NHS
Barnsley
Clinical Commissioning Group

A meeting of the NHS Barnsley Clinical Commissioning Group Governing Body will be held on Thursday 11 July 2019 at 9.30 am in Mapplewell & Staincross Village Hall, Darton Lane, Mapplewell, Barnsley S75 6AL

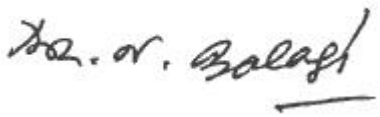
AGENDA
(Public)

Item	Session	GB Requested to	Enclosure Lead	Time
1	Housekeeping		Nick Balac	9.30 am
2	Apologies	Note	Nick Balac	9.30 am
3	Quoracy	Note	Nick Balac	9.30 am
4	Patient Story	Note	Jayne Sivakumar	9.35 am 10 mins
5	Declarations of Interest relevant to the agenda	Assurance	**GB/Pu 19/07/05** Nick Balac	9.45 am 5 mins
6	Patient and Public Involvement Activity Report	Assurance	**GB/Pu 19/07/06** Kirsty Waknell	9.50 am 10 mins
7	Minutes of the meetings held on: • 9 May 2019 • 23 May 2019 (Extra ordinary meeting)	Approval	**GB/Pu 19/07/07** Nick Balac	10.00 am 5 mins
8	Matters Arising Report	Note	**GB/Pu 19/07/08** Nick Balac	10.05 am 5 mins
	Strategy			
9	Chief Officers Report	Information	**GB/Pu 19/07/09** Lesley Smith	10.10 am 10 mins
10	Primary Care Networks Update	Information	**Verbal** Jeremy Budd	10.20 am 10 mins
11	Cervical Screening arrangements	Information	**GB/Pu 19/07/11** Jeremy Budd	10.30 am 10 mins
12	Urgent and Emergency Care Update	Information	**GB/PU 19/07/12** Jamie Wike	10.40 am 10 mins
13	JCC of CCGs revised Manual Agreement	Approval	**GB/PU 19/07/13** Lesley Smith	10.50 am 10 mins

	and Terms of Reference				
14	Maternity Update		Information	**GB/PU 19/07/14** Patrick Otway	11.00 am 10 mins
15	Diabetes Transformation Funding Evaluation		Assurance	**GB/Pu 19/07/15** Dr Krishnasamy	11.10 am 10 mins
16	QUIT Business Case		Decision	**GB/Pu 19/07/16** Jeremy Budd Lynsey Bowker	11.20 am 10 mins
	Quality and Governance				
17	Quality Highlights Report		Assurance	**GB/Pu 19/07/17** Sudhagar Krishnasamy	11.30 am 10 mins
18	Risk & Governance Exception Report		Assurance	**GB/Pu 19/07/18** Richard Walker	11.40 am 10 mins
19	LD Forensic Outreach Liaison Service Urgent Decision		Ratification	**GB/Pu 19/07/19** Patrick Otway	11.50 am 10 mins
	Finance and Performance				
20	Integrated Performance Report		Assurance and Information	**GB/Pu 19/07/20** Roxanna Naylor Jamie Wike	12.00 noon 15 mins
	Committee Reports and Minutes				
21	21.1	Minutes of the Finance and Performance Committee Meeting held on 2 May 2019	Assurance	**GB/Pu 19/07/21.1** Nick Balac	12.15 pm 10 mins
	21.2	Minutes of the Audit Committee Held on 16 May 2019	Assurance	**GB/Pu 19/07/21.2** Nigel Bell	
	21.3	Minutes of the Quality and Patient Safety Committee held on 25 April 2019	Assurance	**GB/Pu 19/07/21.3** Sudhagar Krishnasamy	
	21.4	Minutes of the Membership Council held on 21 May 2019	Assurance	**GB/Pu 19/07/21.4** Nick Balac	
	21.5	Assurance Report Primary Care Commissioning Committee on 30 May 2019	Assurance	**GB/Pu 19/07/21.5** Chris Millington	
	21.6	Minutes of the Health and Wellbeing Board held on 4 June 2019	Assurance	**GB/Pu 19/07/21.6** Nick Balac	
	21.7	Minutes of the South Yorkshire & Bassetlaw Integrated Care System, Collaborative Partnership Board 8	Assurance	**GB/Pu 19/07/21.7** Lesley Smith	

		March 2019			
	21.8	Minutes of the Joint Committee of Clinical Commissioning Groups held on: • 27 February 2019. • 22 May 2019	Assurance	**GB/Pu 19/07/21.8** Lesley Smith	
22	Questions from the Public on Barnsley Clinical Commissioning Group business		Note	Nick Balac	12.25 pm 10 mins
23	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	12.35 pm 5 mins
	General				
24	**Date and Time of the Next Meeting:** Thursday 12 September 2019 at 9.30 am in Hillder House, Barnsley, S75 2PY				12.40 pm Close

Signed



Dr Nick Balac – Chairman

Exclusion of the Public:

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

NHS
Barnsley
Clinical Commissioning Group

GOVERNING BODY

11 July 2019

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 & Assurance
Author	Paige Dawson	Governance, Risk & Assurance Facilitator

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. **Additions / Removals** The following updates to Governing Body declarations have been made since the last meeting: • Lesley Smith is now Interim Accountable Officer NHS Sheffield CCG • Martine Tune is currently on secondment from 1 July 2019 for six months • Jayne Sivakumar has been added to the register as part of her new role as Deputy Chief Nurse • Dr Mark Smith's practice is now a Member of Barnsley Healthcare Federation which may provide services to Barnsley CCG • Dr Hussain Kadarsha is a partner (shareholder) in Primecare Ltd, which now holds the APMS contract for Lakeside Surgery and Goldthorpe • Minor updates have been included to Sarah Tyler and Nigel Bell's interests. 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:	10.1
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	
	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

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

Name	Current position (s) held in the CCG	Declared Interest
Nick Balac	Chairman	• Partner at St Georges Medical Practice (PMS)
		• 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
		• Two Partners at St Georges Medical Practice (PMS) are Partners on the Practice Contract at Kingswell Surgery (PMS).
Nigel Bell	Lay Member - Governance	• Ad hoc provision of Business Advice through Gordons LLP
		• Lay Member representing South Yorkshire & Bassetlaw organisations on the Integrated Assurance Committee of South Yorkshire & Bassetlaw Integrated Care System
John Harban	GP Governing Body Member	• GP Partner at Lundwood Medical Centre and The Kakoty Practice, Barnsley

Name	Current position (s) held in the CCG	Declared Interest
		• 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
		• 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
		• Chair of the Remuneration Committee at Barnsley Healthcare Federation
M Hussain Kadarsha	GP Governing Body Member	• GP Partner in Hollygreen Practice
		• GP Partner in Lakeside Surgey, Goldthorpe (Partner in Company Alliance Primary Care LTD)
		• The practice is a member of Barnsley Healthcare Federation which may provide services to Barnsley CCG

Name	Current position (s) held in the CCG	Declared Interest
		• Member of the British Medical Association
		• Director of YAAOZ Ltd, with wife
		• Malkarsha Properties Ltd (Director)
		• All Stars Medical - Dormant
		• Partner (share holder) in Primecare LTD – holding the APMs contract for Lakeside Surgery and Goldthorpe
Sudhagar Krishnasamy	Associate Medical Director	• GP Partner at Royston Group Practice, Barnsley
		• Member of the Royal College of General Practitioners
		• GP Appraiser for NHS England
		• Member of Barnsley LMC
		• Member of the Medical Defence Union

Name	Current position (s) held in the CCG	Declared Interest
		• 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
Jamie MacInnes	Governing Body Member	• GP Partner at Dove Valley Practice
		• Shareholder in GSK
		• 3A Honorary Senior Lecturer
		• Wife is a T/L Fellow Oncoplastic / breast trainee but applying for a Consulting Post
Chris Millington	Lay Member	• Partner Governor Barnsley Hospital NHS Foundation Trust (ceased July 2018) • Partner Governor Barnsley Hospital NHS Foundation Trust (since 6 February 2019)
Roxanna Naylor	Chief Finance Officer	• Partner works at NHS Leeds Clinical Commissioning Group.

Name	Current position (s) held in the CCG	Declared Interest
Mike Simms	Secondary Care Clinician	• Provider of Corporate and Private healthcare and delivering some NHS Contracts.
Mark Smith	GP Governing Body Member	• Senior Partner at Victoria Medical Centre also undertaking training and minor surgery roles.
		• Director of Janark Medical Ltd
		• Practice is a Member of Barnsley Healthcare Federation which may provide services to Barnsley CCG
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.
		• Interim Accountable Officer NHS Sheffield CCG
Martine Tune (on secondment)	Chief Nurse (Acting)	• Works on an ad-hoc basis for the Care Quality Commission as a Specialist Advisor.
		• Husband is an employee of Rotherham NHSFT at the middle manager level.
Sarah Tyler	Lay Member for Accountable Care	• Volunteer Governor / Board Member, Northern College (who may take referrals from My Best Life)
		• Voluntary trustee / Board Member for Steps (community care provider for early years / nursery)

Name	Current position (s) held in the CCG	Declared Interest
		• Interim Health Improvement Specialist for Wakefield Council (ceased July 2018)
		• Quality For Health developed by Voluntary Action Calderdale and in partnership (VAC) in partnership with the Calderdale Clinical Commissioning Group and working with Greater Huddersfield Clinical Commissioning Group
		• Additional work, employed by Protocol (a provider of flexible staffing and recruitment services in the education, FE, skills, training & public sectors). The role title is Facilitator and the role is supporting people through an apprenticeship programme to become a policy officer, largely based in the civil service. Although the employer is Protocol, the lead partner on the apprenticeship programme is KPMG.

In attendance:

Jayne Sivakumar	Deputy Chief Nurse	• Director of RJS Healthcare Ltd – a healthcare company which receives referrals from healthcare organisations.
		• Husband is a Consultant Surgeon at the Mid Yorkshire Hospital NHS Foundation Trust.

NHS
Barnsley
Clinical Commissioning Group

Governing Body

11 July 2019

Patient and Public Involvement Activity Report

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

	Name	*Designation*
Executive Lead	Lesley Smith	Chief Officer
Presenting	Kirsty Waknell	Head of communications and engagement

3.	**EXECUTIVE SUMMARY**
	Nearly 600 adults and young people living in the Dearne have now taken part in the conversations around emotional resilience. This starts to form a picture of what's happening in people's lives and what they feel is important – a larger scale approach to what matters to me, rather than what is wrong with me. The conversations on the NHS Long Term plan have continued to take place. Together with Barnsley CVS we hosted an event for local voluntary, community and social enterprise organisations in June, aimed at exploring what the sustainability issues were for the sector, what opportunities they saw in the Long Term Plan and also for them to consider how they want to be part of that joined-up approach to improving health and wellbeing in Barnsley. As part of the evaluation of the diabetes support and structured education, we have been visiting local clinics and talking to people living with diabetes to see what the changes and new courses have meant for them.
4.	**THE GOVERNING BODY IS ASKED TO:**
	• Note the content of the report.

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?	*This paper is for assurance and there are no engagement requirements.*
Is actual or proposed engagement activity set out in the report?	*Yes.*

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**
	This report gives an overview of our recent and future patient and public involvement activity in Barnsley CCG.
2.	**INVOLVEMENT ACTIVITY**

How public and patient involvement is influencing the decisions we make.

Activity	Outcomes/findings
NHS Long Term Plan As part of our local conversations in relation to the NHS Long Term Plan, during May, June and July we have attended events and met with a range of people and groups to gain their input and feedback to help shape our local plans. In addition to this, Healthwatch Barnsley has collected at least 250 views via surveys and in local group sessions.	Here is an overview of some of the events we have attended: • 6th June – South Yorkshire and Bassetlaw ICS event held at the Source – supported the regional team at one of two events held that day- attendees were a mixture of patients, members of the public and staff. • 11th June - Emmanuel Methodist Church – community coffee morning – approximately 70 people in attendance • 19th June – Joint event with Barnsley CVS held at Priory Campus for members of the community and voluntary sector – 50 people in attendance representing over 30 organisations locally. • 27th June – Barnsley Patient Council – attendees for this meeting are representatives from Barnsley GP patient groups. • 1st July – Adult Learner conference hosted by Barnsley Council – attendees are adult learners who have been supported by the council.
Emotional Resilience of People of Working Age in the Dearne Area As part of the work taking place in the Dearne to integrate services and have a shared set of priorities which are co-produced with members of the local community, residents have been asked to give their views on emotional resilience and what it's like in their area.	Community champion volunteers have been recruited to have these conversations and this has been overseen by the Dearne Area Council team. Over 300 adults and 250 young people have been in touch and answered the questions below already. Here are the questions being asked of people living in the Dearne: • What do you love about Barnsley/the neighbourhood where you live? • What keeps you and your family well? • What worries you on a daily basis? • Can you get the support you need to help you tackle your worries? • What are the barriers to getting support? • What would you like to see change to make where you live a healthier place to live?

	Diabetes Transformation Funding Evaluation Views have been gathered from people living with diabetes and their carers and clinicians on their experiences of accessing, using, referring into and delivering diabetes services following the additional investment which had been made into structured educations courses. The full findings report forms part of the paper also on the agenda (11.07.19)	As well as contacting people who use the service directly, there was general promotion through the usual channels. In addition CCG staff attended clinics at Woodland Drive Medical Centre, Chapelfield Medical Centre and at the Diabetes Centre at Barnsley Hospital in May and June in order to gain additional feedback via the patient survey. 23 clinicians fed back and there were 57 completed responses/conversations with patient/carers questionnaire have been received. Here is some feedback from someone who attended the week-long DAFNE structured education course for people living with Type 1 diabetes: "What can I say about DAFNE? The words life-changing, mind-blowing and empowering come to mind but even more, the safe environment and free speaking has been amazing."

GB/Pu 19/07/07

Minutes of the meeting of the Barnsley Clinical Commissioning Group Governing Body (PUBLIC SESSION) held on Thursday 9 May 2019 at 9.30 am in the Boardroom, Hillder House, 49/51 Gawber Road, Barnsley, S75 2PY

MEMBERS PRESENT

Dr Nick Balac	Chairman
Dr Adebowale Adekunle	Member (from minute reference GB 19/05/07)
Dr John Harban	Member (from minute reference GB 19/05/02)
Dr M Hussain Kadarsha	Member
Dr Sudhagar Krishnasamy	Member & Associate Medical Director
Dr Jamie MacInnes	Member
Chris Millington	Lay Member for Patient and Public Engagement & Primary Care Commissioning
Roxanna Naylor	Chief Finance Officer
Mike Simms	Secondary Care Clinician
Lesley Smith	Chief Officer
Dr Mark Smith	Member
Martine Tune	Chief Nurse (Acting)
Sarah Tyler	Lay Member for Accountable Care

IN ATTENDANCE

Jeremy Budd	Director of Commissioning
Siobhan Lendzionowski	Lead Commissioning and Transformation Manager
Kay Morgan	Governance & Assurance Manager
Kirsty Waknell	Head of Communications and Engagement
Richard Walker	Head of Governance and Assurance
Jamie Wike	Director of Strategic Planning and Performance

APOLOGIES

Nigel Bell	Lay Member for Governance

MEMBERS OF THE PUBLIC

Peter Deakin	Barnsley Save Our NHS (from minute reference GB 19/05/11)
Jak Gurney	Member of the Public

Agenda Item		Action	Deadline
GB 19/05/01	**QUORACY**		
	The meeting was declared quorate.		

UNADOPTED

Agenda Item		Action	Deadline
GB 19/05/02	**PATIENT STORY**		
	The Governing Body received a patient story about how the NHS uses complaints and feedback. A patient's son voiced his concerns in respect of his deceased father's care and was supported in this process by the PALS (Patient Advice and Liaison Service). He attended a meeting with the health care professionals involved in his father's care to discuss his experience and identify learning. The son subsequently joined the Patient Reference Group at his local GP Practice. ***Dr John Harban joined the meeting***		
	The Governing Body noted the positive endorsement of the PALS service, the importance of effective communication with patients, families and carers and how the learning identified from the complaint is used to improve services and patient experience.		
	The Governing Body noted the Patient Story.		
GB 19/05/03	**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 further declarations were received.		
GB 19/05/04	**PATIENT AND PUBLIC INVOLVEMENT ACTIVITY REPORT**		
	The Head of Communications and Engagement introduced the Patient and Public Involvement Activity Report to the Governing Body. The Lay Member for Accountable Care queried if the CCG was confident in its 'reach' of patient and public involvement activity, particularly in terms of diversity. The Member also advised that there appeared to be glitches in the 'hyperlinks' to surveys and information on the Healthwatch website relating to the NHS Long Term Plan.		
	The Governing Body noted the content of the report.		

UNADOPTED

Agenda Item		Action	Deadline
	Agreed action: ***To clarify and determine the CCGs 'reach' in terms of patient and public involvement.*** ***To check and ensure with Healthwatch that all hyperlinks on the Healthwatch website are operating effectively.***	**KW** **KW**	
GB 19/05/05	**MINUTES OF THE PREVIOUS MEETINGS HELD ON 14 MARCH 2019**		
	The minutes of the previous meeting held on 14 March 2019 were verified as a correct record of the proceedings.		
GB 19/05/06	**MATTERS ARISING REPORT**		
	The Governing Body considered the Matters Arising Report and agreed that the following actions were complete: • Minute reference GBPu 18/09/18 – Committee Reports and Minutes – FPC 18/151 – Sexual Health • Minute reference GBPu 18/11/07 - Chief Officer's Report – Bowel Screening • Minute reference GBPu 18/11/09 - Cancer Update		
STRATEGY			
GB 19/05/07	**CHIEF OFFICER'S REPORT**		
	Dr Adekunle joined the meeting The Chief Officer presented her report to the Governing Body and the following main points were noted: **South Yorkshire and Bassetlaw Integrated Care System (SYB ICS), Chief Executive Report** **Priority Areas for System Working** – Members noted that the Priority Areas for System Working are being taken forward with local authority partners. The Chairman referred to the priority area relating to the impact of loneliness and commented that loneliness did not just affect people living in their own homes, people in care homes can be very isolated.		

UNADOPTED

Agenda Item		Action	Deadline
	Performance Score Card – The Chief Officer provided the Governing Body with current overall improved ICS performance data and commented that performance monitoring should ideally move away from a narrow focus on delivering performance targets towards a broader focus on health improvement and transformation **Patient, Public and Staff Involvement Plan for the development of the South Yorkshire and Bassetlaw 5 Year Strategy -** The Lay Member for Accountable Care referred to the public engagement taking place on the priorities in Long Term Plan and commented that should the public not agree could this create a problem given that the priorities are national directives. **Letters from Sir Andrew Cash, ICS Chief Executive Officer and Alison Knowles, Locality Director – South Yorkshire & Bassetlaw re: the CCG's Annual Review 2018/19** The Governing Body was pleased to note the positive comments from the CCG's Annual Review. The Chairman referred to the Practice Delivery Agreement (PDA) and advised that a light touch approach to governance and audit for the PDA would be adopted and assurance provided to the Governing Body regarding the delivery of the PDA. **SYB ICS Pathology Transformation Programme Update** The national shortage of specialist pathology staff was noted. With regard to timescales it was clarified that a decision on the preferred option for delivery of the Pathology service must be determined in the first instance, although a timeline for the business case can be requested. **The Governing Body:** • **Agreed to support to progress the transformation programme to OBC as described in the paper** • **Agreed that the implementation of a single organisational form for South Yorkshire and Bassetlaw Pathology Services should be subject to**		

UNADOPTED

Agenda Item		Action	Deadline
	the completion of an outline and full business Case • **Supported the resolution of the identified key enablers**		
	The Governing Body noted the Chief Officer's Report for information. ***Agreed action*** ***To provide the Governing Body with reports on workforce locally and at South Yorkshire and Bassetlaw level. To include information about the added value of work force initiatives in Barnsley.***	**LS**	**11.07.19**
GB 19/05/08	**DEVELOPING SYB SYSTEM COMMISSIONING AND CCG JOINT COMMISSIONING ARRANGEMENTS FOR 2019/20**		
	The Chief Officer introduced a report setting out the approach for developing system commissioning for 2019/20, based upon a set of South Yorkshire and Bassetlaw commissioning priorities managed by the Joint Committee of CCGs (JC CCGs), operating under delegated authority from the five CCGs for specific decisions in order to facilitate streamlined decision making as a system.		
	Discussion took place and the Governing Body noted that: • Any delegated authority of Commissioning decisions to the Joint Committee will be clearly listed in the JC CCG Terms of Reference and Manual Agreement. • CCGs will be involved with and sighted on the process with regard to the development of business cases for delegated commissioning. Therefore when the Barnsley CCG representative casts a vote at the JC CCGs they can be confident to do so in the knowledge that the business case has been considered by the NHS Barnsley CCG Governing Body and all other Governing Bodies from CCGs within the South Yorkshire and Bassetlaw area. • The need for robust clinical input on business cases was highlighted.		
	The Governing Body were advised that each SY&B CCG had a vote on the joint committee. JC CCGs Lay Members had also expressed an interest in becoming voting		

UNADOPTED

Agenda Item		Action	Deadline
	members of the Joint Committee. The JC CCG's Terms of Reference including voting arrangements will be submitted to the Governing Body for consideration and approval.		
	The Governing Body: **Considered the content of the paper and supported the approach to develop SYB system commissioning arrangements and the JC CCG in 2019/20 in line with the NHS Long Term Plan requirements** **Supported the review of the JC CCG Terms of Reference and Manual Agreement for 2019/20** **Agreed in principle the request for specific decisions set out in the paper to be delegated from CCGs to the JC CCG in order to support streamlined decision making for system commissioning and support the delivery of the 2019/20 JC CCG priorities subject to final agreement and approval of the Manual Agreement in July 2019.** ***Agreed Action*** ***To inform the Membership Council about the Developing SYB System Commissioning and CCG Joint Commissioning arrangements.*** ***The Governing Body to receive the JC CCGs Terms of Reference on 11 July 2019.***	**LS** **LS**	**11.07.19** **11.07.19**
GB 19/05/09	**INTEGERATED CARE UPDATE**		
	The Director of Commissioning presented an Integrated Care Update to the Governing Body including the position with Primary Care Networks, the neighbourhood approach impacts and next steps, the Frailty initiative and population health management. **Primary Care Networks** It was reported that most practices appear to favour one Barnsley super network hosted by the Federation with 6 locality networks operating within the larger umbrella of the super network. The learning from the Dearne neighbourhood will be rolled out to and aligned to the		

UNADOPTED

Agenda Item		Action	Deadline
	Primary Care Networks. The Chairman advised that before disseminating any learning from the Dearne neighbourhood initiative it was important to take a critical view of the learning, to ensure that the 'learning' makes a difference. A Communications Strategy / Plan and support will be in place for the Primary Care Networks in terms of development and identifying priorities.		
	Partnership Working Maintaining the engagement of all partners within integrated care services was discussed. In particular for example, out of hospital services may create issues for secondary care which should be considered by the partnership as a whole. The Lay Member for Accountable Care commented that clarity may be required around neighbourhood level working, joined up partnership services and alignment to primary care networks.		
	The Governing Body noted the integrated Care Update. ***Agreed action*** ***To present the 'Teamwork in Action' video at the next meeting of the Governing Body on 11 July 2019.***	**JB**	**11.07.19**
GB 19/05/10	**CANCER PROGRAMME SIX MONTHLY ASSURANCE REPORT**		
	Dr Kadarsha, Clinical Lead for Cancer introduced the Cancer Programme Assurance Report to the Governing Body. It was noted that the programme was delivering the priority key areas as expected. In response to a questions raised it was clarified that: • The Barnsley Cancer Steering Group is a partnership group with representation from a number of organisations across Barnsley • There is a real focus on smoking cessation including secondary services and no reduction in the Smoking Cessation Services provided by Barnsley Metropolitan Borough Council.		
	The Governing Body considered the two actions rated as 'red' on the Cancer Programme Action Plan; Early diagnosis of colorectal cancers and workforce planning. It		

UNADOPTED

Agenda Item		Action	Deadline
	was reported that the Barnsley Hospital NHS Foundation Trust had now appointed a clinical lead for colorectal cancer Dr Ali and recommended that Mike Simms offer peer support to him.		
	The Chairman commented that some patients are fit and suitable to have overnight bowel prep whilst some less able patients may require additional support for example a person with a number of comorbidities. It was clarified that the BHNFT triage process will identify people unsuitable for bowel prep and also provide a named nurse whom patients could contact if they have any issues. The Lay Member for Patient and Public Engagement & Primary Care Commissioning requested clarification about whether the additional MRI funding was a one off payment or required as an ongoing resource. It was clarified that this was a one off cancer alliance transformation funding to support clearance of an MRI demand backlog.		
	The Governing Body noted Cancer Programme Assurance Report. ***Agreed action:*** ***To share a presentation about Smoking Cessation and BMBCs Health Lifestyle initiative relating to cancer given to the Barnsley Cancer Steering Group with the Governing Body members.***	**SL**	**11.07.19**
QUALITY AND GOVERNANCE			
GB 19/05/11	**MANAGEMENT OF PATIENT EXPERIENCE POLICY**		
	The Chief Nurse introduced the Management of Patient Experience Feedback Policy to the Governing Body. The Lay Member for Accountable Care queried the volume of complaints received by the CCG and providers and also commented that members of the public may not be aware of where to complain and the routes to take. The Chief Nurse (Acting) advised that the CCG's website contained information about how to make a complaint and the CCG's Quality & Patient Safety Committee received quarterly data relating to the numbers of complaints received at the CCG		

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Agenda Item		Action	Deadline
	and providers. As an indication the CCG currently had one open complaint and a couple of Parliamentary and Health Service Ombudsman enquiries. The Chief Nurse advised that the CCG were very focussed on the safety, quality and effectiveness of services. All quality data received by the CCG is triangulated and reports produced for consideration by the Quality Board.		
	The Governing Body approved the Management of Patient Experience Feedback Policy. **Agreed Action** **The Lay Member for Accountable Care to attend a future Quality and Patient Safety Committee meeting where complaints data is presented.**	**MT/ST**	**11.07.19**
GB 19/05/12	**QUALITY HIGHLIGHTS REPORT**		
	The Chief Nurse (Acting) introduced the Quality Highlights report to the Governing Body and the following main points were noted. **Thames Valley Ambulance Service** - The CQC were assessing the quality and safety of services provided by the Thames Valley Ambulance Service, provider of Patient Transport Services in South Yorkshire & Bassetlaw. The Chief Finance Officer also noted that there were ongoing contractual issues linked to service delivery and quality assurance with this provider which had been discussed at Finance and Performance Committee and the CCG were reviewing options in terms of next steps. **Prevent Training Compliance -** As at 9 May 2019 compliance with the Prevent Training was over the 90% target. **CQC Inspections** - Apollo Court had been taken out of CQC special measures and showcased as an example of good practice.		
	The Governing Body noted the Quality Highlights Report.		

