

3. EXECUTIVE SUMMARY

A public meeting of the Primary Care Commissioning Committee was held on 21 December 2017. The Committee received reports for its information and / or assurance relating to:

- **Estates and Technology Transformation Fund (ETTF)**
- **Winter Planning Arrangements (Primary Care)**
- **Finance Update**
- **Contractual issues** - No decisions on any contractual changes were required at this meeting.
- **Procurement Update** – In accordance with procurement requirements the CCG reopened the AQP contracts for vasectomy and carpal tunnel on Monday 4 December with a closing date of 8 January 2018. A decision to award these contracts will be brought back to Primary Care Commissioning Committee in January 2018.
- **Risk & Governance Update**

There were no specific issues which the Committee felt required to be escalated to the Governing Body. All the above papers are available via the CCG's website and full minutes will also be published once they are adopted.

4. THE GOVERNING BODY IS ASKED TO:

Note the contents of this report.

Agenda time allocation for report:	*5 minutes.*

PART 1B – SUPPORTING INFORMATION

1.	Links to the Governing Body Assurance Framework	Risk ref(s)
	This report provides assurance against the following risks on the Governing Body Assurance Framework:	2.1 and 5.2.
2.	**Links to CCG's Corporate Objectives**	**Y/N**
	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	Y
	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 £.	Y
3.	**Governance Arrangements Checklist**	
3.1	**Financial Implications**	
	Has a financial evaluation form been completed, signed off by the Finance Lead / CFO, and appended to this report?	*NA*
3.2	**Consultation and Engagement**	
	Has Comms & Engagement Checklist been completed?	*NA*
3.3	**Equality and Diversity**	
	Has an Equality Impact Assessment been completed and appended to this report?	*NA*
3.4	**Information Governance**	
	Have potential IG issues been identified in discussion with the IG Lead and included in the report?	*NA*
	Has a Privacy Impact Assessment been completed where appropriate (see IG Lead for details)	*NA*
3.5	**Environmental Sustainability**	
	Are any significant (positive or negative) impacts on the environment discussed in the report?	*NA*
3.6	**Human Resources**	
	Are any significant HR implications identified through discussion with the HR Business Partner discussed in the report?	*NA*

DRAFT

South Yorkshire and Bassetlaw Sustainability and Transformation Partnership

Collaborative Partnership Board

Minutes of the meeting of

10 November 2017

Birch and Elm Room, NHS Rotherham CCG,
Oak House, Moorhead Way, Rotherham, S66 1YY

Decision Summary

Minute reference	Item	Action
114/17	**Workstream Priorities:** Primary Care	The Collaborative Partnership Board did not approve the top 3 priorities for this workstream as presented as they require an out of hospital care model at a place level and at a system level as a result of the clinical strategy from the Hospital Services Review.
	Workforce	Mike Curtis acknowledged that the unregistered workforce is a significant element and amendment is required to ensure the focus of the strategy also reflects the unregistered workforce as well as the registered workforce. Mike Curtis added that a narrative will be drawn up that reflects progress in the workstream and then another narrative will be drawn up and used to help attract people into the service.
	Workstream Charters	The Collaborative Partnership Board: • Would provide feedback to the workstreams. • Would give support for future 'in focus' sessions to enable sharing, further engagement and input to the work.
116/17	**Finance Update**	The Collaborative Partnership Board: • Delegates the decision on the proposed allocation of the £3.2m uncommitted funds to the Executive Steering Group at their meeting on 21st November and Jeremy Cook will report back on the allocations to the December 2017

		Collaborative Partnership Board meeting.
117/17	**Hospital Services Review Update**	Alexandra Norrish said that she would talk to the communications team about the survey being circulated to the Joint Health Overview and Scrutiny Committees if it had not already been done.
118/17	**To consider any other business**	Will Cleary-Gray will implement a system to help Collaborative Partnership Board (CPB) members with the dissemination of public and private papers post CPB meetings.