UNADOPTED

Agenda Item		Action	Deadline
GB 19/05/13	**RISK AND GOVERNANCE EXCEPTION REPORT**		
	The Head of Governance and Assurance presented the Risk and Governance Exception Report. Discussion took place around the CCG's Risk Register. The Head of Governance and Assurance referred to the addition of two new risks to the risk register relating to the Thames Ambulance Service. The risks had identified and rated as 'amber' (high) by Quality and Patient Safety Committee and therefore did not require approval by the Governing Body for inclusion on the risk register. The Director of Strategic Planning and Performance informed the Governing Body that the current provider (Kier / eMBED) of Business Intelligence, Corporate and GP IT and Information Governance to the CCG had confirmed their intention to cease the existing contract. The CCG will therefore need to recommission an alternative new provider for these services and that this may be an emerging potential risk for the CCG's Risk Register. It was determined that the risk may also need to be reflected on the Governing Body Assurance Framework (GBAF) under priority area 9 'compliance with statutory and regulatory requirements'. The Finance and Performance Committee will be the responsible committee for the risk. The Governing Body was informed that work and activity is underway to develop a specification and recommission the services from available providers in the market. It was noted that a South Yorkshire and Bassetlaw approach to procurement could be considered. It was highlighted that any potentials risk relating to the CAHMS service could be considered pending the receipt and outcomes of the IST Report and consideration of this at a Development Session on 30 May 2019.		
	The Governing Body: • **Reviewed the summary of the GBAF for 2018/19, and determined that the risks are appropriately described and scored, and there is sufficient assurance that they are being effectively managed as 10 January 2019** • **Did not Identify any additional positive assurances**		

UNADOPTED

Agenda Item		Action	Deadline
	relevant to the risks on the GBAF • **Reviewed the extract of the Corporate Risk Register to confirm all risks are appropriately scored and described** • **Identified a potential new risk relating to the recommissioning of an alternative provider for the CCG's Business Intelligence, Corporate and GP IT and Information Governance services** • **Considered and approved the new risks in relation to Thames Valley Ambulance Service (TASL)** • **Noted the current position regarding the Registers of Interests, Sponsorship, Gifts & Hospitality** • **Noted the submission of the Draft Annual Report & Accounts in accordance with NHSE timescales** • **Noted the Committee Annual Assurance Reports 2018-19** • **Approved the proposed changes to the Standing Orders, Scheme of Reservation and Delegation, and Prime Financial Policies** • **Noted the review of the Procurement Policy** ***Agreed Actions:*** ***To draft a risk around the procurement of* Business Intelligence, Corporate and GP IT and Information Governance services *for the CCG including scoring and controls to mitigate the risk***.	**JW/RW**	**11.07.19**
FINANCE AND PERFORMANCE			
GB 19/05/14	**INTEGRATED PERFORMANCE REPORT**		
	Finance The Chief Finance Officer presented the key messages from the Financial Report. As at 31 March 2019, the CCG had achieved all financial duties / targets and NHS England business rules, subject to external audit with an in-year surplus of £1m as agreed by the CCG and NHS England. As at 9 May 2019 the external Auditors had not identified any issues to date and a clean audit opinion was expected (subject to confirmation form KPMG once the audit was complete)		

UNADOPTED

Agenda Item		Action	Deadline
	On behalf of the Governing Body and CCG the Chief Officer expressed appreciation to the Finance and Contracting Team for their excellent work in the management of the CCGs overall budget of over £400m. The Governing Body noted the assessment of the CCGs Efficiency Programme and the further work required in relation to demand management schemes for 2019/20. Acute contract activity data shows an overspend of £2.8M across acute contracts with BHNFT being the largest variance. A full reconciliation will be undertaken in May 2019 to determine the final outturn position for 2018/19 with the Trust. The CCG considering options in relation to the required 20% reduction in running costs by April 2020. The Governing Body will be kept informed of the position and any further actions requiring approval will be reported to the Governing Body for consideration.		
	Performance The Director of Strategic Planning and Performance reported the latest performance against key performance indicators by exception to the Governing Body. It was Performance continues to be generally strong for Barnsley patients with key standards in relation to A&E, Cancer (2 week and 62 day), Referral to treatment, diagnosis, mental health and CHC all being achieved for the latest performance period. The Governing Body considered and noted the key performance indicator issues within the exception report. The Director of Strategic Planning and Performance updated the Governing Body with the latest position with these indicators and also in comparison to the performance ranking out of 31other Trusts.		
	The Governing Body noted the contents of the report including 2018/19 performance to date		
GB 19/05/15	**BUDGETS 2019/20 AND PLANNING UPDATE**		
	The Chief Finance Officer and Director of Strategic Planning and Performance presented a Planning		

UNADOPTED

Agenda Item		Action	Deadline
	Update / Budget Approval report to the Governing Body. **Financial Plan** The Governing Body approved the budgets for 2019/20 and considered the efficiency programme. The Chief Offcier noted that plans for 2019/20 were well established with any slippage on efficiency being mitigated with new schemes in the pipeline and other in year mitigations. The Governing Body were advised that schemes in the pipeline to deliver against the 2020/21 plan were limited and this will be further discussed by the Governing Body in private session on 9 May 2019. **Operational Plan** It was noted that the NHSE had commissioned an audit to take place at the Barnsley Hospital NHS Foundation Trust on 22, 23 and 24 May 2019 in order to try and understand the increase in A&E attendances. In response to questions raised the Director of Strategic Planning and Performance noted that the numbers of patients being navigated to Primary Care services remained consistent. It is not currently possible to identify the number of patients being seen in ED who could have been seen by primary care if capacity was available. The Local Urgent and Emergency Care Delivery Board have requested further work to understand this demand. The Governing Body was informed that the system operational plan will be signed off within the next two weeks. By way of assurance, the Chief Officer advised that the Barnsley Operational Plan had been well evidenced and had not required further submission to SYB ICS.		
	The Governing Body noted the contents of the report including: • **The requirements of NHS England national planning guidance in the financial plan.** • **The investments included within the plan in line with approvals at Governing Body and Management Team.**		

UNADOPTED

Agenda Item		Action	Deadline
	• **The £13.1m efficiency requirement to ensure financial duties and targets are achieved.** • **Approved the 2019/20 budgets.** • **Noted the requirement for the development of 2020/21 efficiency plans.** • **Noted the summary of the activity and performance plans against which the CCG will monitor performance and be monitored against during 2019/20.**		
GB 19/05/16	**QIPP DELIVERY REPORT**		
	The Director of Planning and Performance introduced the Quality, Innovation, Productivity and Prevention (QIPP) Programme Report to the Governing Body. The Governing Body considered QIPP Reporting and Escalation Dashboard and it was noted that the position as at 31 March is that the £11.5m target will be delivered, however Month 12 data is not yet available to confirm the position and further work is required in relation to demand management schemes as data to Month 11 shows a shortfall against targets with in-year mitigations being required to ensure delivery of the £11.5m target.		
	The Governing Body: • **Noted the content of the dashboard and position against key performance indicators as at month 11.** • **Noted the current position against the £11.5m target.**		
COMMITTEE REPORTS AND MINUTES			
GB 19/05/17	**COMMITTEE REPORTS AND MINUTES**		
	The Governing Body received and noted the following Committee minutes & assurance reports: • **Finance and Performance Committee Meeting held on 7 March 2019 and 4 April 2019** • **Minutes of the Audit Committee held on 21 March 2019 and 18 April 2019**		

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Agenda Item		Action	Deadline
	• **Quality and Patient Safety Committee held on 21 February 2019** • **Minutes of the Membership Council held on 19 March 2019** • **Assurance Report of the Primary Care Commissioning Committee 28 March 2019** The Governing Body were informed that letters of congratulations had been sent from the Chairman and Chief Officer to the Hollygreen Practice and Kingswell Surgery following their recent successful CHC Inspection receiving an overall rating of good across all domains. • **Assurance Report Equality, Inclusion & Engagement Committee** It was noted that the Equality, Inclusion & Engagement Committee had sought assurance from the Barnsley Metropolitan Borough Council regarding the CCG's financial contribution to the council for patient and public involvement activities. In particular, to ensure that the CCG receives 'value for money' in respect of this contribution. • **Minutes of the Health and Wellbeing Board held on 9 April 2019** • **Minutes of the meeting of the South Yorkshire and Bassetlaw Shadow Integrated Care System Collaborative Partnership Board 9 November 2018**		
GB 19/05/18	**GOVERNING BODY ASSURANCE WORK PLAN/ AGENDA TIMETABLE**		
	The Governing Body received and noted the updated Governing Body Work Plan/Agenda Timetable. ***Agreed Action:*** ***To update the Governing Work Plan/Agenda Timetable as per comments received from the Director of Finance, and changing initials for the Transforming Care Update to PO (complete).*** **To reconsider the work plan with a view to including**	**KM** **LS/KM**	**11.07.19** **11.07.19**

UNADOPTED

Agenda Item		Action	Deadline
	the future of commissioning at a Governing Body Development Session and invite Alison Knowles, Locality Director, South Yorkshire and Bassetlaw.		
GB 19/05/19	**QUESTIONS FROM THE PUBLIC ON BARNSLEY CLINICAL COMMISSIONING GROUP BUSINESS**		
	The Chairman requested questions from members of the public. The following comments, questions and responses were noted: A representative from Barnsley Save Our NHS asked a series of questions as follows: **Question - Paediatrics and Maternity Services** Why has no Integrated Care System recommendation been submitted to the CCG regarding the way forward on changes around paediatrics and maternity and why has no information been provided to the public on the proposed way forward? *Response – The position on way forward re potential for transformation of paediatrics and maternity services in South Yorkshire and Bassetlaw has not yet been determined. Information to Governing Bodies and Foundation Trust Boards is awaited.* **Question – Future of Commissioning & the CCG, SYB Integrated Care System, Long Term Plan, Primary Care Networks and integrated delivery** When will the people of Barnsley be asked whether they want decisions about their healthcare to be made by an unelected body at regional level and do the CCG not think it should follow the statutory guidance provided by NHS England and let people know what is happening and involve them? Members of the public and NHS staff were unaware of the recent Long term Plan (LTP) engagement events which were not advertised far enough in advance. A simplified version of Information about the LTP was not available to inform the public *Response – The CCG believes it* is *fulfilling its statutory requirement to involve the public. The CCG was not aware of the late advertising of the events and survey relating to Long term Plan and will ascertain from Health watch how*		

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Agenda Item		Action	Deadline
	and when events have been advertised, the rates of attendance and outputs. There is a forward plan of events on the LT Plan. *With regard to staff, many staff are aware of the LTP and work is ongoing to engage and inform all staff about the LTP.* **Question - Primary Care Networks (PCNs)** A multi-facetted question was asked about PCNs in Barnsley specifically: • How many PCNs are likely in Barnsley, will they create another level of bureaucracy? • Will the Barnsley CCG contract arrangements, (for example clinical pharmacist, out of hour's services, extended hours (iHeart) and social prescribing) create issues between CCGs and PCNs? • What happens to the GP federation with the creation of PCNs? • What is the public accountability & public involvement for PCNs? • How will the CCG ensure that they meet their section 14U duty 'to promote involvement of each patient' in decisions that relate to the prevention or diagnosis of illness *Response - The Barnsley GP Practices are still in the process of deciding how many PCNs there will be in Barnsley. The PCN's will receive funding for specified services and to reduce health inequalities and will support integration with local networks and services. Public involvement is in the gift of the PCNs although Patient Reference Groups are already established for each Practice with scope for a larger locality group.* *The Chairman advised that the questions asked were complex and extended an opportunity for the Barnsley Save our NHS representative to meet outside of the meeting to further discuss Primary Care networks in Barnsley and this was accepted.* ***Agreed action – To arrange a meeting with the Chairman and Barnsley Save our NHS representative***	**NB**	**11.07.19**

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Agenda Item		Action	Deadline
GB 19/05/20	**REFLECTION ON HOW WELL THE MEETING'S BUSINESS HAS BEEN CONDUCTED**		
	The Governing Body agreed that the business of the meeting had been conducted appropriately. It was agreed that the agenda papers and discussion at meetings should be clear to members of the public with the avoidance of acronyms. **The Governing Body agreed to close the public session of the meeting and proceed to the private part of the agenda**.		
GB 19/05/21	**DATE AND TIME OF THE NEXT MEETING**		
	Thursday 11 July 2019 at 9.30 am in Mapplewell & Staincross Village Hall, Darton Lane, Mapplewell, Barnsley S75 6AL.		

UNADOPTED

NHS
Barnsley
Clinical Commissioning Group

Minutes of the meeting of the Barnsley Clinical Commissioning Group Extraordinary Governing Body held on Thursday 23 May 2019 at 9.30 am in the Boardroom, Hillder House, 49-51 Gawber Road, Barnsley

MEMBERS PRESENT:

Dr Nick Balac (chair)	Chair
Dr Adebowale Adekunle	Member
Nigel Bell	Lay Member, Governance
Dr John Harban	Member
Dr M Hussain Kadarsha	Member
Dr J MacInnes	Member (from minute reference GB/EO **19/05/03.3)**
Chris Millington	Lay Member for Patient and Public Engagement & Primary Care Commissioning
Roxanna Naylor	Chief Finance Officer
Mike Simms	Secondary Care Clinician
Lesley Smith	Chief Officer
Dr Mark Smith	Member
Martine Tune	Chief Nurse (Acting)
Sarah Tyler	Lay Member Accountable Care

IN ATTENDANCE:

Kay Morgan	Governance and Assurance Manager
Richard Walker	Head of Governance and Assurance
Jamie Wike	Director of Planning and Performance

APOLOGIES:

Dr Sudhagar Krishnasamy	Member

Ref	Agenda Item	Action	Deadline
GB/EO 19/05/01	**QUORACY**		
	The Chair declared that the meeting was quorate.		
GB/EO 19/05/02	**DECLARATIONS OF INTEREST, SPONSORSHIP, HOSPITALITY AND GIFTS RELEVANT TO THE AGENDA**		
	The Governing Body received the Declarations of Interest, Sponsorship, Hospitality and Gifts Report. Dr Mark Smith declared that his Practice 'Victoria Medical Centre' was now a member of the Barnsley Healthcare Federation. It was noted that this was an non-financial		

UNADOPTED

NHS Barnsley Clinical Commissioning Group

Ref	Agenda Item	Action	Deadline
	professional interest and was not relevant to the business of the meeting. No other new declarations of interest were received.		
GB/EO 19/05/03	**NHS BARNSLEY CCG AUDITED ANNUAL REPORT AND ACCOUNTS 2018/19**		
	The Chief Finance Officer and Head of Governance and Assurance presented the Governing Body with the CCG's audited Annual Report and Accounts 2018/19. The Governing Body were advised of a range of assurances to be considered in respect of the Annual Report and Accounts: • The production of annual report and accounts had been led by relevant executive lead ensuring strict adherence to national guidance. • The draft Annual Report and Accounts had been reviewed in detail twice by the Audit Committee, on 18 April 2019 and 16 May 2019. On 16 May 2019 the Audit Committee recommended that the final documents be presented to the Governing Body for approval and adoption. • The output from the work of the Internal Audit (every individual piece of internal audit work had provided significant assurance) and Local Counter Fraud Specialist. The Head of Internal Audit Opinion was of 'Significant Assurance' confirming that that there is a sound framework of governance, risk management and control designed to meet the organisations objectives. The Governing Body was asked to consider approval of the Annual Report and Accounts 2018/19 and the Management Representation Letter for signature by the Chief Officer and submission to external auditors on 23 May 2019.		
	3.1 **Performance Report and Accountability Report** The Governing Body received and noted the Performance Report and Accountability Report. The Lay Member for Accountable Care raised two		

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NHS Barnsley Clinical Commissioning Group

Ref	Agenda Item		Action	Deadline
		issues in relation to Sustainability and Staff Composition. Sustainability was not the core business of the CCG however; from a broader thinking perspective could the CCG consider any other potential options which may have a positive impact on sustainability. The staff composition report (page 81) detailed male and female staff but did not breakdown further to reflect for example ethnic minorities and LGBT. In response it was noted that the CCG will consider sustainability issues throughout its work and that the CCG followed the nationally prescribed NHSE requirements and template for production of the Annual Report and Accounts which did not require a more detailed breakdown of staff composition. The CCG does however comply with other requirements e.g. the Workforce Race Equality Standard which provides further detailed analysis of the composition of its workforce.		
	3.2	**Annual Accounts** The Governing Body received and noted the Annual Accounts 2018/19.		
	3.3	**KPMG ISA 260 Summary of Audit Findings 2018/19** The Governing Body received the ISA260 report. It was noted that the External Auditors intended to issue an unqualified ('clean') opinion on the Annual Report and Accounts following their approval and adoption by the Governing Body on 23 May 2019. The ISA 260 had been presented to the Audit Committee by the KPMG Director.		
	3.4	**Head of Internal Audit Opinion & Annual Report 2018/19** The Head of Internal Audit Opinion provided 'significant assurance' that there is a sound framework of governance, risk management and control within the CCG.		

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NHS Barnsley Clinical Commissioning Group

Ref	Agenda Item		Action	Deadline
		The Governing Body received and noted the Head of Internal Audit Opinion & Annual Report 2018/19.		
	3.5	**Annual Report of the Local Counter Fraud Specialist 2018/19** The Governing Body received and noted the Annual Report of the Local Counter Fraud Specialist 2018/19.		
	3.6	**Management Representation Letter** Members were advised that KPMG require the CCG to provide a Representation Letter to confirm that the financial statements are true and that they have been prepared in accordance with the accounting policies directed by NHS England. Members received the draft letter and noted the Audit Committee recommendation to sign this letter.		
	3.7	**Statement as to Disclosure to Auditors** Governing Body was reminded of the Statement as to Disclosure to Auditors which forms part of the Accountability Report. All members present confirmed they were able to make this declaration.		
	3.8	**Approval and Adoption of Annual Report and Accounts and approval of the Letter of Representation**		
		The Governing Body: • **Received the audited Annual Report and Accounts 2018/19** • **Received the ISA260 External Auditor's Report 2018/19** • **Received the Head of Internal Audit Opinion 2018/19** • **Received the Annual Report of the Local Counter Fraud Specialist 2018/19** • **Received and approved the Management Representation Letter 2018/19 and authorised the Chief Officer to sign it on the**		

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NHS Barnsley Clinical Commissioning Group

Ref	Agenda Item	Action	Deadline
	CCG's behalf • **Confirmed that the Statement as to Disclosure to Auditors is accurate** • **Approved and adopted the Annual Report and Accounts 2018/19** • **Authorised the Accountable Officer to sign and date the Performance Report, the Governance Statement including the Statement of Accountable Officer's Responsibilities, the Accountability Report, and the Statement of Financial Position on the CCG's behalf.**		
GB/EO 19/05/04	**GOVERNING BODY ASSURANCE FRAMEWORK (GBAF) 2018/19**		
	The Head of Governance & Assurance introduced the Draft GBAF 2019/20. The Governing Body noted that the GBAF had been refreshed to ensure it remains relevant and fit for purpose and that the Management Team had approved the GBAF on 15 May 2019. The Head of Governance & Assurance advised that a new priority area around IT and Digital Technology had been added to the GBAF. A paper detailing Priority Area 2: Primary Care was tabled. The Chief Officer commented that the priority area 7: Transforming Care for people with Learning Disabilities and / or Autistic Spectrum should be strengthened to recognise the joint work undertaken with the local authority and appointment of a complex case manager. Transforming care is an important area for Governing Body to be sighted on. Discussion took place and it was highlighted that: • Physical health checks for people with Learning Disabilities are undertaken in Primary Care but not included in the PDA. Dr Harban commented that the provision of the physical health checks could be considered by the primary care networks. • Registers of people with learning disabilities held by Practices did not marry up to Social Services Registers.		

UNSIGNED

NHS
Barnsley
Clinical Commissioning Group

Ref	Agenda Item	Action	Deadline
	The Governing Body reviewed and approved the Draft GBAF 2019/20 subject to updating of priority area 7: Transforming Care for people with Learning Disabilities and / or Autistic Spectrum to reflect the joint working with the local authority and appointment of new complex case manager. ***Agree Action:*** ***Primary care networks to consider how to improve issues around the accuracy of registers and physical health checks for people with learning disabilities***.		
GB/EO 19/05/05	**DATE AND TIME OF THE NEXT MEETING** Thursday 11 July 2019, 9.30 am in the Mapplewell and Staincross Village Hall, Darton Lane, Mapplewell, Barnsley S75 6AL.		

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NHS
Barnsley
Clinical Commissioning Group

GOVERNING BODY
(Public session)

11 July 2019

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 9 May 2019.

Table 1

Minute ref	Issue	Action	Outcome/Action
GB 19/05/04	**PATIENT AND PUBLIC INVOLVEMENT ACTIVITY REPORT** To clarify and determine the CCGs 'reach' in terms of patient and public involvement. To check and ensure with Healthwatch that all hyperlinks on the Healthwatch website are operating effectively.	 KW KW	 **COMPLETE** – Built into each report. **COMPLETE** – Message relayed
GB 19/05/07	**CHIEF OFFICER'S REPORT** To provide the Governing Body with reports on workforce locally and at South Yorkshire and Bassetlaw level. To include information about the added value of work force initiatives in Barnsley.	 LS	 **COMPLETE** – Scheduled agenda item for 11 July 2019 GB meeting

GB 19/05/08	**DEVELOPING SYB SYSTEM COMMISSIONING AND CCG JOINT COMMISSIONING ARRANGEMENTS FOR 2019/20** To inform the Membership Council about the Developing SYB System Commissioning and CCG Joint Commissioning arrangements. The Governing Body to receive the JC CCGs Terms of Reference on 11 July 2019.	LS LS	**COMPLETE** – Scheduled agenda item for Membership Council on 16 July 2019 **COMPLETE -** Scheduled agenda item for Governing Body Meeting – 11 July 2019
GB 19/05/09	**INTEGERATED CARE UPDATE** To present the 'Teamwork in Action' video at the next meeting of the Governing Body on 11 July 2019.	JB	**COMPLETE** – Scheduled for 11 July 2019 Governing Body meeting agenda item 10 'Primary Care Networks Update'
GB 19/05/10	**CANCER PROGRAMME SIX MONTHLY ASSURANCE REPORT** To share a presentation about Smoking Cessation and BMBCs Health Lifestyle initiative relating to cancer given to the Barnsley Cancer Steering Group with the Governing Body members.	SL	**COMPLETE**
GB 19/05/11	**MANAGEMENT OF PATIENT EXPERIENCE POLICY** The Lay Member for Accountable Care to attend a future Quality and Patient Safety Committee meeting where complaints data is presented**.**	MT/ST	**COMPLETE**

GB 19/05/13	**RISK AND GOVERNANCE EXCEPTION REPORT** To draft a risk around the procurement of Business Intelligence, Corporate and GP IT and Information Governance services for the CCG including scoring and controls to mitigate the risk.	JW/RW	**COMPLETE** – Risk drafted for consideration by F&P on 4th July prior to approval by Governing Body.
GB 19/05/18	**GOVERNING BODY ASSURANCE WORK PLAN/ AGENDA TIMETABLE** To update the Governing Work Plan/Agenda Timetable as per comments received from the Director of Finance, and to change initials for the Transforming Care Update to PO To reconsider the work plan with a view to the future of commissioning services. Invite Alison Knowles, Locality Director, South Yorkshire and Bassetlaw to a Governing Body meeting.	KM LS/KM	**COMPLETE** **COMPLETE -** Alison Knowles, Locality Director, South Yorkshire and Bassetlaw to attend Governing Body Development Session on 25 July 2019.

2. ITEMS FROM PREVIOUS MEETINGS CARRIED FORWARD TO FUTURE MEETINGS

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

Table 2

Minute Ref	Issue	Action	Outcome/Actions
GBPu 18/11/13	**COMMISSIONING OF CHILDREN'S SERVICES MONITORING REPORT** To provide the Governing Body with a report regarding the 'value	PO	**ONGOING -** A meeting has been planned with SWYPFT

	for money' aspects of the Therapy services and a proposed model of Support for Practices around referrals.		on 31 January 2019 to discuss the demand / capacity modelling.
GBPu 19/01/10	**PRIMARY CARE UPDATE** To discuss the skills, competencies and roles of nursing staff within the Practice Team.	JHa/MT/JHo	The skills, competencies and future roles will be discussed as part of the wider Barnsley Integrated workforce development steering group.
GBPu 19/01/13 GB 19/03/06	**MENTAL HEALTH 5 YEAR FORWARD VIEW BUSINESS CASE** To submit NHSE evidence to the Clinical Forum re how an IAPT-LTC service can reduce acute healthcare costs associated with long term conditions.	PO	**ONGOING –** The IAPT Business Case does provide some of the evidence.
GB 19/03/10	**CHILDRENS COMMISSIONING REPORT** To clarify the figures in relation to costs of the revised over 11 years ASC pathway***.***	PO	Meeting booked with BHNFT colleagues at the end of April to go through the proposal and to clarify costings.
GB 19/03/11	**TRANSFORMING CARE UPDATE** To ascertain the impact of re-provision and gain Governing Body approval.	PO	PO picking up with RN
GB 19/03/14	**MEDICINES ORDERING – SAFETY AND WASTE UPDATE** A business case to facilitate a decision on an "invest to save" permanent option prior to the end of the planned programme work (October 2019) be submitted to the Governing Body. The business case should consider whether the MSOW functions could become part of clinical pharmacists' core work.	CL	Planned now that MOSW functions will be undertaken by core Medicines Management Team and no business case is required.

NHS
Barnsley
Clinical Commissioning Group

GOVERNING BODY

11 July 2019

REPORT OF THE CHIEF OFFICER

1.	**THIS PAPER IS FOR**						
	Decision		*Approval*		*Assurance*		*Information*	X
2.	**REPORT OF**		
		Name	*Designation*
	Executive Lead	Lesley Smith	Chief Officer
	Author	Kay Morgan	Governance and Assurance Manager
3.	**EXECUTIVE SUMMARY**		
	This report provides the Governing Body with a report 'The Changing Face of Clinical Commissioning' published by NHS Clinical Commissioners. The report highlights the strengths and successes of nine clinical commissioning groups, illustrating the positive work happening in health systems across England.		
4.	**THE GOVERNING BODY IS ASKED TO:**		
	Note the report for information.		
5.	**APPENDICES**		
	• Appendix A - NHS Clinical Commissioners: The Changing Face of Clinical Commissioning		

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:	5.1 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	√
	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*

NHS Clinical Commissioners

The independent collective voice of clinical commissioners

May 2019

The changing face of clinical commissioning

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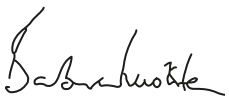
Foreword

The NHS Long Term Plan set out the next steps in changing the way the NHS will work. The aim of triple integration – between health and care, primary and secondary care, and mental and physical health – and new clinical priorities will affect the whole country, but the move to more "streamlined commissioning arrangements to enable a single set of commissioning decisions at system level" will particularly affect clinical commissioners, as neighbouring clinical commissioning groups (CCGs) work more closely or formally merge. Work is well underway to implement the Long Term Plan, and as we look to the future it is also important to reflect on the strengths clinical commissioners have brought to the NHS and to the health of the population over the past six years. These strengths must be retained.

The unique perspective and role of clinical commissioners, as well as their dedication to do what is best for the populations they serve, has seen new ways of working and innovative solutions to the complex challenges within healthcare. As CCGs merge and take a more strategic perspective, it is imperative to retain that strong clinical voice. Clinical input should be felt at neighbourhood, place and system level, as must the collaborative approach CCGs use when working with other organisations in their local area. The examples in this report explore in more depth just some of the ways clinical commissioning is evolving to meet the population's changing health and care needs.

There is still some uncertainty for CCGs as many move to 'typically' one CCG per integrated care system (ICS), not least how many ICSs there will be, and what 'atypicality' might involve. But what we are certain of – and what this report sets out – is the need to retain some commissioning functions separate from the delivery of care, and to allow clinical commissioners to continue to drive real improvements for their populations. In parallel we shall see increased joint decision making between commissioners and providers, at all levels. This collaborative approach will lead to improved outcomes within systems.

This report highlights the strengths and successes of nine clinical commissioning groups in different parts of the country, illustrating the good work happening in health systems across England. It uses these examples to argue that, whatever the changes in the detail, there is a clear need to retain the core commissioning function as well as the expertise brought by the clinical leaders who play a crucial role in getting the best value from the precious NHS pound.



Dr Graham Jackson and Dr Barbara Rushton, Co-Chairs, NHS Clinical Commissioners

Introduction

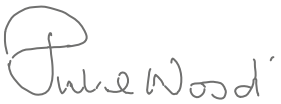
CCGs and NHS Clinical Commissioners, the independent membership organisation representing them on the national stage, have existed since the Health and Social Care Act in 2012. The health landscape has changed a lot since then, but CCGs are still playing a crucial role.

Despite suggestions from some that the development of ICSs signalled the end of the purchaser/provider split, the commissioning role – assessing needs, planning and prioritising, and purchasing and monitoring services – is still seen as important by decision makers. Simon Stevens, chief executive of NHS England, has said that "there is clear benefit from having distinction between the planning and funding functions and the day-to-day delivery of clinical care", and that there still need to be commissioning decisions made in the interests of people living in a specific area. Clinical commissioning fulfils this role, with clinical leadership and expertise – and an insider's knowledge of the local context – feeding into decisions about which services are needed to meet their population's needs.

CCGs will increasingly work across larger populations and more closely with provider and local authority colleagues but the decisions they make should be at the level that is most appropriate, at neighbourhood, place or system level. This principle of subsidiarity means that even as the new NHS landscape emerges, there will be a role for clinical commissioners.

We know that our members are doing things in new ways and will continue to innovate and respond to the changing context. Here we set out what we believe needs to be celebrated and retained as the NHS in England evolves.

We are very grateful to the CCG colleagues who participated in interviews for this piece of work, as well as Brighter Together who authored the report.



Julie Wood, Chief Executive, NHS Clinical Commissioners

Executive summary

CCGs are responsible for improving the health of their populations. They do this by determining the health needs of the people they serve and ensuring there are high-quality services to meet these needs. CCGs are led by accountable officers – with the input of clinical colleagues on their governing body, CCGs have a high level of clinical leadership. These organisations possess many strengths that have led to innovations and improvements across health and social care. They bring together and work collaboratively with other organisations; this role will be even more important as ICSs develop. This report sets out to showcase the strengths that must be retained as NHS and social care systems continue to evolve. To inform it, we spoke to nine different CCGs, exploring their work – these examples provide a snapshot to illustrate the range of great practice taking place across the country.

Clinical commissioners act as respected **clinical leaders** within their communities to promote the best interests of patients while balancing need and resources and driving through change. In Devon the actions of clinical leaders and managers working together saw quality improvements in the CCG's Continuing Healthcare process with a resulting cost reduction of circa £50 million.

Clinical commissioners have no vested interest as a providing organisation – without these constraints, they can take a **system-wide perspective** considering what is best for their whole population and how best to deliver safe and effective care. South Tyneside CCG has worked with partners to align priorities and values and as a result has seen key system-wide outcomes improve.

As well as taking a system perspective, clinical commissioners have **strong links to place** (or local populations) to ensure specific needs and challenges are not forgotten. Leeds CCG has been formed by the merger of three CCGs but recognises the value of working to drive initiatives at a place level – retaining their local relevance.

Clinical commissioners have experience of working with and for their communities and patients over long time periods, providing a **unique perspective**. Wanting to provide a more coordinated service for those with multiple long-term conditions has led Dudley CCG to move towards commissioning an integrated care provider.

Clinical commissioners have a responsibility to **spend their money wisely**, considering the needs of their populations and determining the most effective way of delivering this, both financially and clinically. Blackpool CCG has looked closely at how it spends its resources, choosing to redesign some services such as the musculoskeletal pathway.

Clinical commissioners are motivated by their desire to do best for their patients and are effective at **driving through changes**. Sunderland CCG has facilitated better joint working between providers to transform out of hospital services.

Clinical commissioners recognise the value of **working in partnership** with others for the benefit of patients and have focussed on building relationships. Luton CCG has worked concertedly to partner more closely with their local authority to an extent that budgets and offices are now shared.

Involving patients and the public in their decision-making processes allows clinical commissioners to understand needs and design solutions that are fit for purpose. In Southwark, clinical commissioners have undertaken an extensive patient and public engagement initiative to improve child and adolescent mental health services (CAMHS).

Feedback from their peers allows clinical commissioners to appreciate the issues they are facing and determine if new solutions are working on the ground. For PartnersHealth, a partnership of GP practices providing primary care in Rushcliffe CCG, peer feedback has been an important aspect of their success.

We recommend

As the NHS changes, we need to make sure the following are retained within ICSs and by decision makers:

- tangible 'place' level links and responsibilities – CCGs have formed working relationships with others in their place, especially local government. As they potentially merge to cover larger footprints (to meet the recommendation in the NHS Long Term Plan that there should be 'typically one CCG per ICS'), the important work at place level should not be lost
- 'stewards' and the system perspective – working more collaboratively is important, but having an unbiased view is crucial. CCGs can make sure providers are doing the right thing for their population as they're the only ones without vested interest. Their voices within systems must be heard
- keeping clinical engagement at the core – CCGs have been successful in embedding clinical leaders and the expertise, credibility, and better health outcomes this brings. This must be maintained as we move to more system working.

In 2019/20, NHS Clinical Commissioners (NHSCC) will be working with our members to ensure their role and successes are shared and celebrated. We will be:

- doing more work on 'place' – what this means in practice and how CCGs are ensuring it's retained as they get bigger and work at scale
- helping CCGs understand what the 'typically' one CCG per ICS means in practice, and providing support for those considering merging
- influencing how the NHS England legislative proposals will impact on CCGs – so there is no dilution of their unique perspective even with more collaborative working
- supporting clinical leaders – and their manager colleagues – with delivering the Long Term Plan.

About this report

NHSCC is the independent membership organisation of clinical commissioning groups. We provide CCGs with a strong collective voice and represent them in the national debate on the future of healthcare in England; as well as sharing best practice and learning among our members.

Despite the relatively short lifetime of CCGs and against a backdrop of financial and workforce pressures within the NHS and social care system, clinical commissioning has driven improvements in services and outcomes for patients and delivered value for money for the NHS. The unique perspective and role of clinical commissioners, as well as their dedication to do what's best for their patients, has seen new ways of working and innovative solutions to the complex challenges within healthcare. Within this report we highlight the strengths of clinical commissioning and showcase real case studies of the positive work CCGs are undertaking across the country.

In order to inform this report, we have undertaken a literature review and interviews with nine different CCGs, exploring their work and views on the strengths of clinical commissioning. We thank all those that gave their time and shared their insights and experience.

What is clinical commissioning?

Commissioning is:

- the process of assessing needs
- planning and prioritising
- purchasing and monitoring health services

to get the best health outcomes.

In the NHS in England, commissioning involves a significant level of clinical engagement – and locally is the responsibility of CCGs, which were established in 2012.

CCGs are member organisations made up of GP practices with an elected governing body that includes other health professionals, such as nurses and lay members. There are currently 191 CCGs across England (although this number is likely to change in the future), responsible for approximately two thirds of the NHS England budget.

CCGs contract providers to deliver services for their local populations that include mental health services, urgent and emergency care, many hospital services and community care. The vast majority have also taken on responsibility for commissioning primary medical care from GP practices. Most services they 'buy' are contracted from NHS bodies – like NHS trusts.

Clinical commissioning is a continual process, as commissioners monitor how services are performing and how the needs of their population are changing – as well as what innovation might be needed to improve health. The role of clinical commissioners within the NHS is also evolving, moving towards greater integration and partnership working between all organisations within the health and social care system. This may mean clinical commissioners' roles change as they operate more collaboratively and often at a bigger scale. But their key functions remain, as there will always be a need to assess need, plan and prioritise services, and decide who is best placed to provide a service by contracting them to do so. With this in mind, we wanted to consider the roles that clinical commissioners have played and their key strengths that must be maintained in the changing NHS context.

The strengths of clinical commissioning

Clinical commissioners drive change and improvements across the health and social care system. The role clinical commissioners play, as well as their unique perspective and skills, makes them effective and well placed to deliver these positive impacts for their patients. Alongside this, they work in partnership with other organisations to improve health outcomes across their local area. We explore several of the strengths of clinical commissioning in the case studies that follow.

Clinical leadership

Clinical leaders have the expertise and knowledge to identify and implement the changes that are required across the NHS. They have the credibility and experience that help to bring others with them with the confidence they are trusted by both the public and their clinical colleagues. Evidence shows that engaging doctors, and other health professionals, in leadership drives quality improvement in health services.[1]

Devon

Five years ago, Lorna Collingwood-Burke, chief nursing officer at NHS Northern, Eastern and Western (NEW) Devon CCG, was asked to review the Continuing Healthcare (CHC) process for the NEW Devon CCG because of her background in nursing. Continuing Healthcare allows the NHS to fund social care for some people with long-term or complex healthcare needs. Back in 2014, the NEW Devon CCG CHC budget was financially challenged, and the service needed to be reviewed from a quality and equity perspective.

After undertaking a mini-audit, it became clear that there was variation in the quality of assessments that determined whether a person was eligible for this funding. This was potentially affecting the ability for people to access Continuing Healthcare and raised concerns that it was not an equitable service. Lorna gained agreement that the review of the process needed to be driven by improving quality and not by focusing on finances. The priority was to deliver an equitable and safe service for all people.

"Everyone in the CCG has a focus on quality – led by the executive team and clinical leads. Finance is important but not to the detriment of patient safety and effective care. It is important not to make quick or short-term decisions without truly understanding the quality impact as it may end up costing more in the longer term," Lorna explains. This is why the clinical commissioners in Devon have worked with their quality and finance teams to better understand the impact of high-quality care on finances and vice versa.

Lorna continues: "Quality is about determining the longer-term impacts. These are not always obvious, but you need to consider the longer-term aspects of spending or not spending money. If care is safe and effective, then the patient is more likely to have had a more positive experience of their care and you are more likely to have got that care right first time which reduces the burden on finances."

Lorna believes clinical leadership at the CCG has ensured this focus on quality. When leaders set the values and principles, others will follow.

"The clinical leadership has been absolutely fundamental. They will stand up and talk publicly when changes need to be made and because they are trusted members

1 Policy Research Unit in Commissioning and the Healthcare System (2015), *Exploring the GP 'added value' in commissioning: What works, in what circumstances, and how?*

of their communities they are listened to."

To bring about change to Continuing Healthcare in Devon, Lorna created a 'matrix' team. There is representation from a number of directorates, for example GP clinical leads, nursing, finance, business intelligence and marketing. They meet together once a week and have developed a close working arrangement. A dashboard has been developed and controls are in place around validation of decisions and those assessments that are complex and likely to be of a high cost. As a result of these changes, the Continuing Healthcare expenditure has been reduced by circa £50 million. As far as data suggests, no-one who is eligible for Continuing Healthcare has had their funding request refused.

Leeds

Philomena Corrigan, chief executive of Leeds CCG, attributes their ability to spread change to the involvement of clinical leaders – as they are credible advocates for improvements. In one particularly deprived area of Leeds she has seen GPs working with the voluntary sector introduce initiatives improving the wellbeing of older people with depression who feel socially isolated. She comments:

"Sometimes it takes somebody who is in the same environment with the same background, the same pressures, to be able to stand up and be able to show that kind of real change and demonstrate that it can work."

Her colleague Dr Simon Stockill, Medical Director adds:

"It doesn't happen by accident. We've had a really firm commitment to recognise the value of clinical leadership at practice level, locality level and citywide level. But it's something that's taken a conscious effort, conscious plans, repeated refreshing of our strategy towards identifying clinical leaders, training and supporting them. And that also involves investing in them as well, both in terms of the time available for them to take time out of clinical practice but also to provide them with the skills and support and expertise to continue to do it."

Taking a system-wide perspective

Clinical commissioners take a system-wide view when determining the needs of the people they serve and the best services and solutions to deliver high-quality outcomes. They lead transformative work to identify services or parts of the system which aren't working effectively for patients and, unlike providers, are not constrained by organisational demands to increase income by increasing activity – as some providers may feel pressure to do. Clinical commissioners are motivated to achieve a system where all parties are working together to ensure a healthy population where patients receive the best care and treatment when needed.

South Tyneside

Two years ago, some of South Tyneside's key outcome indicators lay in the bottom 10 per cent in England. Delayed transfers of care (DTOCs) were among the highest in the country and smoking in pregnancy rates were 25 per cent. Today these indicators are in the top 10 per cent, DTOCs have reduced dramatically and smoking in pregnancy rates have dropped to 13 per cent. This impressive turnaround has come about through the CCG working with partners to take a system-wide approach and working together towards shared aims.

Working in this manner began in 2016 when South Tyneside was granted health and social care integration pioneer status and partnered with Canterbury in New Zealand.

"When the CCG was first created, organisations were focused on their own priorities. We were very clear about what we were trying to do, it was to focus on the collective good for our locality and on shifting that behaviour. We could see the inter-connectivity between the work different parts of the system were doing and could see we weren't necessarily spending our money in the most effective way," explains Dr David Hambleton, chief executive officer at South Tyneside CCG.

The CCG followed the lead of Canterbury by adopting the philosophy that all parts of the system needed to succeed together – it would not be possible for one part of the system to work effectively without the other parts also working well – and that decisions should be based on what is best for patients and populations, with the money following afterwards. Rather than focussing on structure and governance, the CCG and partners have worked on developing shared values and behaviours.

The CCG, council, acute trusts and mental health trust chief executives already met regularly. Building on this, key opinion leaders from each of the organisations, the leaders that people would look to, were brought together to create the Alliance Leadership Team. This team has focused on the types of behaviours that they would like to see in the system.

> **"We were very clear about what we were trying to do, it was to focus on the collective good for our locality and on shifting that behaviour."**

David explains:

"Now we talk about doing what's best for patients and for the system. That's in contrast to doing what's best for your organisation. We are essentially asking people to unlearn the behavior they have been taught over the last decade, for example that foundation trusts are businesses that make a profit and generate income. We're asking people to completely change that."

South Tyneside has three system goals. Firstly, to prevent people becoming ill and to ensure they live healthy lives. Secondly, to create good community care as close as possible to people. And thirdly, to provide expert specialist care only when it's needed. Improving delivery of the third goal involved improving the management of finances. The CCG had observed that the system status quo, with payment by results contracts, was not incentivising the right behaviours across the patch, not contributing to keeping people well or delivering care in the community. Changing to a flat block contract arrangement would help to move away from counting activity and shift towards a system that was focussed on the right thing for patients.

"It isn't the block contract itself which is the big achievement, the achievement is changing behaviour of people in the system to focus on doing what is the right thing for patients and for people, and sorting the money out separately. So we've got our hospital chief executive now talking very openly about downsizing the organisation in terms of beds, how we can manage to support people being cared for in the community and how we need to shift the focus to prevention rather than treatment," David adds.

Sunderland

Sunderland CCG has led a move away from transactional principles of providers trying to generate income and commissioners trying to reduce expenditure, to an approach where everyone now works on cost only. The CCG's proactive approach to managing financial and system risk has involved breaking down barriers and making sure everyone is in partnership and not in competition with each other.

Penny Davison, senior commissioning manager at the CCG explains:

"We are talking much more about the system, so providers are no longer worrying about their element of the market and are thinking much more about what is the right thing to do for the system. We have providers saying, 'I may need to make a decision which is not good for my organisation but it is good for the health economy', which is a seismic shift to where they were 12–18 months ago."

From the local to the regional: 'Places' within systems

While clinical commissioners see across healthcare systems and drive organisations to work towards shared outcomes, they also understand the needs and particular circumstances of much smaller, more tangible and local populations within their system's geographical area (sometimes referred to as 'place' but could also be known as a locality). Clinical commissioners work hard to retain their links to these smaller populations or places and ensure this vital insight is not lost. This is especially important as CCGs get bigger and cover larger areas. Often clinical commissioners drive improvements that will benefit populations at a place level, and do this by having working relationships with the right stakeholders in that area – such as local government.

Leeds

In April 2018, the three CCGs within Leeds merged to become one CCG, although the process of amalgamating the three organisations had begun much earlier on.

Philomena Corrigan, chief executive of Leeds CCG, explains the reasons behind the decision to merge:

"There were three CCGs chairs, three CCG governing bodies and three accountable officers and we discussed the benefits of being one organisation for Leeds, partially to do with these decision-making structures, but also for the benefit of our stakeholders, both the council and the providers. We were mindful that actually trying to relate to three separate organisations was difficult. It wasn't the best use of people's time and we thought we could get better benefits and better clinical outcomes by being one organisation."

However, the new CCG wanted to ensure that the links to local populations weren't lost. This was of particular importance to their GP members.

"We've been nudging practices gently over the last few years towards thinking in terms of their obligations to a register, to a collection of registered lists in a locality, to start to bring in that concept of population health management at a local level. And we've been doing that gently by mixing the quality improvement outcomes at both practice and locality level." says Dr Simon Stockill, medical director. "Practices now really value the relationships they are developing with neighbouring practices in their localities and with other providers such as district nurses, matrons, physiotherapists and social workers. As long as that isn't lost in the reorganisation, our stakeholders could see the advantage of a bigger scale citywide organisation."

The CCG is putting in place a partnership executive group across the city with representatives from each locality sitting in the group. This will allow the locality representatives to understand what the system is trying to do and relate that back to practices in their locality, as well as take part in strategic conversations and recognise what needs to done at locality level to implement those strategies. In addition to funding localities for clinical leadership, the CCG also supports the lead GP confederation which has brought together the three federations into one citywide function. Part of the funding agreement for the confederation is to support the delivery of a number of different objectives within the city, one of which is to support practices in the delivery of quality improvement schemes. The

practices receive a payment for this but the network also receives payment for supporting them to do it at scale.

Simon highlights how this is working:

"What we know is that some parts of the city are better at identifying people with major conditions. We're working to close the gap for three major conditions – atrial fibrillation, COPD and hypertension – in areas where we see there is a significant prevalence gap across the city in the identification of these diseases. We've actually identified a series of locality by locality targets and are producing data at a practice, locality and citywide level. Practices in their localities, supported by their citywide confederation, are working to achieve a reduction in unwarranted variation over the course of the next year. This will cut the number of premature deaths and allow people to lead healthier lives."

Luton

Luton is part of the Bedfordshire, Luton and Milton Keynes Integrated Care System (BLMK ICS) which is one of 14 in England. BLMK ICS was one of the pioneers of the Triple Tier Model, the suggestion that the key levels of health and care are locality or neighbourhood (primary care networks), place (local authority) and system or scale (ICS). This has been adopted by the NHS Long Term Plan.

Nicky Poulain, chief operating officer at Luton CCG explains how this works:

"It is our belief that services should be organised as locally as possible, where safety and efficiency allows. As Bedfordshire-Luton-Milton Keynes, we will have some economies of scale (we've got one joint CCG executive team with a joint accountable officer for all three CCGs), and we've got operating officers in each of the three areas, so that the places are sovereign. The role of the Luton chief operating officer with the CCG chair will retain that place focus. The work we are doing to improve services for those with frailty, learning disabilities or mental health conditions is happening at a place level."

Unique perspective

Clinical commissioners have first-hand experience of what is going right and wrong in their community and the challenges both they and their patients face with the health and social care system. They have a local understanding of the population, needs and context and this can aid their decision making to ensure services meet the needs of local people. They also see their population and patients in the round, and not as one condition or set of symptoms, and have an ongoing responsibility for their health. This gives them the ability to take a more holistic and long-term approach to commissioning with an understanding of what is important for patients.

Dudley

Dudley CCG is one of the first to move towards contracting an integrated care provider (ICP). This will see providers collaborating to provide care.