South Yorkshire and Bassetlaw Sustainability and Transformation Partnership

Collaborative Partnership Board

Minutes of the meeting of

10 November 2017

Birch and Elm Room, NHS Rotherham CCG,
Oak House, Moorhead Way, Rotherham, S66 1YY

Name	Organisation	Designation	Present	Apologies	Deputy for
Sir Andrew Cash CHAIR	South Yorkshire and Bassetlaw ACS	ACS Lead/Chair, Sheffield Teaching Hospitals NHS FT, CEO	✓		
Adrian Berry	South West Yorkshire Partnership NHS FT	Deputy Chief Executive		✓	
Adrian England	Healthwatch Barnsley	Chair	✓		
Ainsley Macdonnell	Nottinghamshire County Council	Service Director		✓	Anthony May CEO
Alice Deasy	Health Education England	Leadership Fellow	✓		
Alison Knowles	Locality Director North of England,	NHS England	✓		
Alan Davis	South West Yorkshire Partnership NHS FT	Director of Human Resources	✓		Adrian Berry
Alexandra Norrish	South Yorkshire and Bassetlaw ACS	Programme Director – Hospital Services Review	✓		
Andrew Hilton	Sheffield GP Federation	GP		✓	
Anthony May	Nottinghamshire County Council	Chief Executive		✓	
Ben Jackson	Academic Unit of Primary Medical Care, Sheffield University	Senior Clinical Teacher	✓		
Catherine Burn	Voluntary Action Representative	Director		✓	
Chris Edwards	NHS Rotherham Clinical Commissioning Group	Accountable Officer	✓		
Chris Holt	The Rotherham NHS FT	Deputy Chief Executive & Director of Strategy and Transformation	✓		
Des Breen	Working Together Partnership Vanguard	Medical Director	✓		
Diana Terris	Barnsley Metropolitan Borough Council	Chief Executive		✓	
Greg Fell	Sheffield City Council	Director of Public Health		✓	John Mothersole CEO
Frances Cunning	Yorkshire & the Humber PHE Centre	Deputy Director – Health & Wellbeing	✓		

Helen Stevens	South Yorkshire and Bassetlaw ACS	Associate Director of Communications & Engagement	✓		
Idris Griffiths	NHS Bassetlaw Clinical Commissioning Group	Accountable Officer		✓	
Jackie Pederson	NHS Doncaster Clinical Commissioning Group	Accountable Officer	✓		
Jane Anthony	South Yorkshire and Bassetlaw ACS	Corporate Committee Administrator, Executive PA & Business Manager	✓		
Janette Watkins	Working Together Partnership Vanguard	Director	✓		
Janet Wheatley	Voluntary Action Rotherham	Chief Executive		✓	
Jeremy Cook	South Yorkshire and Bassetlaw ACS	Interim Director of Finance	✓		
John Mothersole	Sheffield City Council	Chief Executive		✓	
John Somers	Sheffield Children's Hospital NHS Foundation Trust	Chief Executive	✓		
Jo Miller	Doncaster Metropolitan Borough Council	Chief Executive		✓	
Julia Burrows	Barnsley Council	Director of Public Health		✓	
Kathryn Singh	Rotherham, Doncaster and South Humber NHS FT	Chief Executive		✓	
Kevan Taylor	Sheffield Health and Social Care NHS FT	Chief Executive		✓	
Lesley Smith	NHS Barnsley Clinical Commissioning Group	SYB ACS System Reform Lead, Chief Officer, NHS Barnsley CCG	✓		
Lisa Kell	South Yorkshire and Bassetlaw ACS	Director of Commissioning Reform	✓		
Louise Barnett	The Rotherham NHS Foundation Trust	Chief Executive		✓	
Maddy Ruff	NHS Sheffield Clinical Commissioning Group	Accountable Officer		✓	
Matthew Groom	NHS England Specialised Commissioning	Assistant Director	✓		
Matthew Sandford	Yorkshire Ambulance Service NHS Trust	Associate Director of Planning & Development		✓	Rod Barnes
Mike Curtis	Health Education England	Local Director	✓		
Neil Taylor	Bassetlaw District Council	Chief Executive		✓	
Paul Moffat	Doncaster Children's Services Trust	Director of Performance, Quality and Innovation		✓	
Paul Smeeton	Nottinghamshire Healthcare NHS Foundation Trust	Chief Operating Executive		✓	
Richard Henderson	East Midlands Ambulance Service NHS Trust	Chief Executive		✓	
Richard Jenkins	Barnsley Hospital NHS Foundation Trust	Chief Executive	✓		
Richard Parker	Doncaster and Bassetlaw Teaching Hospitals NHS FT	Chief Executive	✓		