The work began when the CCG considered the needs of their population, whether the way they were organising care met those needs and therefore what their priorities should be. One of these priorities was care for the increasing number of people with multiple conditions. Dudley CCG wanted to create a multidisciplinary primary care and community service to provide better continuity and coordination of care and so resolve the disjointed service which existed for these people. The CCG and providers worked together to develop and implement the integrated care model under the direction of a system-wide partnership board involving the CCG, all providers, the council and voluntary sector. A few years further on, creation of the ICP is the next logical step forward to deepen the extent of integration across the system of care.

Paul Maubach, accountable officer at Dudley CCG, explains:

"That came from our staff and our patients because what our staff are saying is 'we collaborate together, but it would be so much easier if we were one team working for one organisation to one set of shared objectives'. The big emphasis that we've had on developing the ICP is about establishing shared responsibility (between different staff and with the public) for achieving the same shared objectives for the same shared population. It's really all about alignment."

Paul believes that moving towards an ICP will help to shift the thinking of all those working in the system to focus on the outcomes of the whole population, with prevention becoming a much greater priority. One set of patients who will benefit from this shift is the 20,000 people living with diabetes in Dudley. At present, all of those people are managed by their GP with only a small proportion also being seen by a diabetologist. And while the GP practice is contracted to a set of outcomes, the hospital, for which the diabetologist works, is contracted for how many times the patient is seen, regardless of the outcome. At present the clinicians and organisations across the system don't share a responsibility for the wider population of people with diabetes or those people who may be at risk of developing diabetes. In the new system, the diabetologist and GP will work together to manage all patients, supported by shared organisational and contractual objectives to deliver improved outcomes.

Clinical commissioners will still play an important role within this new system: holding the provider to account through the ICP contract

and taking responsibility for the public engagement on what outcomes need to be achieved. Paul explains:

"There needs to be a mechanism whereby someone is engaging with the public about how their needs are changing and therefore what the expectation requirements are on the NHS to deliver those for the local population. And I think there needs to be some separation between whoever does that activity and whoever is providing the services."

Paul highlights that the strengths of clinical commissioners have helped to push these radical changes along:

"The clinical leadership in this CCG has helped us to understand the needs of the population and how that is presenting on a day-to-day basis. GPs bring home the experiences of patients on their life journey and the effectiveness (or otherwise) of healthcare delivery and how it's experienced by patients."

The continual feedback loop from healthcare professionals on the ground about what is and isn't working is also hugely beneficial.

"It enables you to be much more responsive to whether or not what you're doing is working but also what you need to change in order to improve the system of care. It's almost like, it's helping to create a self-improving system and a learning environment because we're getting that feedback all the time. I think that's pretty powerful."

South Tyneside

Dr David Hambleton, chief executive officer at South Tyneside CCG, explains their unique perspective to improving outcomes across their system:

"We do not try and draw a cause to effect line between any of our individual initiatives. The system is far too complex. The output that we see, we never attribute that to one thing, it is more the collective impact of everything that we are doing."

Spending money wisely

CCGs ensure that public money is spent wisely. They have an understanding of what makes a positive impact for their patients and what doesn't and therefore where best to invest. Having close understanding of their local communities is crucial when it comes to making tough and sometimes unpopular choices, which are needed for the benefit of their populations.

Blackpool

Blackpool is an area of high deprivation. Faced with financial pressures, Blackpool CCG has taken difficult decisions to ensure that resources are being used effectively and money spent wisely. The CCG has led a drive to stop procedures of low clinical value, such as the removal of varicose veins and tonsillectomies for some patients who would not derive clinical benefit, as well as restricting the prescribing of medicines that are readily available over the counter, such as paracetamol, or gluten-free food, now commonly found in supermarkets.

David Bonson, chief operating officer, says:

"It's clinicians who are making these decisions and that makes it easier for other clinicians to come on board. It is not always popular with patients but by engaging we've been able to explain to patients and the public the reasoning behind the decision. People do understand that by spending money on some things, we have less to spend elsewhere. If you have an informed conversation, they understand."

In addition, the CCG has undertaken a drive to review and standardise referrals to secondary and specialist services. The CCG has asked GP practices to look at all of their referral processes and review them, and they have built this into the GP contract. The CCG has a process to check providers do not deliver unnecessary procedures and GP practices do not refer in the first place. There is a further check and balance step in the middle, where the CCG eReferrals team confirm that referrals comply with the CCG's referral policies. All practices check each other's data on referrals and there are regular discussions with practices about how they manage referrals and to identify any outliers.

"This has led to a general reduction in referrals and a reduction in variation between practices, so there is a move towards greater standardisation. We are not restricting referrals, we are checking the appropriateness of them by putting processes in and making it more visible for practices and having conversations with them about referrals. Nobody wants to be an outlier, so we are seeing year-on-year improvements in volume of referrals and appropriateness of them."

Another part of the CCG's work has been to redesign musculoskeletal services (MSK). NHS Right Care identified that the CCG was spending a lot on these services and so by looking at patient journeys and engaging clinicians, MSK services have been redesigned as community services, rather than being delivered by the acute trust. The new service is integrated with community and primary care services. The CCG worked with

GPs to understand pathways and developed more flexible contracting and payment approaches.

The new service triages people within the community and then a clinical review identifies those patients who would benefit from an MSK referral in the community or those who need a referral to orthopedics. It has saved significant activity that was flowing into the acute and independent sector. It has also meant that waiting times have improved and patients have been seen in the right setting, in a timely manner. David Bonson explains that partnership has been key to the success of the MSK redesign. At the heart of the scheme's success is:

"The willingness to do it and the trust and partnership built across multiple organisations."

> "People do understand that by spending money on some things, we have less to spend elsewhere."

> "Nobody wants to be an outlier, so we are seeing year-on-year improvements in volume of referrals and appropriateness of them."

Devon

In Devon, the transforming care partnership identified that one solution to meet the needs of one person with a complex learning disability was to buy a property and make specific adaptations – this needed input from finance, commissioning and nursing colleagues. Lorna Collintgwood-Burke said: **"Using money differently is important and can require strong partnership working, communication, flexibility and determination."**

Driving improvements

Clinical commissioners are well placed to see the problems that exist within a health and social care system and the long-term impacts that decisions can have on the health and wellbeing of their patients. This allows them, working with partners, peers, patients and the public, to identify solutions that work for the whole system and that deliver long-term positive outcomes for patients and their families.

Sunderland

"There's been a drive and a commitment to change and take action forward rather than just write a plan and leave it on the shelf." says Penny Davison, senior commissioning manager at Sunderland CCG.

The CCG has led the development of the All Together Better Alliance, which includes the CCG, local authority and providers, all working to transform out of hospital services. The CCG brought together groups of GPs, practice nurses, practice managers, social workers, local authority colleagues and others to develop how they would envisage their locality working and how they want things to change. The CCG has led changes in behaviours by encouraging open and honest dialogue and by the governing body setting clear outcomes to be delivered.

This approach has led to changes in intermediate care (now called 'recovery at home' following patient and public engagement), integrating community care and care homes and setting up a federation of GP practices to enable extended access. Clinical input and clinical perspective have been intrinsic to delivering these improvements, as the clinical leaders have been clear about the changes they wanted to see. Feedback from patients and staff is positive, particularly around creating community integrated teams.

"That deliberate decision to include clinicians in the widest sense from day one has really been the foundation of our work going forward. Taking on that design means the delivery has been more successful."

One improvement has been providers working together to propose a new model of co-locating community-based services with general practices, reducing costs for the CCG, which facilitated these discussions via the alliance and encouraging discussion and shared ways of working.

"Our leadership team really took clinical commissioning to heart and had that drive to change things together. GPs were now executives with the opportunity to do things differently than before."

> “There’s been a drive and a commitment to change and take action forward rather than just write a plan and leave it on the shelf.”

> “That deliberate decision to include clinicians in the widest sense from day one has really been the foundation of our work going forward.”

Rushcliffe

Rushcliffe CCG invested in the development of PartnersHealth, a partnership of all GP practices in Rushcliffe, encouraging the partners to use that investment to build scale, resilience and infrastructure to enable them to operate as a single entity when it is appropriate to do so. They have adopted and adapted a GP specification first used by Liverpool CCG. The GP specification requires a collective effort, with rewards set at the level of the network, not at the practice level.

“The CCG has been a facilitator and understood that actually to deliver its objectives we need a robust, resilient, ambitious and capable primary care sector and we need to create conditions in which primary care can organise itself instead of prescribing how it’s done,” explains Dr Stephen Shortt, chair of Rushcliffe CCG and co-founder PartnersHealth LLP.

Partnership building

Clinical commissioners have the ability to build relationships and partnerships with other key health and social care organisations across the system such as other CCGs, trusts, local authorities and the voluntary sector. They can bring these partners together to enable change or to join up services, promoting a collective view of the system and putting patients at the heart of decisions. This is only possible by developing relationships and working towards common goals.

Luton

"There's always been a common goal to do good for the people of Luton, many of whom face real difficulties and inequalities. But finding the right way to achieve this, when our priorities and finances can be pulling us in different ways, can be tricky," explains Nicky Poulain, chief operating officer at Luton CCG.

For some years Luton CCG and the local authority had been trying to work in a more integrated way. They had faced challenges in ensuring their population received a consistent approach and often found they were potentially duplicating the work they were doing to serve the same cohort of patients. In 2015 the CCG and local authority signed up to become one of NHS England's 'national demonstrator sites for personalisation'.

They began by considering their care of people with dementia, discovering that both the CCG and the local authority had separate dementia strategies. They established joint meetings between the CCG and local authority leadership team to co-create one vision for the people and families with dementia. This triggered a change in culture and way of working, with a shift to both organisations jointly focusing on the population and outcomes.

In 2018, the chair of Luton CCG and the leader of the council jointly wrote and signed a concordat between the organisations. This was followed with a commitment to have one aligned budget to ensure the Luton pound was effectively used. They have now co-located into the same building and have continued to focus on organisational development.

Nicky explains that this has involved building relationships, understanding the other person's point of view and having a shared outcome:

"You've got to build your relationships, you've got to actually find a common goal and you've got to be very kind to each other because you'll make mistakes along the way. But it's actually building that relationship of trust and respect and, in my view, that continual drive to learn and the continual drive to think about the people that you're serving. Whenever we end up having a cross word we say, 'Hold on a second, there's a very vulnerable person we're talking about here, let's not lose the point.'"

The co-location of teams in the same building is a catalyst to joint working. Nicky highlights some of the advantages of working in the same building:

"People can go to the kitchen and talk to the brokerage team, for example, and you find things out that you didn't know. And I've learned, being in this building only a month,

things that I didn't even know about because I wouldn't have been exposed to them."

This joint approach to working has led to new initiatives across the health and care system. For example, the local authority and CCG have joined up their public engagement processes to clarify the offer to a defined cohort of about 800 people who were identified from the frailty register and had had two or more inpatient admissions in the last 12 months. They've seen improvements across the system such as a reduction in the pressure felt in primary care, reduction in hospital admissions, and people and their families feeling better supported.

> "There's always been a common goal to do good for the people of Luton, many of whom face real difficulties and inequalities."

Southwark

Throughout the process to review and improve CAMHS, Southwark CCG worked very closely with their colleagues in the council and in South London and Maudsley Trust as part of a whole system approach. The CCG's ability to convene a broad range of partners to consider the issue of children's and adolescents' mental health was a real benefit. The breadth and depth of experiences within the CCG's governing body and broader clinical membership brought a combination of understanding of primary care and insight from working on the ground.

Patient and public involvement

Clinical commissioners understand the value of including patients and carers in commissioning decisions so that services meet the needs of those they serve. This involvement can include identifying the priorities for certain patients and helping to design pathways and services. They also recognise the importance of ensuring their populations understand the decisions they are taking.

Southwark

"It's about how we bring people with lived experience into the actual shaping of the strategic agenda," says Ross Graves, managing director of Southwark CCG, explaining how they worked closely with key partners to run a wide-ranging strategic review into how to improve CAMHS. Involving patients and the public helped Southwark CCG, working in a borough in south London, identify that their current service provision was fragmented and confusing. The review team worked hard to hear from young people who, for example, told them about the challenges of stigma and the importance of where services were located.

Southwark CCG, with their partner Southwark Borough Council, agreed to conduct the review to make sure they were delivering the best outcomes and getting value for money. As well as involving service users, families and carers, it also included the South London and Maudsley Mental Health Trust, local schools, public health, nursing, health visiting, school nursing, acute hospitals and also services provided in a general practice or primary care setting. Patients and the public were involved from the very start.

A range of channels were used to gain people's views. These included a survey, a focus group of head teachers and safeguarding leads, a focus group of young women, a carers' focus group and a parents' focus group. It all culminated in a large stakeholder engagement event, with about 75 attendees, including parents and carers, young people and professionals. This event included presentations, group discussions and prioritisation exercises.

Ross explains:

"What we were seeking to do was to have a range of different channels that we were exploring as part of the engagement. And also to try and get away from a purely health-focused approach. There is always a risk that these reviews become focused on the more specialised, but actually we recognised the importance of young people, communities and schools and social workers, teachers and so on, and actually trying to get that much bigger broader picture."

The CCG's links with the local health communities, and the local authority's links with the local education network meant the strategic review was able to seek the views of users in all parts of the system.

The process of involvement of patients, carers, teachers and the public identified that service users were finding it really difficult to understand different services and pathways and what was available and how to navigate them; the system was fragmented. The patient and public engagement will

continue while Southwark rolls out recommendations from the review, including service improvements and simplifying the pathway.

> **There is always a risk that these reviews become focused on the more specialised, but actually we recognised the importance of young people, communities and schools and social workers, teachers and so on, and actually trying to get that much bigger broader picture.**

Dudley

Paul Maubach from Dudley CCG explains their approach to involving patients in decision making:

"We do a lot of public engagement and our public engagement always includes clinicians as part of that process, because actually patients want to hear from clinicians. They don't really want to hear from managers. When it comes to public engagement, it makes sense to have patients interacting with clinicians because that's the trusted interface. I think we work effectively when we're listening to both patients and clinicians and encouraging them to talk to each other. And for us to listen to the outcome of that conversation."

Peer feedback

Clinical commissioners seek direct feedback from their GP peers within their CCG, both allowing them to hear first hand about the issues that exist at a community level and share learning between GPs. This provides a feedback loop providing an understanding of whether changes are bringing about desired improvements. The King's Fund and Nuffield Trust have found that CCGs have secured better clinical engagement than previous forms of commissioning[2] and are now seen by the majority of their GP members as an influential part of their local health economy.

Rushcliffe

Peer support and feedback from fellow GPs and other clinicians is a key part of the success of PartnersHealth, a network of GP practices providing primary care in Rushcliffe CCG. Good working relationships that have been established and developed over very many years enable the partnership working that continues today.

Incentivised and supported by the CCG, PartnersHealth has taken a life stage approach, identifying clinical leads from wellness to disease prevention and long-term conditions management, mental health and end of life care. There are dozens of GPs involved in leadership positions in a distributed leadership model across the CCG who are supported by CCG managers to help to deliver better care.

Peer feedback is a key part of success. Every month GPs and staff from all practices meet together, to share progress against their clinical strategy and focus on business objectives, discussing what drives their experiences and where there might be opportunities for improvement. They use data to help them, taking into account utilisation metrics, trend information on user resource and audit activity to see what is positive and what is not so positive.

"It's an absolutely critical meeting. The room is crowded, it's buzzy, it's vibrant, it's energetic, and there's good participation. We come together and enthusiastically look at how to solve the problems of delivery, some which are about care pathways and interfaces with the secondary care sector," says Stephen Shortt, chair of Rushcliffe CCG.

Even though Rushcliffe has had significant investment in its primary care funding via the new models of care programme, it is professionalism that has driven change in Rushcliffe. By bringing together colleagues and supporting them to think constructively about being the best clinical professionals they can be, the CCG and PartnersHealth have driven improvements. Other motivations driving the clinicians include overcoming day to day frustrations and enhancing self and peer respect, as Stephen explains:

"One of the positive things around getting together on these monthly occasions is actually to celebrate

2 Robertson R, Holder H, Ross S, Naylor C, Machaqueiro S (2016), *Clinical Commissioning: GPs in charge?* The King's Fund and Nuffield Trust.

that competitive edge. When practices pore over the figures and look at how they benchmark against their peers, it is motivating, it enhances self and peer respect, it encourages us to continue to look forward, to carry on."

In addition, there are dedicated work streams run by different clinical groups, with appropriate management support, so work can continue outside of the key monthly meeting. Stephen comments:

"The ideas come from clinicians, not only GPs, but sometimes, for example, for end of life care, residential home staff, from nursing colleagues and psychiatry colleagues in mental health, but always from the point of view or from clinicians. Clinicians witness every single day experiences of patients and the outcomes of patients in the health and care system and understand how the system is good in parts and can be improved in others."

The result of working together and sharing feedback is the development of more than 50 new care pathways in the last three years and better management of financial resources. They have rolled out self-prescribing, changed the urgent care pathway, invested in health coaches as well as new approaches to mental health, prevention, end of life care service. As Stephen says:

"Fundamentally, our focus is to better understand how system performance can be improved through clinical transformation, as the system's quality, performance and use of resources derives directly from how medicine is practiced and care is delivered and the aggregate of thousands and thousands of care decisions, which take place every day in general practice and community services, and which we try to make better."

Devon

Lorna Collingwood-Burke, chief nursing officer at Devon CCG explains the importance of the relationships clinical commissioners have with their peers:

"All the GPs working for the CCG have a good relationship locally with their counterparts. Those relationships are really important because you can have a conversation that everyone understands and you know you aren't going to have to go and talk to someone who doesn't know you or what you do. Our successes were made because the relationships were always there."

Conclusion

It is clear that clinical commissioners have valuable and unique strengths. Their clinical expertise, understanding of their local communities and patients and their unique perspective presents opportunities to lead changes and bring about improvements across the health and social care system. The NHS Long Term Plan has signalled the need for focus on prevention, supporting people in the community to stay healthy and improving care for everyone. Clinical commissioners are imperative in creating this health and social care service fit for the future. Clinical leadership must continue within the commissioning function at all levels – neighbourhoods, places and system.

By April 2021, if the NHS Long Term Plan is put into practice, then a lot of the 'architecture' of the NHS is likely to be different. Equally, many activities will be different too. It's likely to mean there are fewer CCGs, and they will operate in a more strategic way – something that CCGs have been working towards for a number of years, as we explored in our previous publications *The future of commissioning and Steering towards strategic commissioning*. It also means that CCGs will potentially share some functions and roles with their colleagues across local systems and places as explored in our publication *Driving forward system working*.

When describing their vision for a new, collaborative NHS, we've also heard from the leaders of the NHS that they still see a clear need for someone to make planning and funding decisions. The role of commissioners, and the strengths they bring, must therefore be retained. The snapshot of work from this report shows that CCGs have brought together partners to achieve change. They have embedded clinical leadership, and the ethos of population health management that considers their whole population and uses data to plan and deliver proactive care to achieve maximum impact.

Without a strong voice of clinical commissioners in all places and systems, we will lose a vital perspective when working to achieve better health for all.

Further reading

NHS Clinical Commissioners (2016), *The future of commissioning*

NHS Clinical Commissioners (2017), *Steering towards strategic commissioning: Transforming the system*

NHS Clinical Commissioners and NHS Providers (2018), *Driving forward system working: A snapshot of early progress in collaborative commissioning*

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Our job is to help CCGs get the best healthcare and health outcomes for their communities and patients. We give them a strong influencing voice from the front line to the wider NHS, national bodies, government, parliament and the media. Our networks provide members with the opportunity to share experience and expertise, and provide information, support, tools and resources to help CCGs do their job better.

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NHS
Barnsley
Clinical Commissioning Group

Governing Body

11 July 2019

Cervical Screening Pilot

PART 1A – SUMMARY REPORT

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

	Name	Designation
Clinical Lead	Dr Kadarsha	Governing Body GP and Clinical Lead for Cancer
Author	Julie Frampton	Senior Primary Care Commissioning Manager

3. SUMMARY OF PREVIOUS GOVERNANCE

The matters raised in this paper have been subject to prior consideration in the following forums:

Group / Committee	Date	Outcome
Management Team	15/05/19	Approved the cervical screening extended service pilot.

4. EXECUTIVE SUMMARY

This paper is to provide Governing Body with information regarding an extended access Cervical Screening pilot service which has been agreed by Management Team in May 2019.

There has been significant anecdotal evidence that some women struggle to access cervical screening during normal surgery hours and, whilst data and evidence is not always easy to access to support this, offering a Cervical Screening service outside normal GP hours may be a way to test this issue.

It is also hypothesised that the difficulty in accessing appointments during the day has a negative impact on the uptake of cervical screening and that for some women this is not always the most convenient time of day to attend. A trial of alternative appointment times may also test this hypothesis.

	It should be noted that new commissioning arrangements, by Barnsley Metropolitan Borough Council, for sexual health and contraception services has led to a reduction in the available alternative access sites for cervical screening. This may have contributed to the reduced uptake of screening. Trialling this service provision may help to overcome this shortfall and identify if an alternative out of hours access will increase screening rates.
5.	**THE GOVERNING BODY IS ASKED TO:**
	• Note the contents of this paper
6.	**APPENDICES / LINKS TO FURTHER INFORMATION**
	• None

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:	2.1
2.	**Links to CCG's Priority Areas**	**Y/N**
	1 - Urgent & Emergency Care	
	2 - Primary Care	Y
	3 - Cancer	Y
	4 - Mental Health	
	5 - Integrated Care System (ICS)	
	6 - Efficiency Plan	
	7 - Transforming Care for People with Learning Disabilities and / or Autistic Spectrum Conditions	
	8 - Maternity	
	9 - Compliance with Statutory and Regulatory Requirements	
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?	*Cross refer or state NA*
3.2	**Consultation and Engagement**	
	Has Comms & Engagement Checklist been completed?	*NA*
	Is actual or proposed engagement activity set out in the report?	*Cross refer or state 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/ BACKGROUND INFORMATION

Barnsley CCG commission Barnsley Healthcare Federation to deliver its Enhanced Hours contract across the population of Barnsley. This service has a very good uptake of available appointments however, despite regular review of delivery; there is still capacity within the commissioned service.

Whilst data and evidence is not always easy to access, there has been significant anecdotal evidence to suggest some women struggle to access cervical screening during normal surgery hours. This potential difficulty in accessing appointments may have a negative impact on the uptake of screening and therefore early detection of cervical cancer.

It is also known that although the cervical screening rates are above the national average, this conceals the large variation of uptake between different GP practices across Barnsley. The table below shows this variation:

Screening	Barnsley Average	National Average	Barnsley variation
Cervical screening	76.2%	71.7%	62.0% - 81.9%

In order to use this available capacity productively Primary Care Commissioners would like to undertake a trial, over a 12 month period, to understand the impact that offering cervical screening during the weekend and in an evening has on the uptake of screening and if this reduces the variation across GP practices in Barnsley. In order to achieve this BHF would need to roster a suitable qualified nurse to i-HEART's extended hour's team who can provide cervical screening.

2. DISCUSSION/ISSUES

Cervical screening is a routine test available to all women aged 25 to 64, every three to five years and prevents 75% of cervical cancers from developing in the UK, yet one in four women do not attend cervical screening when invited, normally due to fear or embarrassment or not understanding its importance.

It is thought that many women are also put off attending due to GP appointments being unavailable at times convenient to them. It is hoped uptake of the screening will increase if women can schedule their appointments on an evening or weekend at one of i-HEART's Hubs, these are located at:

- Woodland Drive Medical Centre
- Chapelfield Medical Centre

Service Delivery:

1. i-HEART appointments are offered each weekday evening between 18:30 – 22:30 and 10:00 – 13:00 over the weekends and Bank Holidays. Ideally the following would be most effective:

	• One clinic on a weekday evening • One on a Sunday (providing there is no bank holiday the following Monday). This will allow for the samples to be received at the laboratory in the timescales required. 2. Each clinic would be planned for 3-4 hours and each appointment would be for 20 minutes with the last appointment "closed" to allow for the necessary administration work to be completed. 3. To maximise the uptake of appointments a combination of pre-bookable and opportunistic appointments would be available. GP practices would also be able to book directly into slots, on a pro rata basis, based on their list size and where the women meets the criteria i.e. cannot attend at their GP practice, prefer an alternative provider or the waiting list at the GP practice will deter them especially if they have a track record of not attending. 4. The results from the tests will go back to the usual GP. 5. An audit would be completed to ensure the effectiveness of the service and KPIs would be put in place and monitored through the existing BHF Enhanced Hours contact management process. 6. Use of direct booking or utilising the NHS e-Referral system will enable Practices provide patients with an appointment whilst they are in the Practice. 7. All tests will be read coded and confirmed to the Practice. 8. All test costs will be met via NHS England's commissioning arrangements and arranged via the i-Heart service It will be vital to raise awareness of this service offer and promote the importance of cervical cancer screening. A link with the Be Cancer SAFE movement would be established to actively engage communities and members of the public. Practices will also be encouraged to promote the service to women they identify via the PDA indicator that targets the uptake of patients who Do Not Attend (DNA) for screening.
3.	**IMPLICATIONS**
3.1	**Financial implications** • It is envisioned that this service will use the capacity currently not utilised within the Enhanced Hours service. • This will not impact on the required min/1000 population reporting and achievement. • This would be cost neutral due to using the unused capacity that is already commissioned and the service utilising NHS England commissioning arrangements for cervical screening.