Richard Stubbs	The Yorkshire and Humber Academic Health Science Network	Acting Chief Executive	✓		
Rob Webster	South West Yorkshire Partnership NHS FT	Chief Executive		✓	
Rod Barnes	Yorkshire Ambulance Service NHS Trust	Chief Executive		✓	
Roger Watson	East Midlands Ambulance Service NHS Trust	Consultant Paramedic Operations	✓		Richard Henderson
Rupert Suckling	Doncaster Metropolitan Borough Council	Director of Public Health	✓		
Ruth Hawkins	Nottinghamshire Healthcare NHS FT	Chief Executive		✓	
Sandra Crawford	Nottinghamshire Healthcare NHS FT	Associate Director of Transformation Local Partnerships Division	✓		Paul Smeeton
Sharon Kemp	Rotherham Metropolitan Borough Council	Chief Executive		✓	
Simon Morritt	Chesterfield Royal Hospital	Chief Executive		✓	
Steve Shore	Healthwatch Doncaster	Chair		✓	
Tim Moorhead	NHS Sheffield Clinical Commissioning Group	Clinical Chair		✓	
Victoria McGregor-Riley	NHS Bassetlaw CCG	Director of Primary Care	✓		
Will Cleary-Gray	South Yorkshire and Bassetlaw ACS	Sustainability & Transformation Director	✓		

Minute reference	Item	Action
108/17	**Welcome and introductions** The Chair welcomed members to the meeting	
109/17	**Apologies for absence** The Chair noted apologies for absence.	
110/17	**Minutes of the previous meeting held 13th October 2017** The minutes of the previous meeting were agreed as a true record.	
111/17	**Matters arising** **93/17(a) – Finance Update** This is work in progress, a report will be brought back to the next Collaborative Partnership Board meeting. **93/17(b) – Finance Update** This item will be discussed by the Executive Steering Group on	

	17th October 2017 and will then be brought back to the next Collaborative Partnership Board meeting. **94/17(a) – Cancer 62 day assurance** At the Executive Steering Group it was agreed to look more closely at the 62 days cancer performance target. The approach taken will be the preparation of a performance report that will be collated from data available and this will be combined with visits by a peer review service report (the team is currently being selected and will have input from NHSE and NHSI). **94/17(b) – Cancer 62 day assurance** Chesterfield Royal Hospital Foundation Trust and Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust have responded regarding their Cancer Alliance Board membership. All other items were either completed or would be picked up as part of the agenda.	
112/17	**National Update** **CEO ACS Report** The Chair gave his Chief Executive Officer report to the meeting. This monthly report provides members with an update on: • The work on the ACS CEO over the last month. • A number of key priorities not covered elsewhere on the agenda. In addition to the report the Chair added: • The Autumn Budget on 22/11/17 will be important. • The UK Life Sciences Industrial Strategy has recently been launched and there is potentially funding in the region of £4billion that could be available. The Chair asked members to consider how we as an ACS approach research and development and industry link-ups in the future. Richard Stubbs added that the health aspect of the UK Life Sciences Industrial Strategy is important in relation to research and development. • There will be a second wave of ACSs in April 2018; ACSs are a system with a large geographical footprint with responsibilities for provision, commissioning and regulation. • Lesley Smith has chaired the first of the Staff Partnership Forum meetings between SYB ACS and staff trade unions. Future meetings will progress on a bi-monthly meeting basis between both parties. • Chris Ham of the King's Fund will be working with SYB ACS regarding governance for phase one (01.04.18 –	