	Risks There is a risk that the service is used by women who could have attended an appointment at their GP Practice which will be mitigated by monitoring this via the service audit. The NHS England screening lead will continue to work with practices to monitor the impact and by ensuring the patient eligibility criteria is taken into account. NOTE: NHS England has been made aware of this initiative and is supportive of the trial.
4.	**CONCLUSION**
	The trial provision of cervical screening offered through the i-Heart Enhanced Hours service would offer greater choice to women as to where and when they can access cervical screening clinics. It would also provide robust evidence to support, or otherwise, the following: • The significant anecdotal evidence that women struggle to access cervical screening during normal surgery hours or would prefer alternative provider. • Whether the offer of wider choice as to where and when cervical screening clinics happen will improve surveillance uptake. The service would have other benefits which are: • Improved early diagnosis and screening for cervical cancer. • Improved management of patients identified with cervical cancer. • Improved population health through healthier lifestyle promotion. The trial would be scrutinised through the existing BHF contact management arrangements with additional audits and KPIs to monitor the effectiveness of the service throughout the trial. It would also be monitored via NHS England Screening Leads commissioning monitoring arrangements and the CCG Cancer programme governance.

NHS
Barnsley
Clinical Commissioning Group

GOVERNING BODY

11 July 2019

Urgent and Emergency Care Update

PART 1A – SUMMARY REPORT

1. THIS PAPER IS FOR

Decision		*Approval*		*Assurance*	X	*Information*	X

2. REPORT OF

	Name	*Designation*
Clinical Lead	Dr Sudhagar Krishnasamy	Associate Medical Director
Author & Exec Lead	Jamie Wike	Director of Strategic Planning and Performance

3. SUMMARY OF PREVIOUS GOVERNANCE

The matters raised in this paper have been subject to prior consideration in the following forums:

Group / Committee	Date	Outcome
Governing Body	8/3/18	Approved procurement approach for new Integrated Urgent Care Clinical Advice Service.
Governing Body	12/4/18	Noted the work of the A&E Delivery Board to deliver improvements to UEC services in Barnsley
Governing Body	10/1/19	Received an update on progress being made in delivering 5YFV Urgent Care deliverables

4. EXECUTIVE SUMMARY

The purpose of this paper is to provide the Governing Body with a final update on the progress made in delivering the 'Next Steps on the NHS Five Year Forward View' Urgent Care 2018/19 deliverables along with details of other Urgent and Emergency Care developments being delivered locally and across South Yorkshire and Bassetlaw as part of the Integrated Care System

	transformation programme. The paper also sets out the Urgent Care expectations included within the NHS Long Term Plan with a summary of the current position against these. Locally, oversight of Urgent and Emergency Care performance and improvement activity is provided by the Barnsley Urgent and Emergency Care Delivery Board however it should be noted that the responsibility for commissioning services to meet the national NHS Constitution Standards, including delivery of the 4 hour waiting time standard for A&E, remains with the CCG.
5.	**THE GOVERNING BODY IS ASKED TO:**
	• Note the current position and progress in delivering the Urgent Care Key Deliverables of the Next Steps on the NHS Forward View. • Note the Urgent Care expectations included within the NHS Long Term Plan with a summary of the current position against these.
6.	**APPENDICES / LINKS TO FURTHER INFORMATION**
	• Appendix 1 – Update against the 2018-2019 Deliverables of the Next Steps on the NHS Five Year Forward View. • Appendix 2 – South Yorkshire & Bassetlaw Shadow ICS – Programme Highlight Report

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
2.	**Links to CCG's Priority Areas**	**Y/N**
	1 - Urgent & Emergency Care	Y
	2 - Primary Care	Y
	3 - Cancer	N
	4 - Mental Health	Y
	5 - Integrated Care System (ICS)	Y
	6 - Efficiency Plan	Y
	7 - Transforming Care for People with Learning Disabilities and / or Autistic Spectrum Conditions	N
	8 - Maternity	N
	9 - Compliance with Statutory and Regulatory Requirements	N
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.	**INTRODUCTION/ BACKGROUND INFORMATION**
	Improvements in Urgent and Emergency Care have been a priority in Barnsley since the inception of the CCG in April 2013 and during this period has also continued to be a national priority with Sir Bruce Keogh highlighting key areas for improvement in his review of Urgent and Emergency Care in England in 2013 and the inclusion in the NHS Five Year Forward View. The 'Next Steps on the NHS Five Year Forward View' published in March 2017 set out the overall goals and expected deliverables and these formed a key strand of the NHS Planning Guidance. This paper provides an update to Governing Body on the 2018/19 deliverables along with details of other Urgent and Emergency Care developments being delivered locally and across South Yorkshire and Bassetlaw as part of the Integrated Care System transformation programme.
2.	**DISCUSSION/ISSUES**
2.1	The overall goal for Urgent and Emergency Care for 2017-19 was to redesign and strengthen the urgent and emergency care system to ensure that patients receive the right care in the right place at the right time.
2.2	The key deliverables for 2018/19 were: • Ensure performance against the four-hour A&E standard is at or above 90% in September 2018 and achieving the 95% standard in the month of March 2019 • Provision of access to enhanced NHS111 services, with increased access to clinical advice – Delivered through and Integrated Urgent Care Clinical Assessment Service (IUC CAS) • Managing Transfers of Care • Improving patient flow inside hospitals and reducing inappropriate length of stay for admissions. • Make progress towards the 2020/21 deliverable to have in place mental health crisis liaison services which meet the needs of people of all ages. • Ensuring that less than 15% of NHS continuing healthcare full assessments take place in an acute setting. Appendix 1 provides a progress update against each of these key deliverables.
2.3	The CCG have also continued through 2018/19 to contribute to the work of the Urgent Care Steering Board as a partner in the Integrated Care System. The May programme highlight report is attached at Appendix 2 to provide an update on work areas and progress.
2.4	The NHS Long Term Plan, published in January 2019 looks to build upon the progress made since the publication of 'Next Steps on the Forward View' with a focus upon reducing pressure on emergency hospital services by boosting 'out of hospital' services. The plan does however also recognise that there are also substantial pressures in looking after emergency patients and therefore sets out a number of areas where improvement is required. The 2019/20 Planning Guidance also included specific deliverables for 2019/20. The key areas for

	improvement within the NHS Long Term Plan are:
	
	• Pre Hospital Urgent Care
	• Reforms to Hospital Emergency Care – Same Day Emergency Care (SDEC)
	• Cutting Delays in patients being able to go home
	
	The milestones for urgent and emergency care are:
	
	• 24/7 Integrated Urgent Care Services to be in place in 2019, accessible via NHS111 or online [In place]
	• All hospitals with a major A&E department will:
	  ○ Provide SDEC services at least 12 hours a day, 7 days a week by the end of 2019/20 **[In place but plans to expand]**
	  ○ Provide an acute frailty service for at least 70 hours per week **[In place]**
	  ○ Aim to record 100% of patient activity in A&E and SDEC via the Emergency Care Dataset by March 2020 **[A&E recorded through ECDS, awaiting guidance on SDEC]**
	  ○ Test and begin implementing the new emergency care standards by October 2019 **[Awaiting outcome of testing – Rotherham are one of the test sites]**
	  ○ Further reduce Delayed Transfers of Care, in partnership with Local Authorities **[Arrangements in place to manage transfers of care and minimise delays]**
	• By 2023, Clinical Advice Services will typically act as the single point of access for patients and carers and health professionals for integrated urgent care and discharge from hospital. [Plans being developed with YAS across South Yorkshire]

3.	**APPENDICES TO THE REPORT**
	• Appendix 1 – Update against the 2018-2019 Deliverables of the Next Steps on the NHS Five Year Forward View. • Appendix 2 – South Yorkshire & Bassetlaw Shadow ICS – Programme Highlight Report May 2019

Progress against the 2017-2019 Deliverables of the Next Steps on the NHS Five Year Forward View

<table>
<tr><th>Key Deliverables</th><th>Current Position</th></tr>
<tr><td>Ensure performance against the four-hour A&E standard is at or above 90% in September 2018 and achieving the 95% standard in the month of March 2019</td><td>Whilst attendances at Barnsley Hospital Emergency Department were approximately 15% above the number in 2017/18, performance has been strong throughout the year 94.65%, which was above plans and agreed trajectories.

Performance into 2019/20 has continued to be strong with above 95% of patients being seen and treated within 4 hours in the first 2 months and in June (as at 20 June)

<table>
<tr><th></th><th></th><th></th><th>May-18</th><th>Jun-18</th><th>Jul-18</th><th>Aug-18</th><th>Sep-18</th><th>Oct-18</th><th>Nov-18</th><th>Dec-18</th><th>Jan-19</th><th>Feb-19</th><th>Mar-19</th><th>Apr-19</th><th>May-19</th></tr>
<tr><td rowspan="3">A&E 4 Hour Wait</td><td>Number over 4 hours</td><td rowspan="3">95%</td><td>585</td><td>362</td><td>642</td><td>214</td><td>102</td><td>377</td><td>204</td><td>277</td><td>790</td><td>563</td><td>341</td><td>352</td><td>376</td></tr>
<tr><td>Total Attendances</td><td>8,390</td><td>7,901</td><td>8,136</td><td>7,630</td><td>7,554</td><td>8,156</td><td>7,969</td><td>8,387</td><td>8,862</td><td>7,876</td><td>8,612</td><td>8,726</td><td>8,626</td></tr>
<tr><td>Performance</td><td>93.0%</td><td>95.4%</td><td>92.1%</td><td>97.2%</td><td>98.6%</td><td>95.4%</td><td>97.4%</td><td>96.7%</td><td>91.1%</td><td>92.9%</td><td>96.0%</td><td>96.0%</td><td>95.6%</td></tr>
</table>
</td></tr>
<tr><td>Provision of access to enhanced NHS111 services, with increased access to clinical advice – Delivered through and Integrated Urgent Care Clinical Assessment Service (IUC CAS)</td><td>Following work across SYB to contribute to the development of an enhanced specification for delivery of the national integrated care specification through an IUC CAS which includes NHS 111 telephony, Call Handling and a Core Clinical Advice Service and a successful procurement a the recommendation of the procurement panel was approved in December 2018 with the new contract commencing in April 2019.

NHS 111 online was also rolled out across South Yorkshire and Bassetlaw in 2018/19 ensuring access to integrated urgent care services was available to 100% of the population through NHS111 by telephone or on-line.

Progress has been made on linking local services with the new IUC service with Direct Booking now enables for some Primary Care Services (Extended Access and/or OOH) in each of the 5 places across South Yorkshire and Bassetlaw and over 50% of people calling 111 now receive some form of clinical advice, either in the Core CAS or in a local service.

The Directory of Services (DoS) is currently being reviewed by services to ensure that all appropriate services are available as dispositions on the DoS and in turn reducing the number of ‘A&E by default’ returns for patients.</td></tr>
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<tr>
<td>Managing Transfers of Care</td>
<td>Barnsley performance in managing transfers of care has consistently been good with very low levels of Delayed Transfers of Care. A sub group of the Urgent and Emergency Care Delivery Board has reviewed and delivered improvements identified in the ‘High Impact Change Model – Managing transfers of care between hospital and home. This has included implementation of discharge to assess arrangements with Care Homes, improved discharge planning, introduction of red to green (to improve flow and avoid unnecessary delays) and improved support for care homes.

In 2018/19 the required performance for Barnsley in relation to delayed transfers of care was to maintain or reduce the average number of delayed days from the baseline period of Q3 2017/18. The 2018/19 DTOC levels areincluded in the table below.

<table>
<tr><td></td><td>Target (Based on Q3 2017/18</td><td>DTOC 2018/19</td></tr>
<tr><td>Total delayed days</td><td>8.7</td><td>2.35</td></tr>
<tr><td>NHS attributable</td><td>7.6</td><td>1.5</td></tr>
<tr><td>Social Care attributable</td><td>0.7</td><td>0.49</td></tr>
<tr><td>Jointly attributable</td><td>0.4</td><td>0.36</td></tr>
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</td>
</tr>
<tr>
<td>Improving patient flow inside hospitals and reducing inappropriate length of stay for admissions.</td>
<td>Improving flow through and out of hospital has been a key focus during 2018/19 and was the subject of work by the UEC Delivery Board as part of a regional Action on A&E programme supported by NHS Improvement and NHS England.

Ensuring sufficient in hospital capacity and effective processes for flow through and out of the hospital was also a key priority for 2018/19 with work taking place to:

1. Improve assessment and streaming processes and pathways, patient transfers to inpatient wards, frailty pathways, urgent care therapy and developing criteria led discharge processes to increase nurse led discharges.
2. Improve ambulatory pathways, development and education of a ‘Medic in Charge’ role, Children’s Assessment and Paediatric Pathways, development of in-reach services and YAS /Rightcare signposting.
3. Improve orthopaedic pathways, use of surgical admissions and increase the use of nurse led clinics.
4. Enhance the use of expected discharge date and discharge planning, standardisation of ward to board round, introduction of electronic patient flow data, embedding Red2Green and SAFER Care bundles across all wards.
5. Improve discharge processes with partners to enable more same day discharges, expanding the discharge to assess programme, reducing readmissions from other services and managing long lengths of stay.
6. Utilise capacity and demand analysis to map activity to capacity, reconfigure the bed layout and ward floor plans, establishing a flexible summer/winter model to provide for increased demand. The work has saw the creation of a flexible bed base, providing up to approximately 80 escalation beds when required without the requirement to open up specific escalation wards.
</td>
</tr>
</table>

	7. Strengthen on-call arrangements, restructure the site management/patient flow teams, discharge team and Rightcare Barnsley team. This enabled the Trust to re-align resources and introduce a patient flow matron to provide leadership capacity for patient flow, supporting ward teams along with patient flow coordinators to support the ward teams with patient flow decisions. 8. Undertake engagement with employees to ensure understanding and buy-in to the changes and to enable staff to input to the proposed changes. This work has helped to ensure that the number of patients with length of stay above 21 days has exceeded the agreed trajectory by reducing the average daily number of patients from 41 to around 20.
Ensuring mental health crisis liaison services are in place to meet the needs of people of all ages	There is a 24/7 Mental Health Crisis Liaison Service in place which meet appropriate standards and provides high quality access to mental health service. The current service is for adults with CAMHS currently providing support for children and young people. Work has however been undertaken during 2018/19 to strengthen the service and begin to move towards an all age model.
Ensuring that less than 15% of NHS continuing healthcare full assessments take place in an acute setting.	CHC assessment arrangements are strong and utilising a trusted assessor model enables patients to be discharged from hospital with care and support whilst the assessment process is completed. No CHC assessments currently take place in an acute setting. There were some challenges in meeting the 28 day assessment target due to capacity issues within the CHC however the additional resources put in place to address backlogs and ensure capacity to meet ongoing demand have ensured that performance in quarter 4 increased to 90% against the national target of 80%.

South Yorkshire & Bassetlaw Shadow ICS – Programme Highlight Report

Programme: Urgent and Emergency Care Network		**Provider CEO sponsor:** Louise Barnett	
Date of report: May 2019		**Report completed by:** Rachel Gillott	
Progress Assessment Current Period (RAG)	Amber	**Progress Assessment Previous Period (RAG)**	Amber

Plan for 2017-19	**ICS Priorities** 1. Diversionary Pathways (avoidance of conveyance to Emergency Departments) – Respiratory, Care Homes and Mental Health 2. Care co-ordination (out of hospital) – Role of SPAs, admission avoidance, discharge support, 111/CAS 3. IUC mobilisation – CAS interconnectivity, oversight of implementation of new service model and focus upon direct booking 4. Improve patient flow - focus on care homes (links to diversionary pathways) 5. Clinical Theme – Respiratory (reducing non-elective admissions) including exemplar project 6. Improve system intelligence (EMSPlus) 7. Work in tandem with Hosted Network for A&E (Barnsley) to compliment the work programme 8. Oversight of A&E performance **National Deliverables** • NHS 111 Online: By March 2019 30% of the population should have access to NHS online (Complete – no issues reported) • NHS 111 Calls: Clinical advice to be offered to 50% of callers by March 2019 (Complete) Direct booking to be offered to 30% by March 2019 rising to 40% • GP Access: Coverage of enhanced access to reach 100% by March 2019 • Urgent Treatment Centres: All services designated as UTCs to meet the guidelines and be in place by December 2019 (Complete - Doncaster) • Hospitals: 95% achievement of the 4hr A&E standard by March 2019 **Interdependencies:** • Mental Health (crisis and diversionary pathways) • Digital (new technologies, direct booking, admission avoidance) • Primary Care (Primary Care Networks, Local Care Networks i.e. IUC, care coordination, respiratory)
MOU commitments	Good progress made against the MOU commitments albeit there are some risks on specific requirements.
Engagement	Ongoing engagement for HSR.
Progress	**1. Diversionary Pathways** Task and Finish Group established and linking in with national conveyance work. Current diversionary pathways identified, and priority areas agreed (Care Homes, Mental Health, Respiratory). Mental health being progressed through MH&LD workstream. Priority action plan for Care Homes and Respiratory developed and being progressed. **2. Care-coordination** Agreement to share current state of provision and service offer in each care co-ordination centre/SPA

3. IUC Mobilisation

IUC mobilisation/launch event facilitated by YAS on 12 March 2019
Commitment made to fund the enhancement of the DoS - Senior Clinical Module and NHS Service Finder
Service Development Officer recruited and due to commence in post in May 2019.
Direct Booking target of 30% currently being achieved (34% as per March 2019). Implementation plans in place.
GP contract for 2019/20 includes direct booking – 1 slot per 3,000 population per day and a requirement for practices to enable at least 25% of appointments for online booking (including direct booking by 111).

4. Improve Patient Flow

Best practice shared around bed capacity and System Perfect
Non-recurrent funding received to establish an 'innovation hub' to test out digital technologies in care homes

5. Clinical Theme – Respiratory

Analysis completed on respiratory non-elective admissions and baselines established of current service provision against RightCare best practice
Exemplar project progressing to support initiatives in UEC/Respiratory

6. Improve System Intelligence

Performance flashcard developed
EMSPlus implemented across 5 places in SYB. Current contract due to conclude on 30 April 2019. Next steps to be considered and agreed at the May 2019 Steering Board.
Care Home Capacity Tracker rolled out across SYB

7. Work in Tandem with Hosted Network for A&E (Barnsley)

Presentation received by the March Urgent and Emergency Care Steering Board

8. Oversight of A&E Performance

Delivery of the 4-hour standard remains challenging - programme of shared learning established as part of Urgent and Emergency Care Steering Board agenda.
Learning from Chesterfield Royal Hospital's Primary Care Streaming model shared at April Steering Board.
Funding provided to support system escalation pressures – HALO+ deployment and inter-facility transfers
High Intensity User Service Development workshop held 29 April 2019

Interdependency - Digital

Future Gov working with NHS Digital and NHS England to explore the role digital could play in better supporting staff to deliver expert care to enable patients to access the right care at the right time. SYB ICS chosen as 1 of 3 UEC locations in England to;

- Share in-depth insight with NHS Digital on challenges and opportunities for delivering local UEC services
- Inform NHS Digital's prioritisation of opportunities and future roadmap where digital can make real difference
- Get involved creating and giving feedback on ideas for how to improve UEC experiences

Agreed for focused engagement to be undertaken with patients and staff across Doncaster (and Bassetlaw) 13-31 May 2019

South Yorkshire & Bassetlaw Shadow ICS – Programme Highlight Report

Next steps – over next month	**1. Diversionary Pathways** Meeting scheduled 20 May 2019. Action plan being progressed. **3. IUC Mobilisation** Review of DoS to be undertaken ensuring completion for services both in and out of hours. Gaps to be reviewed and addressed Implications of DX05 direct booking to be explored Ongoing engagement with primary care and digital colleagues around direct booking **5. Improve System Intelligence** Evaluation and next steps for EMSPlus and analysis of online survey for mutual support **6. Oversight of A&E Performance** Visit to be arranged to Chesterfield Royal Hospital's Primary Care Streaming.
Benefits	Expansion of capacity and services to provide better support and experiences for patients. Increased consistency in accessing urgent and emergency care services.

Risks	Pre-mitigation RAG	Post-mitigation RAG	Mitigating Action	Due date
Insufficient programme capacity to progress priorities	Red	Amber	Small amount of non-recurrent additional resource from NHSE North PMO has been received. Agreement and mobilisation of spending plan in progress.	February 19
Not all providers & partners engage fully with the implementation of EMSPlus and unable to develop/test out collaborative working and potential for mutual support.	Red	Amber	Next steps for EMSPlus to be agreed at May 2019 Steering Board	Ongoing
Non-achievement of the A&E standard	Red	Amber	Programme of shared learning established as part of UEC SB agenda.	Ongoing
Lack of commitment to the protocol of mutual support	Red	Amber	Evaluation of mutual support teleconferences held in January in progress.	Ongoing
Unable to progress direct booking due to technical inoperability	Red	Amber	Dependent upon national solutions. Ability to commit non-recurrent funding to progress this area of work.	March 19

SYB Joint Commissioning Committee of CCGs

2019/20 Priorities, Terms of Reference and Manual Agreement

Briefing for Barnsley CCG Governing Body
11 July 2019

Meeting in Public

Author(s)	**Lisa Kell - Director of Commissioning, SYB ICS**
Sponsor(s)	**SYB Accountable Officers**

Is the paper for Approval / Consideration / Noting

For discussion and approval

Purpose

This paper sets out:

- the list of 2019/20 SYB JC CCGs system commissioning priorities developed by the JC CCGs, Accountable Officers, members of SYB Governing Bodies and Directors of Commissioning.
- the revised Manual Agreement and Terms of Reference which the JC CCGs has recommended to Governing Bodies for sign off in Public.
- delegated authority for specific decisions to be devolved to the JC CCGs to streamline decision making in an integrated care system. The priority areas requested by commissioners for delegated decision making are listed in the paper and in the enclosed revised JC CCGs Manual Agreement and the Terms of Reference.

Background

The Long Term Plan (LTP) sets out the intent that NHS commissioning arrangements will evolve over the next few years. SYB commissioners have been working together over the last year to build on the joint commissioning arrangements already in place in the joint committee established in 2017.

Over the last few months the JC CCGs has finalised a set of system commissioning priorities and reviewed the Manual Agreement and Terms of Reference to better support system working, enable single decision making and facilitate delivery of the priorities for 2019/20.

The JC CCGs priorities will continue to develop and grow with new areas added during 2019/20 as SYB system commissioning arrangements are discussed with CCGs. The JC CCGs Terms of reference has a 6 month tenure and will be reviewed again in December 2019 to incorporate any further changes agreed.

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

Resource implications as a result of system commissioning will be quantified and discussed with CCGs during 2019/20.

Recommendations

Members of the Governing Body are asked to:

1. Agree the JC CCGs priorities and the requested areas for delegation for 2019/20

2. Agree the revised Manual Agreement and Terms of Reference and note the December 2019 review date

3. Note the ongoing development of system commissioning in SYB and potential new areas that may be added to the list of priorities over the coming months where agreed by Governing Bodies.

4. Note a quarterly JC CCG progress report will be provided for Governing Bodies.

SYB Joint Commissioning Committee of CCGs

2019/20 Priorities, Terms of Reference and Manual Agreement

1. **Purpose**

1.2 This paper sets out the joint commissioning arrangements in SYB for 2019/20 through a set of agreed commissioning priorities developed and managed by the Joint Committee of CCGs (JC CCGs) strengthened with delegated authority for specific decisions in order to support streamlined decision making across SYB.

2. **Background**

2.1 The SYB CCGs have worked together since the inception of CCGs in 2012 (and prior to that as PCTs) to deliver commissioning and contracting responsibilities as efficiently as possible on behalf of each other focussing on best use of resources, standardisation to improve quality and outcomes and to avoid duplication.

2.2 In 2018/19 the SYB commissioners with involvement from CCG Governing Bodies set out the intention to explore opportunities for further system commissioning to support the development of Integrated Care Partnerships (ICPs) at place and working together strategically in a wider Integrated Care System with the following specific aims:

- **At SYB** – to commission, plan and deliver some activities and functions once across SYB where it demonstrably adds value for the system; reducing unwarranted variation improving equity of access, standardisation and quality of service and improves population health

- **At Place** – to commission, plan and deliver services locally, with a focus on integrated care with partners to improve population health through new models of care, and a consistency in approach to support providers to deliver services more equitably for local populations.

2.3 At the end of 2018/19 the JC CCGs established a set of priorities along with a requirement for some delegated decision making.