	31.03.19.). There are meetings arranged for discussion with the Local Authorities on 30th November 2017, the SYB ACS Governance Group and the Audit Chairs, 1st December 2017 and the Health and Wellbeing Chairs. • The SYB ACS workstreams are agreeing their top 3 priorities which will result in 45 priorities. These 45 will next be streamlined and a workshop will be arranged in January 2018 for Chief Executive Officers and Accountable Officers to undertake this task. The Chair requested a brief update from each place on their Accountable Care Partnerships(ACP): **Barnsley** Lesley Smith informed members that the ACP Partnership Board is in place and will be moving to shadow board in 2018. The ACP and Board will be meeting in public for the first time next month and will be the accountable organisation for Barnsley in 2019. A Programme Director has been appointed. **Doncaster** Jackie Pederson informed members that the ACP has refreshed its governance. The ACP consists of the town's leadership team. A memorandum of understanding has been drawn up and this will go to NHS Doncaster CCGs Governing Body. Delegated authority will be given to the provider alliance and a framework is being drawn up for this agreement. Contracting will commence from 1st April 2018. . There is currently an interim Programme Manager in place. **Rotherham** Chris Edwards informed members that an ACP board will be the accountable organisation for Rotherham. Place plans are currently being aligned. The ACP has identified its 3 key priorities identified which are: • Locality development • Rotherham health record • Development of the Rotherham ACP agreement. There is no Programme Director in place however as an interim measure the executive team is managing matters. **Sheffield** John Somers informed members that the Sheffield ACP has a development board and programme board. A Programme Director is in post. The ACP had a workshop on 12th October which resulted in their 3 key areas being identified (children and maternity, long term conditions and urgent care). The ACP may have to form a virtual team to ensure progress of transformational change.	

	Bassetlaw Victoria McGregor-Riley informed members that the Bassetlaw ACP has made good progress and is reviewing its priorities. It has established a primary care approach model and is seeking a Programme Director. The Chair highlighted that information from NHSE and NHSI regarding contract disputes for 2018-2019 would be circulated today and advised colleagues to look out for this information. The Chair noted that finances across the system was a challenge this financial year. The Collaborative Partnership Board noted the update.	
113/17	**Integrated Operational Report** Alison Knowles requested members to note the current published performance against key national indicators for the South Yorkshire and Bassetlaw Accountable Care System. She highlighted that SYB ACS had achieved the national standard targets across 7 of the 10 indicators. The Executive Steering Group has discussed the 62 day Cancer target earlier in this meeting and Lesley Smith has identified earlier in this meeting this is being dealt with. Richard Jenkins added that the Echocardiograph Diagnostic Target Performance will be discussed at the next Executive Steering Group meeting on 21st November 2017. Alison Knowles said that the granular reporting will be taken to December and January meetings, the architecture is in place but we need clarification regarding next year and this information will help to finalise the scorecards. Alison Knowles would investigate the Chairs request of having the data available in 'real time'. The Chair thanked Alison Knowles for her report.	
114/17	**Workstream Priorities –** slides will be circulated to members after this meeting **Mental Health and Learning Disabilities** Jackie Pederson presented the Mental Health and Learning Disabilities workstreams top 3 priorities for the Collaborative Partnership Boards approval as: • Integrated IAPT and Liaison Mental Health • Perinatal Mental Health	