2.4 The JC CCGs has taken into account the requirements in the NHS Long Term Plan that commissioning arrangements will evolve over the next few years and lCS's will need to have in place streamlined commissioning arrangements to enable a single set of commissioning decisions in an integrated care system.

3. **Principles for SYB Joint Commissioning**

3.1 A guiding principle for any changes to commissioning and/or joint decision making must be that it demonstrates added value, including improvement in outcomes and population health, standardisation of care, financial efficiency, better use of resources including scarce workforce and avoids unnecessary duplication. Unintended significant risks for a CCG, place or ICS should be avoided.

1.2 It is important that system commissioning priorities are clinically developed to ensure an agreed SYB consensus to pathways, policies and protocols. A clinical engagement and assurance process has been agreed by the Joint Committee to ensure all SYB priorities being developed are underpinned by robust clinical evidence and best practice and a locally managed process is in each place for clinicians to engage, influence develop and agree the work. Clinical engagement will be sought from across the wider system to ensure clinical consensus in each place.

2. Review of the JC CCG Terms of Reference and Manual Agreement

4.1 Due to a number of changes to the JC CCGs for 2019/20 including; the establishment of a Joint Committee sub group to operationally support the JC CCGs; associate CCG membership changes, consideration of JC CCGs voting rights; new priorities for joint commissioning; the request for delegation of some decisions, wider ICS interim governance changes for 2019/20, and meetings are now held in public, the Terms of Reference and the Manual agreement have been revised (enclosed). Governing Bodies are asked to agree the revised Terms of Reference and the Manual agreement.

3. Request to Delegate Authority to Joint Committee of CCGs

5.1 A high level subset of the 2019/20 JC CCGs priorities that require delegated authority from CCGs to the JC CCGs are shown below. The detailed list of all the priorities agreed by the JC CCGs is enclosed. Governing Bodies are asked to agree the list of priorities and the request for delegation to JC CCGs.

priorities consistent with the LTP

2019/20 SYB System Commissioning Priorities requiring delegated authority	**Requested delegation to the JC CCGs to:**
System Contracting • 999 system lead contractor (YAS) for 4 SYB CCGs • 111 system lead contractor (YAS) for 5 SYB CCGs	• develop and agree a % financial threshold of contract value against contract baseline for the lead contractor to negotiate on behalf of each CCG during 19/20 contract negotiations.
Outpatients • Review of outpatient follow ups across SYB by specialty, develop clinical protocols to standardise practice and reduce unwarranted variation * • Review of outpatient first appointments (as above) *	• identify and agree the specialities in scope of the review • develop and sign off clinical protocols developed with SYB clinical engagement from both commissioners and providers and patients/ public as necessary • implement clinical protocols in Providers standard NHS contracts 2019/20
Commissioning Outcomes • Commissioning for Outcomes – new stage 2	• identify and agree the clinical priorities in the policy • sign off 19/20 policy through the CRG ensuring public consultation /engagement has taken place • implementation of protocols and included formally in standard NHS contracts 2019/20
IVF • Explore options for a SYB approach to the number of IVF cycles	• develop IVF options appraisal and financial modelling for consideration by CCG Governing Bodies

Cancer • Standard implementation of national cancer pathways across SYB tom improve outcomes and equity of access*	• implement standard cancer pathways in NHS provider contracts and across the 5 SYB places
Medicines and Prescribing • Medicines optimisation – standardisation of policies across SYB	• Identify opportunities for medicines standardisation • develop and sign off policies developed with SYB clinical engagement from clinicians, patients / public as necessary
Hospital Services Programme • Governing Bodies agreeing next steps on the work programme of the Hospital Services Programme,	• The conclusions on next steps on transformation and reconfiguration and implementation of these

Reporting of the JC CCG Priorities

Governing Bodies will receive a quarterly report on the progress of the work priorities and any decisions made by the JC CCGs. The minutes and actions of the JC CCGs meetings will continue to be shared with Governing Bodies each month.

Recommendations

Members of the Governing Body are asked to:

5. Agree the JC CCGs priorities and the requested areas for delegation for 2019/20

6. Agree the revised Manual Agreement and Terms of Reference and note the December 2019 review date

7. Note the ongoing development of system commissioning in SYB and potential new areas that may be added to the list of priorities over the coming months where agreed by Governing Bodies.

8. Note a quarterly JC CCG progress report will be provided for Governing Bodies.

Paper prepared by

Lisa Kell
Director of Commissioning
SYB ICS

South Yorkshire and Bassetlaw JC CCG Priorities 2019/20 Final 27th June 2019

Key points

- **The Joint Committee CCGS (JC CCGs) is established to make a set of single decisions across SYB according to the agreed JC CCG priorities, the Manual Agreement and 2019/20 priorities**
- **The Sub Group (JCSG) manages operational detail for each priority and reports is accountable to the JC CCG**
- **A JC CCG progress report will be provided by the JCSG on a quarterly basis for the JC CCG, Governing Bodies and other ICS governance meetings as appropriate**

ICS Transformation Programme SRO & PD support	Joint Commissioning Priority	Ambition	CCG lead and time line	Joint working done through the JCSG to deliver the priorities	Proposed level* of decision making delegated from CCG GBs to the JC CCG [*NON STATUTORY]	Benefits (for CCG/ Place) and risks	NOTES
Urgent and Emergency Care **SRO Commissioner TBC** **ICS Program Director - RG**	**999/111 SYB lead Contractor**	1. Strengthen the lead commissioning arrangements over and above the current lead commissioner role with more contractual decision making authority given to Sheffield CCG through a 'SYB system contracting MOU'.(developed Q1) 2. Sheffield CCG to contract for SYB 111 on behalf of 5 CCGs and 999 4 CCGs 3. The MOU could include contract value thresholds for contract negotiation within an agreed % tolerance for each CCG –(Developed by end Q2) 4. The MOU arrangement will be managed by Sheffield and reported back to the CCGS through the JCSG with close links to the UEC ICS transformation workstream 5. The MOU would enable Sheffield to act with agreed CCG authority for elements of finance, clinical standards/ protocols on behalf of the 4 CCGs for 999 and 5 CCGs for 111, working with the lead commissioner, Huddersfield CCG, on contract intentions, contract negotiations and contract monitoring in year. 6. Any significant disputes outside the agreed MOU thresholds will be managed directly by the 5 CCG AOs 7. Public engagement to be done through CCGS/ Governing Bodies in line with legal requirements and best practice	Sheffield CCG Jan 19	• Authority given via the MOU from the 5 CCGs to Sheffield CCG to act on behalf of SYB • Agreed £ limits within the Financial threshold • Included in SYB Commissioning intentions 19/20 • Monthly report provided to the JCSB during contract round sep – march 19/20	**Yes** **Financial threshold to be agreed by each CCG**	• Less duplication from SYB CCG contracting staff. • Ability to manage the contract round more efficiently and timely as able to act on behalf of SYB commissioners	999 /111 SCCG lead commissioner role already underway and MOU being developed by SCCG This priority will be managed by Sheffield CCG (lead contractor) and supported by the JCSG. Escalated issues/ Risks to go to JCCCG MOU to be signed off by 5 CCGS through the JCSG and approved at JC CCG CCG financial % thresholds to be agreed between Sheffield CCG and CCGs and included in the MOU
Electives **SRO Commissioner IG ICS Programme Director JR** **DCCG lead AF**	**Out-patient follow ups**	1. Aim to reduce unwarranted clinical variation and eliminate unnecessary and avoidable OP Follow ups, (in line with the LTP OP priority) 2. Doncaster CCG has established an OP working group with support and coordination from the ICS electives transformation workstream to lead a scoping review of OP F/ups by specialty on behalf of SYB (starting with a high volume speciality Orthopaedics. Other specialties to consider reviewing during 2019/20) are Ophthalmology, general medicine and dermatology 3. Ensure SYB CCG and provider clinical engagement and involvement takes place in the workgroup to enable a SYB clinical consensus and agreement of standard OP pathway protocols. 4. Develop and agree standardised OP F/UP pathway protocols using national clinical guidelines / best practice to improve patient outcomes and experience 5. Consider different modes of delivery of OP f/Ups (ie phone , tele med, f/ups - or firsts- in community) 6. The JCSG subgroup will oversee the detail of the OP work which has links with the Electives workstream and the ICS System Efficiency Board. 7. Progress reports will be provided to the JCSG 8. Public / Patient / service user involvement to be done jointly between the ICS and CCGs in line with legal requirements and best practice *Note:* *Include in SYB Commissioning intentions 19/20* *Link this work into the LTP OP requirements*	Doncaster CCG April 19	SYB CCGs Joint development of ICS OP clinical protocols by speciality, starting with orthopaedics. • consistent implementation in SYB acute provider contracts - include in 2019/20 SYB commissioning intentions (and aligned with LTP OP f/up requirements) • Derby and Derbyshire CCG to be included in the *work if their patient flows are proportionately involved* • *A* SYB standard approach to F/Ups will require thorough clinical involvement from commissioners and providers and will need to demonstrate a robust clinical evidence based approach • Oversee the development of any business cases for OPs (ie outside of hospital) and any financial modelling as required	**Yes**, Proposed delegation given to JCCCG for: 1. the specialities identified to review and propose changes 2. Develop and Sign off clinical OP F/UP protocols (these will have been developed with SYB clinical engagement and providers throughout the programme 3. Implementation of OP F/UP protocols formally included in standard NHS contracts in 19/20 20/21	• Reduced unwarranted variation and inconsistent op F/Ups • Improved patient experience and outcomes • Better use of resources - workforce and clinic capacity • Efficiency savings from reducing avoidable activity to reinvest back into patient care • OP to link to provider tariff reform as highlighted in the LTP (and the work of the	OP Work has already started with Electives workstream and DCCG work group. **Clinical engagement** -JCSG has developed a clinical engagement process to provide assurance to JCCCG and GBs of clinical involvement across SYB. All priorities to follow the process. **Out of area patients and border CCG involvement** – where OP volumes are large enough to actively involve associates Derby and Derbyshire CCG they will be invited to join the work

						SYB System Efficiency Board work) programme	
	Out-patient firsts	• As above for OP f/ups but work to commence in qtr. 2 as F/ups work has started to inform approach and process *Note:* *Include in SYB Commissioning intentions 19/20* *Link this work into the LTP OP requirements*	Doncaster CCG July 19	As above	**Yes,** as above	• as above	
	Commissioning for outcomes CfO – *NEW (tranche 2) Policy*	1. Develop a **tranche 2** CfO Policy 2019/20 SYB to be implemented consistently in SYB 2. The existing CfO policy is being evaluated in early 2019 by the ICS electives workstream and learning / outputs from the evaluation will be included where appropriate in any new 2019/20 CfO policy 3. Ensure robust clinical engagement from SYB in the development of new priorities based on clinical guidelines and best practice. evidence following the agreed JCSG process. This work will also be supported by the IFR team clinical expertise to develop a tranche 2 policy 4. Patient and public engagement plan to date has been via individual CCGs, ICS to lead going forwards *Note:* *Include in SYB Commissioning intentions 19/20* *Link this work into the LTP OP requirements*	Rotherham CCG Evaluation Feb/March 19 April 19	• Develop the 2nd tranche CfO policy for 19/20 Implementation across SYB with commissioner and provider and stakeholder input • Work is supported through electives workstream with required CCG/ place clinical engagement	**Yes**, Delegation given to JCCCG: 1. To agree the Clinical priorities in the policy 2. Sign off 19/20 policy 3. Implementation through standard NHS contracts and primary care networks	• Standard policy implemented across SYB – equity of service and access for patients • Improve population health outcomes	
	IVF	1. Inclusion and exclusion criteria are already consistent as part of the IFR policy 2. Number of IVF cycles in SYB to be reviewed in an options appraisal in 2019/20 3. Patient and public engagement SYB to take place in line with legal requirements and best practice *Note* *Include in SYB Commissioning intentions 19/20*	ICS with IFR team July 19	• Financial impact and options appraisal developed by JCSG	**Yes** Delegation given to JCCCG: 1. Consider options appraisal including financial impact of any potential change 2. Agree implementation - *depending on outcome of no. 1 above*	• Aim for consistent no of cycles in SYB equitable from patient perspective	
Cancer **SRO** **Commissioner LS** **Programme Director JJ** **Diagnostics** **SRO** **Commissioner IG** **Programme Director JR**	**Cancer – supporting the SYB ND Cancer Alliance Board, the LWABC programme board and the planning guidance cancer delivery plan**	1. Standard SYB adoption and implementation of Living With and Beyond Cancer service pathways, risk stratification recovery package in :– breast, colorectal, prostate pathways (pathways currently being taken forward by CCGs) 2. JCSG and JC CCG will work closely with the Cancer alliance to ensure it provides the support required 3. Patient & public engagement led by the cancer alliance supported by each CCG 4. Support achievement of Cancer waiting times standards through joint decisions to standardise care pathways *Note* *Include in SYB Commissioning intentions 19/20*	Cancer Alliance Underway 2018/19	• Standardised implementation of cancer alliance and LWABC developed pathways set out in column 3 (already underway) • Need to involve D&Derby CCG for their cancer pathway flows into SYB • Financial impact assessment of implementation	**Yes** Delegation given to JCCCG to support cancer alliance developed priorities: 1. Implementation of cancer pathways in all 5 SYB places to support the Cancer Alliance Board 2. Further detail being worked up on specific joint commissioning decisions to support the alliance	• Consistent clinical approach and pathway reduce variation and improve patient outcomes and experience • Reduce inequity of access for patients	Derby and Derbyshire CCG involvement in this priority as appropriate through the cancer alliance.
	Chemo/Faecal Immunochemical Testing (FIT)	1. Implementation of FIT in all 5 places 2. Bowel cancer symptomatic diagnostic	Cancer Alliance Underway 2018/19	• FIT already implemented in all 5 places • In commissioning intentions			
	Rapid Diagnostic centres (RDC) roll out	1. Implementation of additional Rapid Diagnostic Centres within the Cancer Alliance geography 2. Expand scope of existing RDC in line with the national RDC programme	2018/19	• Part of 19/20 planning guidance national requirements			

	Lynch testing	3. Implementation of Lynch test screening across 5 places *Note* *Include in SYB Commissioning intentions 19/20*	Alliance April 2019	• Protocol will be developed by ICS Cancer Alliance • JCSG to facilitate consistent SYB implementation for Lynch Testing			
System Efficiency Board (SEB) / Finance	**Independent sector reform** **Out Patient transformation** **E-rostering** **Theatre utilisation & efficiency**	1. JCCCG and JCSG to work closely with the System Efficiency Board on the 4 priorities 2. JC CCG will be required to support any changes proposed by the SEB requiring commissioning decisions 3. Patient and public involvement to take place in line with legal requirements and best practice	SEB and workstreams to lead April/ May 2019	• JCCCG and JCSG to develop, test and implement new approaches of commissioning and contracting activity across SYB developed jointly with providers	**TBC** when work has evolved more	• Financial and resources efficiency, reduced unwarranted variation	JCSG to work with workstreams and the SEB, JC CCG to receive proposals from JCSG where a joint commissioning approach or decision will be required – particularly for the first 2 priorities listed
Medicines Optimisation (MO) **SRO Commissioner IG** **Programme Director JR**	**Over the counter prescribing**	1. Some over the counter policies already developed and introduced across CCGs through the MO workstream 2. Develop the list of medicines further to expand opportunities for equitable SYB approach *Note* *Include in SYB Commissioning intentions 19/20*	Bassetlaw CCG April 2019	• Development of SYB prescribing protocols • Supported by clinically led development across SYB through MO work stream • Financial impact modelling done for the CCGS via the MO workstream overseen by the JCSG • Must ensure SYB clinical involvement throughout programme	**Yes,** Delegation given to JCCCG: 1. Development, agreement and implementation of GB supported MO protocols 2. Standard implementation of CCG GB agreed prescribing protocols across SYB	• Standard SYB prescribing policies – equity, cost saving and improving population health	SYB Comms and engagement plan required
	Gluten free	1. A SYB Gluten Free policy to be developed for adults 2. Patient and public involvement to take place in line with legal requirements and best practice	Rotherham CCG July 2019				
	Avastin	1. Consider SYB implementation of Avastin, 2. Requires joint working providers and patient and public engagement 3. Patient and public involvement to take place in line with legal requirements and best practice *Notes* *Include all prescribing priorities in SYB Commissioning intentions 19/20, also consider additional joint prescribing projects with secondary care*	April 2019				
	Nutrition	1. Consider re-specification of stoma services across SYB to deliver improvements in quality and patient experience for stoma supplies and equipment through service redesign 2. If decide to progress patient and public involvement to take place in line with legal requirements and best practice	October 2019				
	Stoma care	1. Consider re-specification of stoma services across SYB to deliver improvements in quality and patient experience for stoma supplies and equipment through service redesign 2. If decide to progress patient and public involvement to take place in line with legal requirements and best practice	November 2019				
	Continence	1. Consider re-specification of continence services across SYB to deliver improvements in quality and patient experience for stoma supplies and equipment through service redesign	Rotherham CCG October 2019				
	Branded Medications Policy	1. Develop a single SYB Branded Medication Policy	Sheffield CCG June 2019				
Population Health **SRO Commissioner TBC**	**Population Health Management**	1. Commissioning focus on improving population health and outcomes. Develop PHM interventions– ie Population segmentation tools, risk stratification to inform commissioning and decision making in service transformation 2. Identify from population health data sources interventions that the ICS can undertake as a system that demonstrably adds value and avoids duplication across five places	June 2019	• PHM plan in development will confirm requirements from JCSG in qtr 1	**TBC**	• Developing population health tools once on behalf of SYB such as population segmentation	

Programme Director LK						modelling and stratification	
	QUIT in hospital scheme	1. Reducing smoking prevalence and tobacco dependency –patients targeted in hospital setting and directed to smoking cessation service. MH providers already do it as part of CQUIN requirements	All CCGs April 2019	• NB - Implication to consider re capacity of current SYB LA smoking cessation services to manage the increased demand and potential of additional prescribing costs. • JCSG to discuss in June 2019	**TBC**	• Reduce smoking prevalence- *LTP priority* • Improve population health and outcomes	
Stroke HASU **SRO Commissioner LS** **Programme Lead MH**	**Stroke HASU**	1. Sheffield CCG Lead contractor (already underway) – Standardised quality and outcomes achieved through same service specification implemented in all HASU providers 2. Joint working with providers required to deliver change 3. Less involvement and duplication from the 4 CCGs contracting teams	Sheffield CCG ongoing	• Finalising the implementation of the transformation programme • update report is already provided to the JCSG	**Yes** –the Stroke HASU service transformation programme is **already delegated** to the JCCG	• Consistent contracting approach to the new clinical model	Delegated authority for Stroke HASU already granted to JCCCG in 2017
Mental Health & Learning Disability **SRO commissioner JP** **Programme Director RG**	**Perinatal Mental Health outreach**	1. Development of a specialist community perinatal mental health service across Doncaster, Rotherham and Sheffield 2. Design a provider led outreach service model, and co-ordinate delivery working jointly with the service providers 3. Define contract requirements for the new service model and implement in 2019/20 contracts 4. Patient and public involvement to take place in line with legal requirements and best practice	Doncaster CCG April 2019	• Discussions with programme lead to establish how the JC CCG can support the outreach pathway through new PMH contracting arrangements in 19/20	**TBC** – discussions with MH workstream underway to clarify joint commissioning requirements / support	• Equity of service offer access across commissioned footprint	Discussions with Programme ops lead to determine JCCCG involvement in work stream and any joint commissioning decisions required
	AHD ASD service	1. Develop an ICS-wide adult ASD and ADHD service 2. Patient and public involvement to take place in line with legal requirements and best practice		As above			
	Transforming Care (LD)	1. Development of Individual Placement and Support (IPS) for people with severe mental illness, in the context of an ICS mental health employment strategy 2. Patient and public involvement to take place in line with legal requirements and best practice		As above			
Hospital Services Programme **SRO Provider RJ** **Programme Director AN**	**Secondary care consistency in transformation ie policy / stds,** **Supporting the implementation of Hosted clinical networks** **Any SYB agreed plans for reconfiguration**	1. Supporting the HSP ICS work programme to implement the agreed recommendations of the HSR 2. JC CCG to consider commissioning models that support hosted networks and changes to service provision (reconfiguration and service transformation) 3. Patient and public involvement to take place in line with legal requirements and best practice	HSP team and ICS Workstreams ongoing	• Taking specific <u>planning process</u> decisions through JCCCG for quicker aligned decisions to • Supporting the development and implementation of provider hosted networks and one provider models with a system commissioning model to the new provider approach • Governing Bodies to agree next steps on the work programme of the Hospital Services Programme,	Yes -The Hospital Services Programme conclusions on next steps on transformation and reconfiguration and implementation of these	• Joint commissioning decisions for standardisation and expediency re agreement and decisions to change	<u>Derby and Derbyshire CCG</u> involvement in this priority with voting right when/ if appropriate.
Specialised Commissioning (NHSE)	**Chemotherapy delivery** **Complex Neurological Rehabilitation** **CAMHS #tier 4**	1. Spec Com membership on JC CCG and include as part of JC CCG ToR & Manual Agreement 2. Outline of plan for the priorities being drafted together 3. Patient and public involvement to take place in line with legal requirements and best practice	Spec com	• Specific priorities were agreed in qtr4 18/19 • Spec com progress updates to be presented to JCSG monthly	TBC – discussions underway with Spec com and ICS programme leads to clarify joint commissioning requirements	TBC	

Manual Agreement and Terms Of Reference

of the

Joint Committee of Clinical Commissioning Groups

South Yorkshire and Bassetlaw

2019/20

Final Version

27 June 2019

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Chapter	Content	Detail	Page
1.	Introduction and Overview	Short Introduction setting out:- • Background to creating Joint Commissioning of Clinical Commissioning Groups (JC CCGss). • Context for decision making and purpose. • Overview of role in local health system. • Purpose of this agreement/manual.	
2.	Commissioning intentions and statutory duties	Set out:- • Regional/Local commissioning intentions. • Application of existing arrangements. • Complying with the Statutory Duties of CCGs (should include those relating to procurement and competition as well). • Governance, including provision of assurance to members, for JC CCGss.	
3.	Delegation	Delegation pursuant to section 14Z3:- • State purpose of delegation, what it means and the CCGs who have made it. • Set out minute and resolution [separately drafted] of delegation. • Explain terms of delegation in context of joint commissioning approach.	
4.	Terms of reference of joint committee : setting out the role and operation of the committee	Provisions setting out:- • Role • Delegated decisions [defined list as set out in terms] • Reserved decisions [All other than defined list] • Meetings and frequency	

		• Agenda and Minutes • Voting • Electronic meetings • Resolutions [form] • Quorum • Ability to create sub-committees and further delegate (as set out in terms)	
5.	Additional terms supplementing the terms of reference	Matters to be addressed:- • Guiding Principles for JC CCGss. • Definitions and interpretation [especially delegated decisions and reserved decisions] and how to deal with disputes on definitions. • Approach to Conflicts of Interest. • Liability and indemnities. • Disputes and process to be followed to resolve. [This section may also go on to consider ability for members to revoke the delegation. • Information Sharing and General Data Protection Regulation (GDPR) • Approach to Freedom of Information Requests (FOIA) requests. • Compliance with procurement and competition law obligations (to extent not dealt with in statutory duties section) • List of any other relevant protocols • Clarification and/or additional commercial terms • Process to make variations to Delegation, ToR and/or agreement/manual • Explanation of how ratification works and process to apply. • JC CCGss reporting obligations to members and form of such reports. • Set out how finance for the programme will be dealt with, including issues such as pooled	

		funding. • Process and form for issuing Notices by JC CCGss. • What happens if a member leaves the JC CCGss • Supporting the JC CCGss and how the Programme Management Office (PMO) will operate. • Implementing change through NHS Standard Contract and variations to it. • Workforce and Staffing considerations within decision making.	
6.	Appendices	• JC CCGss Terms of Reference (ToR), • statutory duties checklist and all protocols which the JC CCGss need to follow. • Clinical engagement and assurance process • Communications and Engagement assessment and assurance process	

Chapter 1 - Introduction and Overview

1. Background

1.1 The purpose of the Handbook/Agreement is to set out in practical terms how the local health system will work together in both commissioning and providing health services to the public, as well as how it will interact with the delivery of social care.

1.2 The local health commissioners have created a joint committee, through which they can both consider and undertake system wide commissioning decisions.

1.3 The CCG members of the joint committee ('**the JC CCGs**) are:

- NHS Barnsley Clinical Commissioning Group;
- NHS Bassetlaw Clinical Commissioning Group;
- NHS Doncaster Clinical Commissioning Group;
- NHS Rotherham Clinical Commissioning Group;
- NHS Sheffield Clinical Commissioning Group;
- NHS England Specialised Commissioning;

and Associate* Member CCG

- NHS Derby and Derbyshire Clinical Commissioning Group;

*Associate CCG is a partner CCG outside of the SYB footprint with commissioned patient flows into SYB for acute provider secondary and tertiary care services. Derby and Derbyshire CCG is also a member of the SYB and North Derbyshire Cancer Alliance. Our Associate CCG is involved in the commissioning arrangements, decisions and voting managed through the JC CCGs where their patients are affected by any proposed change as appropriate. Associate CCGs are <u>non-voting members</u> of the JC CCGs where they do not have a patient interest in a proposed change overseen by the JC CCGs.

1.4 In terms of the legal basis on which the CCGs have agreed to jointly exercise a group of their functions through delegating them to the JC CCGs, this has been done using their powers under section 14Z3 of the NHS Act 2006 (as amended) ('**the Act**'), which provides:

"(1) Any two or more clinical commissioning groups may make arrangements under this section.

(2) The arrangements may provide for—

(a) one of the clinical commissioning groups to exercise any of the commissioning functions of another on its behalf, or

(b) all the clinical commissioning groups to exercise any of their commissioning functions jointly.

(2A) Where any functions are, by virtue of subsection (2)(b), exercisable jointly by two or more clinical commissioning groups, they may be exercised by a joint committee of the groups….

(7) In this section, "commissioning functions" means the functions of clinical commissioning groups in arranging for the provision of services as part of the health service (including the function of making a request to the Board for the purposes of section 14Z9)."

1.5 The JC CCGs exercises both commissioning functions and those related to commissioning, according to those set out in each CCGs delegation to it. The **actual Delegations from each CCG are set out in Appendix 1 and the Terms of Reference are in Appendix 2**. This should enable and support a more integrated system approach to support the SYB Integrated Care System (ICS).

2. Purpose of the JC CCGs

2.1 The JC CCGs has the primary purpose of enabling the CCG members to work effectively together, to collaborate and take joint decisions in the areas of work that they agree, by exercising the Joint Functions.

2.2 A guiding principle for any changes to commissioning and/or joint decision making through the JC CCGss must be that it demonstrates added value, including improvement in outcomes and population health, standardisation of care, financial efficiency, better use of resources including scarce workforce and avoids unnecessary duplication. Unintended significant risks for a CCG, place or ICS should be avoided.

2.3 The Joint Functions are those set out in the Delegation, appended in Appendix 1 (*Delegation*) and summarised. below.

2.4 In agreement with CCG Governing Bodies the purpose of the JC CCGs may expand to support implementation of the ICS strategic plan in addition to the delivery of the JC CCGs priorities.

2.5 The role of the JC CCGs, as set out in Clause 3.1 of the Terms of Reference is:

2.5.1 Development of collective strategy and commissioning intentions;

2.5.2 Development of co-commissioning arrangements with NHS England;

2.5.3 Joint contracting with Foundation Trusts and other service providers;

2.5.4 System transformation, including the development and adoption of service redesign and best clinical practice across the area – which may include the continuation or establishment of clinical networks in addition to those nationally established;

2.5.5 Representation and contribution to Alliances and Networks including clinical networks nationally prescribed;

2.5.6 Work with NHS England and Improvement on the outcome and implication of national or regional service reviews;

2.5.7 Work with the NHS England on system management and resilience;

2.5.8 Collaboration and sharing best practice on Quality Innovation Productivity and Prevention (QIPP) initiatives; and Cost Improvement Plans (CIP)

2.5.9 Mutual support and aid in organisational development.

2.6 Generally, the JC CCGs will work across the system to develop a strategic approach to commissioning sustainable, efficient services that are patient centred and focussed on improving population health outcomes. Further, it will enable the development of integrated working with social care and wider community and voluntary sector partners so that the patients receive a more seamless service.

3. Role in local health and care system

3.1 As indicated above, the JC CCGs will support the development of a clear system strategic plan for the SYB ICS. In bringing commissioning leaders together, it will support strategic planning and provide an interface with both providers of health services and social care. The work which it can do with places and local authorities on creating better integrated health and social care services will support meeting the sustainability, quality and financial challenges in the coming years.

3.2 In terms of looking at strategic issues across the ICS footprint the JC CCGs will feed in to the work on such as:

- Leadership and governance and the best ways to set up joint working, taking account of the ability of providers and commissioners to set up shared governance structures. Some key issues to work through are conflicts and procurement, as well as good governance using the Handbook approach and assurance.
- Working out how best to play in your ongoing integrated care programmes and vanguards, especially in looking to implement change to benefit patients.
- Engagement and consultation strategies, both overall and when changes are needed to improve services.
- Productivity strategies, especially around joint and integrated working proposals.

4. Status of this Manual and Interpretation

4.1 This Manual sets out the arrangements that apply in relation to the exercise of the Joint Functions of the JC CCGs. If there is any conflict between the provisions of this Manual and the provisions of the Terms of Reference, the provisions of the Terms of Reference will prevail. This Manual is to be interpreted in accordance with Schedule 1 (*Definitions and Interpretation).*

5. Term

5.1 The Manual has effect from the date of the Terms of Reference and will remain in force unless terminated in accordance with Clause (*Termination of the Manual*).

5.2 Individual Member CCG(s) may terminate their membership of the JC CCGs and so no longer be obliged to work in accordance with this Manual under Clause (*Leaving the Joint Committee*).

Chapter 2- Commissioning Intentions and Statutory Duties

6. System / local commissioning intentions

6.1 Commissioning intentions relating to Hyper Acute Stroke services and Children's Surgery and Anaesthesia and the 2019/20 JCCCG priorities requiring delegated authority set out below:

2019/20 JCCCG Priorities requiring delegated authority	Requested delegation to the JC CCGs to:
System Contracting • 999 system lead contractor (YAS) for 4 SYB CCGs • 111 system lead contractor (YAS) for 5 SYB CCGs	• develop and agree a financial threshold of contract value against contract baseline for the lead contractor to negotiate on behalf of each CCG during 19/20 contract negotiations.
Outpatients • Review of outpatient follow ups across SYB by specialty, develop clinical protocols to standardise practice and reduce unwarranted variation * • Review of outpatient first appointments (as above) *	• identify and agree the specialities in scope of the OP review • develop and sign off clinical protocols developed with SYB clinical engagement from both commissioners and providers and patients/ public as necessary • implement clinical protocols in Providers standard NHS contracts 2019/20
Commissioning Outcomes • Commissioning for Outcomes – new stage 2	• identify and agree the clinical priorities in the policy • sign off 19/20 policy ensuring public consultation /engagement has taken place • implementation of protocols and included formally in standard NHS contracts 2019/20
IVF • Explore options for a SYB approach to the number of IVF cycles	• develop IVF options appraisal and financial modelling for consideration by CCG Governing Bodies
Cancer • Standard implementation of national cancer pathways across SYB tom improve outcomes and equity of access*	• implement standard cancer pathways in NHS provider contracts and across the 5 SYB places

Medicines and Prescribing • Medicines optimisation – standardisation of policies across SYB	• Identify opportunities for medicines standardisation • develop and sign off policies developed with SYB clinical engagement from clinicians, patients / public as necessary
Hospital Services Programme • Governing Bodies agreeing next steps on the work programme of the Hospital Services Programme,	• The conclusions on next steps on transformation and reconfiguration and implementation of these

* *Consistent with Long Term Plan Requirements*

6.2 A clinical engagement and assurance process has been developed by the Joint Committee Sub Group to provide assurance to the JC CCGs and Governing Bodies that the work to take forward and deliver the JC CCGs 2019/20 priorities is clinically led (appendix 4).

6.3 A communications and engagement Assessment Process for Section 14Z2 Duty for Public Involvement has also been agreed to provide assurance and support the work of the JC CCGs priorities (appendix 5).

7. Any existing arrangements

7.1 Commissioning intentions relating to Hyper Acute Stroke services and Children's Surgery and Anaesthesia agreed by the JCCCG in 2017.

8. Complying with the Statutory Duties of CCGs

8.1 The JC CCGs will need to be clear that is exercising functions it meets the statutory obligations of the CCGs which are its members. A failure to do so could lead to challenge to decisions made and an inability to assure the CCG Governing Bodies that their delegated functions are being properly exercised. Such an inability would impact on a CCG's ability to assure NHS England and Improvement that it was operating in accordance with the CCG Improvement and Assessment Framework.

8.2 The statutory duties which need to be taken into account are summarised in the Checklist in Appendix 3.

8.3 Further, each CCG should note that under s.14Z3(6) of the Act "*any delegation of functions to a joint committee of CCGs do not affect the liability of a clinical commissioning group for the exercise of any of its functions."*

8.4 The result of this is that:

a) the Member CCGs need to ensure that the JC CCGs is complying with the CCGs' statutory duties, as the Member CCGs continue to be responsible if there are any failings in decision making; and

b) the Member CCGs need to ensure that an appropriate reporting mechanism from the JC CCGs to them is in place. This will allow the Member CCGs to maintain effective oversight of the JC CCGs's processes and decision making.

8.5 In effect, the JC CCGs will stand in the place of the multiple CCGs who are its members for decision making, <u>but those individual CCGs will continue to have liability for those</u>

decisions. It is therefore essential that the JC CCGs understand the statutory framework within which it will make decisions.

9. **Governance**

9.1 It is important that CCGs maintain effective oversight of the activities of the JC CCGs.

- The JC CCGs will make a quarterly written report to the Member CCG governing bodies. This will cover, as a minimum summary of key decisions.
- The JC CCGs will review aims, objectives, strategy and progress and will publish quarterly reports on progress made.
- As to conducting business the JC CCGs will operate in accordance with the Terms of Reference approved by each CCG member when delegating functions to it. It shall also adopt the Standing Financial Order (SFO) and Standing Instructions (Sis) of Sheffield CCG in respect to the operation of committees, with all CCG members assuring themselves that will enable their own constitution, SFIs and SOs to be met.
- Regular reporting will take place with all member CCGs to include formal decisions and minutes.
- Decisions and minutes will be made public and will be posted onto the SYB ICS website.
- Reports will be prepared by the SYB ICS secretariat.
- Reports from any JC CCGs sub-committee will be shared with CCGs by agreement or request of the JC CCGs as appropriate.

Chapter 3 – Delegation

10. Purpose of delegation

10.1 The Member CCGs have agreed to delegate functions to the JC CCGs in order to enable the Member CCGs to work effectively together, to collaborate and to take joint decisions in those areas of work delegated.

10.2 The Member CCGs also consider that the delegation of functions will help the CCGs more easily collaborate and take joint decisions with NHS England in respect of those services which are directly commissioned by NHS England for example specialised services.

10.3 This will also link in to the work that each ICS needs to undertake to support the delivery of the NHS Long Term Plan within the South Yorkshire and Bassetlaw ICS Strategic Plan.

10.4 The JC CCGs forms a critical element of the interim governance arrangements agreed by the SYB ICS executive and the mechanism by which future collective commissioning decisions can be made.

11. The delegation

11.1 The delegation of functions from each CCG to the JC CCGs is set out in the delegation document at Appendix A (*Delegation*). A summary of what that means is:-

> Under s.14Z3 of the NHS Act 2006 each CCG delegates a range of its commissioning functions to a joint committee, in particular to allow the joint committee to take decisions on current and future transformation programmes which involve all, or a sub-set, of the CCGs.

11.2 The delegated functions are referred to in this Manual as the **"Joint Functions".**

11.3 As is noted above, the JC CCGs needs to also comply with statutory duties which the CCGs have. As a result, the Delegation also delegates the requirement to comply with statutory requirements relevant to the delegated functions.

12. Terms of delegation in context of joint commissioning

12.1 The JC CCGs will work with NHS England on ensuring commissioning is joined up and collaborative across such as primary and specialist care under existing agreements.

Chapter 4 - Terms of reference of joint committee

13. Terms of Reference of the JC CCGs

13.1 The CCGs have established the JC CCGs in accordance with the Terms of Reference, see Appendix 2. The JC CCGs and each member will act at all times in accordance with the Terms of Reference and that means the decisions of the JC CCGs will be binding on the Member CCGs.

13.2 The JC CCGs may at any time agree to make a decision or decisions through a common process with a CCG that is not a member of the JC CCGs. The common process would include the non-member CCG being in the same room as the JC CCGs, with the same papers and making a decision at the same time as the JC CCGs but as a separate CCG.

13.3 In determining those matters on which they want to share decision making, the CCGs have also agreed a number of areas in which they are not planning to make joint decisions. The following are functions which have not been delegated to the JC CCGs:

14. Reserved Functions

14.1 All functions are reserved for statutory organisations that are not specifically stated in the scheme of delegation.

14.2 It will be important for the JC CCGs to be cognisant of the above Reserved Functions and to engage with member CCGs if any of those arise in the context of the functions which the JC CCGs are to exercise.

14.3 Exercise of the Joint Functions

The JC CCGs must exercise the Joint Functions in accordance with:

- the Terms of Reference;
- the terms of this Manual;
- all applicable law, see framework in Appendix 3;
- all applicable Guidance issued by health system regulators; and
- good Practice.

Chapter 5- Additional terms supplementing the Terms of Reference

15. Key Objectives and Guiding Principles for JC CCGs

15.1 The JC CCGs shall work towards achieving the Key Objectives of the JC CCGs and all members of the JC CCGs shall act in good faith to support achievement of the Key Objectives.

15.2 The Key Objectives of the JC CCGs are:

15.2.1 To achieve better patient experience, better outcomes and more efficient service delivery through the Member CCGs collaborating in the commissioning of services, by:

15.2.1.1 working together on contractual and service issues with providers several or all of the Member CCGs use, due to patient flows;

15.2.1.2 sharing clinical expertise, best practice and management resource in service redesign, enabling more focussed commissioning capacity and leadership;

15.2.1.3 working together on patient and public participation in commissioning health and care, taking into account updated guidance.

15.2.1.4 leading transformation change where working together is necessary to ovate change;

15.2.1.5 achieving economies of scale through shared representation and input to clinical networks, specialised commissioning and primary care commissioning (where CCGs will wish to influence primary and tertiary commissioned pathways, and specialised and primary care commissioners will wish to influence secondary care and enhanced care pathways);

15.2.1.6 coordinate work with NHS England, particularly on specialised and primary care, where this improves experience for patients, giving consistency along pathway interfaces and avoiding duplication;

15.2.1.7 resolving cross boundary issues, where the action of one Member CCG could have an impact on a neighbour Member CCG;

15.2.1.8 providing leadership to the health system in the area covered by the Member CCGs; and

15.2.1.9 ensuring equity of access to services collaboratively commissioned; and

15.2.1.10 To support ongoing effective working of the Member CCGs.

15.3 The JC CCGs shall adopt and follow the JC CCGs Guiding Principles and all members of the JC CCGs shall act in good faith to follow the Guiding Principles.

15.4 The Guiding Principles of the JC CCGs are set out in the Terms of Reference and are:

- To collaborate and co-operate. Do it once rather than repeating or duplicating actions and increasing cost across the CCGs. Establish and adhere to the governance structure set out in the Terms of Reference and in this Manual, to ensure that activities are delivered and actions taken as required;
- To be accountable. Take on, manage and account to each other for performance of the respective roles and responsibilities set out in the Terms of Reference and in this Manual;
- To be open. Communicate openly about major concerns, issues or opportunities relating to the functions delegated to the JC CCGs, as set out in Appendix 1 (*Delegation)*;
- To learn, develop and seek to achieve full potential. Share information, experience, materials and skills to learn from each other and develop effective working practices, work collaboratively to identify solutions, eliminate duplication of effort, mitigate risk and reduce cost whilst ensuring quality is maintained or improved across all the Member CCGs;
- To adopt a positive outlook. Behave in a positive, proactive manner;
- To adhere to statutory requirements and best practice. Comply with applicable laws and standards including EU procurement rules, data protection and freedom of information legislation.
- To act in a timely manner. Recognise the time-critical nature of the functions delegated to the JC CCGs as set out in Appendix 1 (*Delegation*), and respond accordingly to requests for support;
- To manage stakeholders effectively;
- To deploy appropriate resources. Ensure sufficient and appropriately qualified resources are available and authorised to fulfil the responsibilities set out in the Terms of Reference and in this Manual; and
- To act in good faith to support achievement of the Key Objectives and compliance with these Principles.

16. Sub committees of the JC CCGs

16.1 The JC CCGs shall be able to appoint sub-committees, which shall include:

16.1.1 **Joint Committee Sub Group**

17. Finances/ Pooled Funding

17.1 The Member CCGs may, for the purposes of exercising the Joint Functions under this Manual, establish and maintain a pooled fund in accordance with section 14Z3 of the NHS Act 2006. Specifically, member CCGs may want to look at how to support the implementation of the decisions they make from service reconfiguration processes through to enabling strategic system change across the region. Pooling funds for use across the region for the overall benefit of all patients would ensure that best use of limited resources is achieved. It will also mean that implementation of decisions is less

likely to stall due to financial challenges in that a pooled fund provides greater regional support options than CCGs seeking to implement change individually.

In some instances, consideration can also be given to getting better value for money by consolidating purchasing/commissioning power in a pooled fund.

18. Secretariat

18.1 SYB ICS will provide the secretariat to the JC CCGs

18.2 JC CCGs associated ICS staffing resource are hosted by Sheffield CCG

19. Staffing

19.1 See 18 above

20. Conflicts of Interest.

20.1 The Member CCGs must comply with their statutory duties set out in Chapter A2 of the NHS Act 2006, including those relating to the management of conflicts of interest as set out in section 14O of the Act.

20.2 Each member of the JC CCGs must abide by NHS England's guidance *Managing conflicts of interest – statutory guidance for CCGs a*s updated from time to time *(https://www.england.nhs.uk/commissioning/pc-co-comms/coi/)* and all relevant Guidance and policies of their appointing body in relation to conflicts of interest.

20.3 In addition, the JC CCGs shall operate a register of interests and has a Conflicts of Interest Policy. Members of the JC CCGs shall comply with the JC CCGs's conflicts of interest policy and shall disclose any potential conflict; where there is any doubt or where there is a divergence between the terms of the conflicts of interest policy of a member's appointing CCG and that of the JC CCGs, the member should always err on the side of disclosure of any potential conflict.

20.4 Where any member of the JC CCGs has an actual or potential conflict of interest in relation to any matter under consideration by the JC CCGs, that member must not participate in meetings (or parts of meetings) in which the relevant matter is discussed, or make a recommendation in relation to the relevant matter. The relevant appointing body may send a suitable deputy to take the place of the conflicted member in relation to that matter.

20.5 Any breaches of the JC CCGs conflicts of interest policy or NHS England guidance on managing conflicts of interest shall be reported to the Member CCGs promptly and in any event within 5 business days of the breach having come to light.

21. General Data Protection Regulation (GDPR) 2018

21.1The Member CCGs shall all comply with GDPR requirements.

21.2 The GDPR introduces a principle of *'accountability'*. This requires that CCGs and organisations must be able to *demonstrate compliance*. The key obligations to support this include:

- the recording of all data processing activities with their lawful justification and data retention periods
- routinely conducting and reviewing data protection impact assessments where processing is likely to pose a high risk to individuals' rights and freedoms
- assessing the need for data protection impact assessment at an early stage, and incorporating data protection measures by default in the design and operation of information systems and processes
- ensuring demonstrable compliance with enhanced requirements for transparency and fair processing, including notification of rights
- ensuring that data subjects' rights are respected (the provision of copies of records free of charge, rights to rectification, erasure, to restrict processing, data portability, to object, and to prevent automated decision making)
- notification of personal data security breaches to the Information Commissioner
- the appointment of a suitably qualified and experienced Data Protection Officer.

21.3 The Member CCGs agree that, in relation to information sharing and the processing of information for the purposes of the Joint Functions, they must comply with:

21.3.1 all relevant Information Law requirements including the common law duty of confidence and other legal obligations in relation to information sharing including those set out in the NHS Act 2006 and the Human Rights Act 1998;
21.3.2 Good Practice; and
21.3.3 relevant Guidance (including guidance given by the Information Commissioner).

22. IT inter-operability

22.1The Member CCGs will aim to develop inter-operable IT systems (where necessary for the exercise of the Joint Functions) in line with national Information Governance (IG) rules to enable data to be transferred between systems securely, easily and efficiently.

23. Confidentiality

23.1 Where information is shared with the JC CCGs of a confidential or commercially sensitive nature information will be treated under the confidential policy of the host CCG.

24. Freedom of Information

24.1 Each Member CCG acknowledges that the other Member CCGs are a public authority for the purposes of the Freedom of Information Act 2000 (**"FOIA"**) and the Environmental Information Regulations 2004 (**"EIR"**).
24.2 Each Member CCG may be statutorily required to disclose information about the Agreement and the information shared or generated by the Member CCGs pursuant to this Agreement and the Terms of Reference, in response to a specific request under FOIA or EIR, in which case:

24.2.1 each Member CCG shall provide the others with all reasonable assistance and co-operation to enable them to comply with their obligations under FOIA or EIR;

24.2.2 each Member CCG shall consult the others regarding the possible application of exemptions in relation to the information requested, giving them at least 5 working days within which to provide comments. Such consultation shall be effected by contacting [the CCG Representative named in Column 2 of Schedule 2 (*Member CCGs*)]; and

24.2.3 each Member CCG acknowledges that the final decision as to the form or content of the response to any request is a matter for the Member CCG to whom the request is addressed.

25. Procurement

25.1 Commissioners are required to ensure that their decisions to procure services, which relates to many commissioning decisions , comply with the National Health Service (Procurement, Patient Choice and Competition) (No. 2) Regulations 2013. Key questions are set out under each heading below to assist you when considering whether you are meeting these requirements. Commissioners are also required to comply with EU/UK general procurement law but this is not covered in the list below.

The real procurement objective is to -

'*To secure the needs of patients and improve quality and efficiency of services*'

Therefore, part of considering how robust your decision is in terms of meeting procurement obligations is to look at:

- What have you done to assess patient need and do you have evidence to support your findings?
- How are you assessing the quality of services and the performance of the current providers? How have you assessed whether the service is offering value for money?
- Have you reviewed the current service specification to ensure it is working well and whether there is scope for further improvement? In particular, it would be helpful to have a schedule of all existing contracts and relationships, including performance monitoring on contracts.
- What steps have you taken to assess equitable access to services by all patient groups?

25.2 In achieving the main objective, the regulations contain three general requirements, which are:

25.2.1 To act transparently and proportionately and in a non-discriminatory way.

- What steps have you taken to make providers and stakeholders aware of your plans? Have you provided reasons to support your decisions?
- Are you publishing details in a timely manner and have you kept records of decision making, e.g. board minutes and briefing papers?
- Do providers understand the selection criteria you are using and are they able to express an interest in providing the services? Can you show that you have not favoured one provider over the other?
- Is your approach proportionate to the nature of the services in relation to the value, complexity and clinical risk associated with the provision of the services in question?

25.2.2 To contract with providers who are most capable of meeting the objectives and provide best value for money

- How have you identified existing and potential providers and objectively evaluated their relative ability to deliver the service specification, improve quality and meet the needs of patients?
- Are you satisfied providers are capable and robust enough to deliver a safe and efficient service and provide the best value for money in doing so?

25.2.3 Consider ways of improving services through integration, competition and patient choice

- What evidence do you have to show the steps you taken to determine whether it might be better for patients if the services are integrated with other health care services?
- Have you asked providers, patients, and other stakeholders for their views?
- Does your specification or performance monitoring process incentivise delivery of care in a more integrated manner?
- Have you considered whether competition or choice would better incentivise providers to improve quality and efficiency? Do you have evidence to support your findings?

25.3 Advertisements and expressions of interest

To ensure providers are able to express an interest in in providing any services which includes the requirement to publish opportunities and awards on a website

- How have you gathered evidence about the existing and potential providers on the market?
- Have you published your intentions to the market by way of commissioning intentions or publication on a website?

25.4 Award of a new contract without a competition

A new contract may be awarded without publishing a contract notice where the commissioner is satisfied that the services in question are capable of being provided only by that provider, e.g. A&E services in a particular area or where it is not viable for providers to provide one service without also providing another service.

- What steps have you taken and what evidence are you relying on to satisfy yourself that there is only one capable provider?

25.5 Conflict of Interests

Commissioners are prohibited from awarding a contract where conflicts, or potential conflicts, between the interests of Commissioners in commissioning services and the interests involved in providing the services affect, or appear to affect, the integrity of the award of the contract.

- Have you recorded how you have managed any conflict or potential conflict?

This will be an issue over which the ICS needs to be sensitive given the collaborative working between commissioners and providers. Further information and guidance is available in section 20 above.

25.6 Anti-competitive behaviour

Not to engage in anti-competitive behaviour unless to do so would be in the interests of people who use NHS services

- Are you acting in an anticompetitive manner – for instance have you prevented new providers from entering the market or caused a provider to exit the market?

- If so, is it objectively justifiable as being in the interests of users and stakeholders? What evidence do you have to support this?