	• Children and Young People's Mental Health Chris Edwards added that the linkages should be noted between the Perinatal Mental Health priority and the Children and Maternity workstream. There will be many areas where the Children and Maternity workstream could offer help and support. It should also be noted that Urgent and Emergency Care could offer support to the first priority and Children and Maternity workstream to the third priority. Matthew Groom stated that discussion should start now regarding Child and Adolescent Mental Health Services (CAMS) and new models of care as there will be a new wave of funding to bid into in the New Year. The deadlines are tight so the ACS should be prepared and progress the work required now. Jackie Pederson informed members that she was keen to understand the new architecture across SYB and specifically from an Improving Access to Psychological Therapies (IAPT) perspective how we commission as CCGs to mental health providers. She added that the workstreams need to get a co-ordinated approach across the SYB ACS area in terms of consistent monitoring and progress. Members discussed the Transition Care Programme (TCP) and it being a financial risk to SYB ACS therefore a system approach was required to try and alleviate this risk. Jackie Pederson replied that the TCP is a £100m issue nationally and a £4.5m issue in the SYB area. A future discussion session on TCP is required. The Collaborative Partnership Board approved the top 3 priorities for this workstream as presented. **Primary Care** Will Cleary-Gray presented the Primary Care workstreams top 3 priorities for the Collaborative Partnership Boards approval as: • Implementation of GP Forward View • Local Care Networks • Digital Will Cleary-Gray highlighted that this workstream has connections across all the other workstreams. He added that there is a risk to the transformational programme of not giving the focus that the development of primary care required. There is a national workstream for primary care which this workstream is connected with. Karen Curran is supporting Maddy and Tim with the development of this workstream. The workstream is having discussions regarding urgent and emergency care and the primary care agenda and how we approach the agendas at a national level and then at a local level. There is an event on	

	the 29th November that is focused on support for primary care and the GP workforce. Des Breen stated that the digital workforce goes across systems in 9 areas and has 4 core themes the first one being the interact-ability therefore we should avoid any duplication and effort with the 3rd workstream priority identified. Members were informed that Nicola Heywood-Alexander has been invited to attend and give a presentation at the event on the 29th November 2017 as it is noted digital interdependencies are huge and the ACS has an opportunity to combine digital across the workstreams in a coherent manner. Lesley Smith noted that we require a new model of care for patients when are being treated in the community instead of in the hospital. The Collaborative Partnership Board did not approve the top 3 priorities for this workstream as presented as they require an out of hospital care model at a place level and at a system level as a result of the clinical strategy from the Hospital Services Review. **Workforce** Mike Curtis presented the Workforce workstreams top 3 priorities for the Collaborative Partnership Boards approval as: • Developing the current SYB workforce • Increasing Future Supply • Enabling and Aligning Effective Workforce Planning across organisations, ACPs and ACS Mike Curtis informed members that SYB ACS has a comprehensive workforce strategy. He highlighted that the Workforce workstream was keen not to duplicate priorities in other workstreams and streamlining to ensure no duplication occurs has already been completed by Working Together partnership Vanguard. It is a principle of this workstream to build on what is already happening. He acknowledged that the unregistered workforce is a significant element and amendment is required to ensure the focus of the strategy also reflects the unregistered workforce as well as the registered workforce. Mike Curtis added that a narrative will be drawn up that reflects progress in the workstream and then another narrative will be drawn up and used to help attract people into the service. Andrew Cash noted this is a very complex and important area as the workforce is prevalent across all the other workstreams. The Collaborative Partnership Board approved the top 3	**Maddy Ruff** **Kevan Taylor/ Mike Curtis** **Kevan Taylor/ Mike Curtis**

	priorities for this workstream as presented. **Workstream Charters** Will Cleary-Gray presented the Workstream Charters report that introduced the Medicines Optimisation charter (which can be accessed via the ACS website): The Collaborative Partnership Board: • Noted and would provide comment taken to develop more detailed plans. • Received programme Medicines Optimisation Programme Charter as a work in progress, accessed via the web link • Would provide feedback to the workstreams. • Would give support for future 'in focus' sessions to enable sharing, further engagement and input to the work.	**ALL** **ALL**
115/17	**Communications and Engagement** Helen Stevens introduced the ACS Awareness Campaign ("honest and clear") presentation to the meeting (a copy has been circulated to members previously). Some members stated that being "honest" should be a given as it is an affirmation of one of the organisations core values. Helen Stevens added that: • This campaign has been built on feedback from patients and clinicians and revised based on further comments from staff and the public. • The "honest and clear" logo would sit within the NHS branding it is not intended to be used as a standalone brand. • Patients and the public recruited to the focus groups have given the ACS Awareness Campaign their approval. The Collaborative Partnership Board approved the ACS Awareness Campaign as presented. Adrian England stated that Healthwatch and its stakeholders have been involved in a lot of the work regarding this campaign and by the feedback received the stakeholders involved do comprehend that SYB ACS is being honest and clear in its approach.	
116/17	**Finance Update** Jeremy Cook, Interim Director of Finance SYB ACS, presented his finance report to the meeting. The report updated members	

	on a number of items e.g. recent meetings of Directors of Finance, system control total and payment reform, transformation funds and ACS budget – 2017/18, transformation funds and budget 2018/19 and financial reporting. The Collaborative Partnership Board: • Noted the contents of the report. • Delegates the decision on the proposed allocation of the £3.2m uncommitted funds to the Executive Steering Group at their meeting on 21st November. This will be reported back to the December 2017 Collaborative Partnership Board meeting. The Chair thanked Jeremy Cook for his report and for presenting the information contained therein. The Chair informed members that the Collaborative Partnership Board will not receive the same level of detail in future finance reports as the detail will be reported and discussed by the Executive Steering Group.	**Jeremy Cook**
117/17	**Hospital Services Review Update** Alexandra Norrish updated the group on progress on the Hospital Services Review. She said that the first report of the Review had been published on the 27th October and the launch had some media interest. There had been a five day period for the hospitals to brief their own staff before the publication of the report. She also updated the group on the progress of the Clinical Working Groups. The first round of meetings for each of the five groups was now complete, and the second round was underway. The first round had focused on the problems with the services; the themes which had emerged had included workforce, and inconsistency in clinical standards and protocols, and variation in the services offered on different sites. The Review team felt that themes which needed further exploration included efficiency and consultant numbers. Alexandra Norrish said that the Overarching Group had also met. This was a small group of individuals who have a cross-system role, e.g. NHSE, HEE and the ACS. The conversation had focused around testing the conclusions of the CWG conversations, and beginning to think through what the workstrand on the role of the DGH might look like, including how SYB works as a single footprint, and the implications of the ACS for the acute sector. Alexandra Norrish said that the evaluation criteria would be used to narrow down the longlist of options that the Review team were developing from the CWG input. She flagged to the group that their organisations had (via the Oversight and	

	Assurance Group) been asked to give their views on which were the most important evaluation criteria. The most important criteria would be applied in a first 'gateway' process that would begin in November and last into the New Year, as options were initially assessed. The options which were kept in would then be assessed more rigorously against all of the criteria. Alexandra Norrish said that the public had also been asked to give their views on a simplified version of the criteria, which summarised the 23 criteria into 10. She said that these had been published in an online survey: there had been two changes to the survey since it was published, to add a free text box and to change the definition of one of the criteria around travel times to define it as a 'safe' travelling distance. The Chair stated the launch had gone well and invited comments. The following points were raised in discussion: • whether the survey had been circulated to the Joint Health Overview and Scrutiny Committees. Alexandra Norrish said that she would talk to the communications team about doing this if it had not already been done. • Whether the evaluation criteria would be made public. Alexandra Norrish said that the summarised version was already on the public survey, and that the full list would be made public in the second interim report of the Review (to be published in the New Year). The Chair thanked Alexandra Norrish for her presentation and attendance at this meeting.	**Alexandra Norrish**
118/17	**To consider any other business** Will Cleary-Gray informed members that there will shortly be a system in place to help Collaborative Partnership Board (CPB) members with the dissemination of public and private papers post CPB meetings. This will ensure that there is consistency in the distribution of papers and information across the system. There was no other business brought before the meeting.	**Will Cleary-Gray**
119/17	**Date and Time of Next Meeting** The next meeting will take place on 8th December 2017 at 9.30am to 11.30am in The Boardroom at 722 Prince of Wales Road, NHS Sheffield CCG.	