26 Competition Issues

26.1 Requirement to Notify the Competition and Markets Authority (CMA)

The obligation to notify the CMA sits with the provider and guidance is set out below on when that duty bites. It should also be noted that if a provider has given any undertakings to the CMA or its predecessor, the Competition Commission, then they may prohibit a statutory transaction and should be checked. A brief overview of the merger regime is set out below:

26.2 Merger control rules

The merger control regime may apply to NHS service reconfigurations where two or more services are merged and the transaction meets the jurisdictional tests.

26.3 Jurisdictional Tests

The CMA has jurisdiction to examine a merger where:

26.3.1 Two or more enterprises cease to be distinct (change of control)

26.3.2 and either

- the UK turnover of the acquired enterprise exceeds £70 million; or
- the enterprises which cease to be distinct together supply or acquire at least 25% of all those particular services of that kind supplied in the UK or in a substantial part of it. The merger must also result in an increment to the share of supply, i.e. the merging providers must supply or acquire the same category of services.

[**Enterprise**: NHS foundation trusts and NHS trusts controlling hospital, ambulance services, mental health service, community services or individual services or specialities may be enterprises for the purpose of merger control.

Change in control: Two enterprises (or services) cease to be distinct if they are brought under common ownership or control. There must be a change in the level of control over the activities of one or more enterprises (or services) for merger control to apply.]

26.4 Competition test

The CMA assesses qualifying mergers to decide whether they are likely to lead to a substantial lessening of competition ('SLC'). An SLC occurs when competition is substantially less after the merger.

26.5 SLC assessment

The CMA will require detailed information about the reconfiguration. This will include:

- service overlaps;
- GP referral data / catchment area analysis; and
- Hospital share of GP practice referrals.

26.6 CMA merger assessment timetable

The process is divided into two stages:

- Phase I: an initial 40 working day investigation; and
- Phase II: a possible 24 weeks in-depth investigation, which can be extended if the CMA considers it necessary.

27 Liability and indemnities.

27.1 In accordance with section 14Z3 of the NHS Act 2006, the Member CCGs retain liability in relation to the exercise of the Joint Functions.

28 Breach of this Manual and Remedies

28.1 Any breach of this manual will be raised by the Chair and identified senior officer. Disputes will be dealt with under 29 below.

29 Dispute Resolution

29.1 Where any dispute arises within the JC CCGs in connection with this Manual, the relevant Member CCGs must use their best endeavours to resolve that dispute on an informal basis within the JC CCGs.

29.2 Where any dispute is not resolved under clause on an informal basis, any CCG Representative (as set out in Column 2 of Schedule 2 (*Member CCGs*) may convene a special meeting of the JC CCGs to attempt to resolve the dispute.

29.3 If any dispute is not resolved under clause , it will be referred by the [Chair] of the JC CCGs to the Accountable Officers of the relevant Member CCGs, who will co-operate in good faith to resolve the dispute within ten (10) days of the referral.

29.4 Where any dispute is not resolved under clauses , or , any CCG Representative may refer the matter for mediation arranged by an independent third party to be appointed by [the Chair of the JC CCGs] [CEDR], and any agreement reached through mediation must be set out in writing and signed by and the relevant Member CCGs.

30 Leaving the JC CCGs

30.1 Should this joint decision making arrangement prove to be unsatisfactory, the governing body of any of the Member CCGs can decide to withdraw from the arrangement, but has to give a minimum of six months' notice to partners, with consideration by the JC CCGs of the impact of a leaving partner - a maximum of 12 months' notice could apply.

30.2 The Member CCG who wishes to withdraw from the JC CCGs will work together with the other Member CCGs to ensure that there are suitable alternative arrangements in place in relation to the exercise of the Joint Functions.

30.3 After leaving the JC CCGs, that CCG shall no longer be a Member CCG but shall remain bound by Clauses 23 (confidentiality)

31 Termination of the Manual

31.1 This Manual shall no longer apply if the JC CCGs is terminated.

31.2 Such termination shall be effective if all Member CCGs agree in writing that the JC CCGs shall end and withdraw the delegation of their functions to the JC CCGs.

32 Notices

32.1 Any notices given under this Manual must be in writing, must be marked for the [CCG Representative noted in Column 2 to Schedule 2 (*Member CCGs")].*

32.2 Notices sent:

32.2.1 by hand will be effective upon delivery;
32.2.2 by post will be effective upon the earlier of actual receipt or five (5) working days after mailing; or
32.2.3 by email will be effective when sent (subject to no automated response being received).

33 Variations

33.1 Any variation to the Delegation, Terms of Reference or this Manual will only be effective if it is made in writing and signed by each of the Member CCGs.

33.2 All agreed variations to the Delegation, Terms of Reference or this Manual must be appended as a Schedule to this Manual.

34 Counterparts

This Manual may be executed in any number of counterparts, each of which when executed and delivered shall constitute an original of this Manual, but all the counterparts shall together constitute the same agreement.

35 Applicable Law

This Manual shall be interpreted in accordance with the laws of England and Wales and each party to this Manual submits to the exclusive jurisdiction of the courts of England and Wales.

Schedule 1
Definitions and Interpretation

In this Manual, the following words and phrases will bear the following meanings:

Manual	means this agreement between the Member CCGs comprising the body of the Manual and its Schedules;
Data Controller	shall have the same meaning as set out in the GDPR;
Delegation	means the delegation of functions set out in Appendix 1 to this Manual;
Good Practice	means using standards, practices, methods and procedures conforming to the law, reflecting up-to-date published evidence and exercising that degree of skill and care, diligence, prudence and foresight which would reasonably and ordinarily be expected from a skilled, efficient and experienced commissioner;
GDPR	means the General Data Protection Regulation 2018;
Guidance	means any applicable health and social care guidance, guidelines, direction or determination, framework, standard or requirement issued by NHS England or any other regulatory or supervisory body, including the Information Commissioner, to the extent that the same are published and publicly available;
Information Law	The, GDPR, DPA, the EU Data Protection Directive 95/46/EC; regulations and guidance made under section 13S and section 251 of the NHS Act; guidance made or given under sections 263 and 265 of the Health and Social Care Act 2012; the Freedom of Information Act 2000; the common law duty of confidentiality; the Human Rights Act 1998 and all other applicable laws and regulations relating to processing of Personal Data and privacy including General Data Protection Regulation requirements;
JC CCGs	means the joint committee of the Member CCGs established on the terms set out in the Terms of Reference;
Joint Functions	means the functions jointly exercised by the Member CCGs through the decisions of the JC CCGs in accordance with the Terms of Reference and as set out in detail in clause [add] of the Delegation;

Law	means: (i) any applicable statute or proclamation or any delegated or subordinate legislation or regulation; (ii) any enforceable EU right within the meaning of section 2(1) European Communities Act 1972; or (iii) any applicable judgment of a relevant court of law which is a binding precedent in England and Wales, in each case in force in England and Wales;
Member CCG	means the CCGs which are part of the JC CCGs and are set out in the Terms of Reference and Column 1 of Schedule 2 (*Member CCGs*) to this Manual.
NHS Act 2006	means the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012 or other legislation from time to time);
NHS England	means the National Health Service Commissioning Board established by section 1H of the NHS Act, also known as NHS England;
Non-member CCG	means a CCG which is not a member of the JC CCGs
Non-Personal Data	means data which is not Personal Data;
Personal Data	shall have the same meaning as set out in the DPA and shall include references to Sensitive Personal Data where appropriate;
Sensitive Personal Data	shall have the same meaning as in the DPA; and
Terms of Reference	means the terms of reference for the JC CCGs agreed between the CCG(s).

Schedule 2
Member CCGs

Column 1 **Clinical Commissioning Groups**
NHS Barnsley Clinical Commissioning Group; NHS Bassetlaw Clinical Commissioning Group; NHS Doncaster Clinical Commissioning Group; NHS Rotherham Clinical Commissioning Group; NHS Sheffield Clinical Commissioning Group; NHS England Specialised Commissioning And associate CCG: NHS Derby and Derbyshire Clinical Commissioning Group;

Appendix 1

Delegation by CCGs to JC CCGs

A. The CCG functions at B will be delegated to the JC CCGs by the member CCGs in accordance with their statutory powers under s.14Z3 of the NHS Act 2006 (as amended) (**"the NHS Act"**). Section 14Z3 allows CCGs to make arrangements in respect of the exercise of their commissioning functions and includes the ability for two or more CCGs to create a Joint Committee to exercise functions.

B. The delegated functions relate to the health services provided to the member CCGs by all providers they commission services from in the exercise of their functions. The CCGs delegate their commissioning functions so far as such functions are required for the Joint Committee to carry out its role, as set out in the Terms of Reference (appendix 2).

The CCGs delegate the functions to enable the Joint Committee to take decisions around future transformation projects, specifically and limited to transformation and redesign of Hyper Acute Stroke services and Children's Surgery and Anaesthesia services and the specific delegation requirements for JC CCGs set out in the agreed 2019/20 JCCCG priorities which are summarised below:

2019/20 SYB System Commissioning Priorities requiring delegated authority	**Requested delegation to the JC CCGs to:**
System Contracting • 999 system lead contractor (YAS) for 4 SYB CCGs • 111 system lead contractor (YAS) for 5 SYB CCGs	• develop and agree a financial threshold of contract value against contract baseline for the lead contractor to negotiate on behalf of each CCG during 19/20 contract negotiations.
Outpatients • Review of outpatient follow ups across SYB by specialty, develop clinical protocols to standardise practice and reduce unwarranted variation * • Review of outpatient first appointments (as above) *	• identify and agree the specialities in scope of the OP review • develop and sign off clinical protocols developed with SYB clinical engagement from both commissioners and providers and patients/ public as necessary • implement clinical protocols in Providers standard NHS contracts 2019/20
Commissioning Outcomes • Commissioning for Outcomes – new stage 2	• identify and agree the clinical priorities in the policy • sign off 19/20 policy ensuring public

	consultation /engagement has taken place • implementation of protocols and included formally in standard NHS contracts 2019/20
IVF • Explore options for a SYB approach to the number of IVF cycles	• develop IVF options appraisal and financial modelling for consideration by CCG Governing Bodies
Cancer • Standard implementation of national cancer pathways across SYB tom improve outcomes and equity of access*	• implement standard cancer pathways in NHS provider contracts and across the 5 SYB places
Medicines and Prescribing • Medicines optimisation – standardisation of policies across SYB	• Identify opportunities for medicines standardisation • develop and sign off policies developed with SYB clinical engagement from clinicians, patients / public as necessary
Hospital Services Programme • Governing Bodies to agree next steps on the work programme of the Hospital Services Programme,	• The conclusions on next steps on transformation and reconfiguration and implementation of these

C. Each member CCG shall also <u>delegate the following functions to the JC CCGs</u> so that it can achieve the purpose set out in (B) above:

1. Acting with a view to securing continuous improvement to the quality of commissioned services. This will include outcomes for patients with regard to clinical effectiveness, safety and patient experience to contribute to improved patient outcomes across the NHS Outcomes Framework
2. Promoting innovation, seeking out and adopting best practice, by supporting research and adopting and diffusing transformative, innovative ideas, products, services and clinical practice within its commissioned services, which add value in relation to quality and productivity.
3. The requirement to comply with various statutory obligations, including making arrangements for public involvement and consultation throughout the process and taking into account updated guidance on patient and public participation in commissioning health and care. That includes any determination on the viability of models of care pre-consultation and during formal consultation processes, as set out in s.13Q, s.14Z2 and s.242 of the NHS Act.
4. The requirement to ensure process and decisions comply with the four key tests for service change introduced by the Secretary of State for Health, which are:
    - Support from GP commissioners;
    - Strengthened public and patient engagement;
    - Clarity on the clinical evidence base; and

- Consistency with current and prospective patient choice.

5. The requirement to comply with the statutory duty under s.149 of the Equality Act 2010 i.e. the public sector equality duty.
6. The requirement to have regard to the other statutory obligations set out in the new sections 13 and 14 of the NHS Act. The following are relevant but this is not an exhaustive list:

   ss.13C and 14P - Duty to promote the NHS Constitution
   ss.13D and 14Q - Duty to exercise functions effectively, efficiently and economically
   ss.13E and 14R – Duty as to improvement in quality of services
   ss.13G and 14T - Duty as to reducing inequalities
   ss.13H and 14U – Duty to promote involvement of each patient
   ss.13I and 14V - Duty as to patient choice
   ss.13J and 14W – Duty to obtain appropriate advice
   ss.13K and 14X – Duty to promote innovation
   ss.13L and 14Y – Duty in respect of research
   ss.13M and 14Z - Duty as to promoting education and training
   ss.13N and 14Z1- Duty as to promoting integration
   ss.13Q and 14Z2 - Public involvement and consultation by NHS England/CCGs
   s.13O - Duty to have regard to impact in certain areas
   s.13P - Duty as respects variations in provision of health services
   s.14O – Registers of Interests and management of conflicts of interest
   s.14S – Duty in relation to quality of primary medical services

7. The JC CCGs must also have regard to the financial duties imposed on CCGs under the NHS Act and as set out in:

   - s.223G – Means of meeting expenditure of CCGs out of public funds
   - s.223H – Financial duties of CCGs: expenditure
   - s.223I - Financial duties of CCGs: use of resources
   - s.223J - Financial duties of CCGs: additional controls of resource use

8. Further, the JC CCGs must have regard to the Information Standards as set out in ss.250, 251, 251A, 251B and 251C of the Health & Social Care Act 2012 (as amended).
9. The expectation is that CCGs will ensure that clear governance arrangements are put in place so that they can assure themselves that the exercise by the JC CCGss of their functions is compliant with statute.
10. The JC CCGs will meet the requirement for CCGs to comply with the obligation to consult the relevant local authorities under s.244 of the NHS Act and the associated Regulations.
11. To continue to work in partnership with key partners e.g. the local authority and other commissioners and providers to take forward plans so that pathways of care are seamless and integrated within and across organisations.
12. The JC CCGs will be delegated the capacity to propose, consult on and agree future service configurations that will shape the medium and long terms financial plans of the constituent organisations. The JC CCGs will have no contract negotiation powers meaning that it will not be the body for formal annual contract negotiation between commissioners and providers. These processes will continue to be the responsibility of Clinical Commissioning Groups (and NHS England) under national guidance, tariffs and contracts during the pre-consultation and consultation periods.

Appendix 2

JC CCGs Terms of Reference

1. Introduction

.1 The NHS Act 2006 (as amended) ('**the NHS Act**'), was amended through the introduction of a Legislative Reform Order ("**LRO**") to allow CCGs to form joint committees. This means that two or more CCGs exercising commissioning functions jointly may form a joint committee as a result of the LRO amendment to s.14Z3 (CCGs working together) of the NHS Act.

1.2 Joint committees are a statutory mechanism which gives CCGs an additional option for undertaking collective strategic decision making and can include NHS England, who may also make decisions collaboratively with CCGs.

1.3 Individual CCGs and NHS England will still always remain accountable for meeting their statutory duties. The aim of creating a joint committee is to encourage the development of strong collaborative and integrated relationships and decision-making between partners.

1.4 The Joint Committee of Clinical Commissioning Groups ('**JC CCGs**') is a joint committee of:

(1) NHS Barnsley Clinical Commissioning Group;

(2) NHS Bassetlaw Clinical Commissioning Group;

(3) NHS Doncaster Clinical Commissioning Group;

(4) NHS Rotherham Clinical Commissioning Group;

(5) NHS Sheffield Clinical Commissioning Group;

(6) NHS England Specialised Commissioning; Non voting

And *Associate CCG members:

(6) NHS Derby and Derbyshire Clinical Commissioning Group;

***Associate CCG** is a partner CCG outside of the SYB footprint with commissioned patient flows into SYB for acute provider secondary and tertiary care services. Derby and Derbyshire CCG is also a member of the SYB and North Derbyshire Cancer Alliance. Our Associate CCG is involved in the commissioning arrangements and decisions managed through the JC CCGs where their patients are affected by any proposed change as appropriate. Associate CCGs are <u>non-voting</u> members of the JC CCGs where they do not have a patient interest in a proposed change overseen by the JC CCGs. The involvement of the associate CCG in the JC CCGs work (where voting rights would be appropriate for that specific priority) is clarified on the list of JC CCGs work priorities.

It has the primary purpose of enabling the CCG members to work effectively together, to collaborate and take joint decisions in the areas of work that they agree.

1.5 In addition the JC CCGs will meet collaboratively with NHS England to make integrated decisions in respect of those services which are directly commissioned by NHS England.

1.6 Guiding principles:

- Collaborate and co-operate. Do it once rather than repeating or duplicating actions and increasing cost across the CCGs. Establish and adhere to the governance structure set out in these Terms of Reference and in the JC CCGs Manual (as updated from time to time), to ensure that activities are delivered and actions taken as required;
- Be accountable. Take on, manage and account to each other for performance of the respective roles and responsibilities set out in these Terms of Reference and in the JC CCGs Manual (as updated from time to time);
- Be open. Communicate openly about major concerns, issues or opportunities relating to the functions delegated to the JC CCGs, as set out in Schedule 1; ensuring our collective decisions are based on the *best* available evidence, that these are fully articulated, heard, and understood.
- Learn, develop and seek to achieve full potential. Share information, experience, materials and skills to learn from each other and develop effective working practices, work collaboratively to identify solutions, eliminate duplication of effort, mitigate risk and reduce cost whilst ensuring quality is maintained or improved across all the CCGs;
- Adopt a positive outlook. Behave in a positive, proactive manner;
- Adhere to statutory requirements and best practice. Comply with applicable laws and standards including EU procurement rules, data protection and freedom of information legislation.
- Act in a timely manner. Recognise the time-critical nature of the functions delegated to the JC CCGs as set out in Schedule 1, and respond accordingly to requests for support;
- Manage stakeholders effectively;
- Deploy appropriate resources. Ensure sufficient and appropriately qualified resources are available and authorised to fulfil the responsibilities set out in these Terms of Reference and in the JC CCGs Manual Agreement (as updated from time to time);
- Act in good faith to support achievement of the Key Objectives as set out in the JC CCGs Manual and compliance with these Principles.
- The JC CCGs has a commitment to ensuring that in pursuing its Key Objectives it does not increase inequalities or worsen health outcomes for any local populations.
- From time to time programmes boards may be established to oversee individual programmes of work. Where these are established under the direction of the JC CCGs these will be accountable to the JC CCGs.

2. Statutory Framework

2.1 The NHS Act which has been amended by LRO 2014/2436, provides at s.14Z3 that where two or more clinical commissioning groups are exercising their commissioning functions jointly, those functions may be exercised by a joint committee of the groups.

2.2 The CCGs named in paragraph 1.5 above have delegated the functions set out in Schedule 1 to the JC CCGs.

3. Role of the JC CCGs

3.1 The role of the JC CCGs shall be:

- Development of collective strategy and commissioning intentions;
- Development of co-commissioning arrangements with NHS England;
- Joint contracting with Foundation Trusts and other service providers;
- System transformation, including the development and adoption of service redesign and best clinical practice across the area – which may include the continuation or establishment of clinical networks in addition to those nationally established;
- Representation and contribution to Alliances and Networks including clinical networks nationally prescribed;
- Work with NHS England and Improvement on the outcome and implication of national or regional service reviews;
- Work with the NHS England Area on system management and resilience;
- Collaboration and sharing best practice on Quality Innovation Productivity and Prevention initiatives; and
- Mutual support and aid in organisational development.

3.2 At all times, the JC CCGs, through undertaking decision making functions of each of the member CCGs, will act in accordance with the terms of their constitutions. No decision outcome shall impede any organisation in the fulfilment of its statutory duties.

4. Geographical coverage

4.1 The JC CCGs will comprise those CCGs listed above in paragraph 1.5, NHSE/I specialised commissioning covering the South Yorkshire and Bassetlaw, Derby and Derbyshire areas (associate members).

5. Membership

5.1 Membership of the committee will combine both Voting and Non-voting members and will comprise of: -

5.2 Voting members:

- Two decision makers from each of the five SYB member CCGs: the Clinical Chair and Accountable Officer. Each CCG has one vote.

5.3 Non-voting attendees:

- Two Lay Members
- One Director of Finance chosen from the member CCGs.
- A Healthwatch representative nominated by the local Healthwatch groups
- SYB ICS Chief Executive or deputy
- SYB ICS Director of Commissioning
- SYB ICS Communications and Engagement lead
- NHSE Specialised Commissioning lead
- Associate CCG member (where no or minimal patient interest in proposed changes, see para 1.4)

5.4 The JC CCGs may invite additional non-voting members to join the JC CCGs to enable it to carry out its duties

5.5 Committee members may nominate a suitable deputy when necessary and subject to the approval of the Chair of the JC CCGs. All deputies should be fully briefed and the secretariat informed of any agreement to deputise so that quorumum can be maintained.

5.6 No person can act in more than one role on the JC CCGs, meaning that each deputy needs to be an additional person from outside the JC CCGs membership.

5.7 The SYB ICS will act as secretariat to the JC CCGs to ensure the day to day work of the JC CCGs is proceeding satisfactorily. The membership will meet the requirements of the constitutions of the CCGs named above at paragraph 1.4.

5.8 The JC CCGs will be Chaired by a respective CCG Clinical Chair and vice clinical Chair. For 2019/20 the chair is Doncaster CCG Clinical Chair, Deputy Chair is Rotherham CCG Clinical chair. The tenure of the role is 12 months.

6. Meetings

6.1 The JC CCGs shall adopt the standing orders of NHS Sheffield Clinical Commissioning Group insofar as they relate to the:

a) notice of meetings;

b) handling of meetings;

c) agendas;

d) circulation of papers; and

e) conflicts of interest.

7. Voting

7.1 The JC CCGs will aim to make decisions by consensus wherever possible. Where this is not achieved, a voting method will be used. The JC CCGs has five CCG members and 1 vote for each CCG. The voting power of each individual present will be weighted so that each party (CCG) possesses 20% of total voting power.

7.2 It is proposed that recommendations can only be approved if there is approval by more than 80%.

8. Quorum

8.1 At least one full voting member from each CCG must be present for the meeting to be quorate. The Healthwatch representative must also be present.

9. Frequency of meetings

9.1 Frequency of meetings will usually be monthly, but the Chair has the power to call meetings of the JC CCGs as and when they are required.

9.2 Meetings may be held by telephone or video conference, JC CCGs members can participate and included as quorum in a face to face meeting, by telephone or by video link.

10 Meetings of the JC CCGs

10.1 Meetings of the JC CCGs shall be held in public unless the JC CCGs considers that it would not be in the public interest to permit members of the public to attend a meeting or part of a meeting. Therefore, the JC CCGs may resolve to exclude the public from a meeting that is open to the public (whether during the whole or part of the proceedings) whenever publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted or for other special reasons stated in the resolution and arising from the nature of that business or of the proceedings or for any other reason permitted by the Public Bodies (Admission to Meetings) Act 1960 as amended or succeeded from time to time.

10.2 The Chair shall set the agenda and arrange papers to be circulated 5 working days prior to the JC CCGs meeting

10.3 Members of the JC CCGs have a collective responsibility for the operation of the JC CCGs. They will participate in discussion, review evidence and provide objective expert input to the best of the knowledge and ability, and endeavour to reach a collective view.

10.4 The JC CCGs may call additional experts to attend meetings on an ad hoc basis to inform discussions.

10.5 Each JCCCG member must abide by all policies in relation to conflicts of interests. Where any JC CCGs member has an actual or potential conflict of interest in relation to any matter under consideration at any meeting, the Chair (in their discretion) shall decide, having regard to the nature of the potential or actual conflict of interest, whether or not that member of the JC CCGs can participate / vote in the meeting or part of the meeting where the item is discussed

10.6 The JC CCGs has the power to establish sub groups and working groups and any such groups will be accountable directly to the JC CCGs.

10.7 Members of the JC CCGs shall respect confidentiality requirements as set out in the Standing Orders referred to above unless separate confidentiality requirements are set out for the JC CCGs, in which event these shall be observed.

10.8 The right of attendance at meetings by members of the public as referred to in paragraph 10.1 does not give the right to such members of the public to ask questions or participate in that meeting, unless invited to do so by the Chair.

10.9 Members of the public or press may not record proceedings in any manner whatsoever, other than in writing, or make any oral report of the proceedings as they take place, without the prior written agreement of the Chair.

10.10 Questions must be submitted in writing to the JC CCGs secretariat by noon on the Monday before the meeting.

10.11 Answers to submitted questions relating to the agenda received in advance of the meeting will be published on the JCCCG section of the South Yorkshire and Bassetlaw Integrated Care System website following the meeting.

10.12 Up to 15 minutes will be set aside at the beginning of the meeting in public to respond to written questions. Additional verbal questions and /or statements requested by members of the public are answered at the chairs discretion. Questions or

statements that are not deemed appropriate to the business of the JC CCGs and agenda will not be accepted.

10.13 Confidential items will be considered in a closed private meeting of the JC CCGs.

10.14 The Chair may exclude any member of the public from a meeting of the JC CCGs if they are interfering with or preventing the proper or reasonable conduct of that meeting.

11. Secretariat provisions

The secretariat to the JC CCGs will:

a) Take and circulate the minutes, conflicts, matters arising action notes and decisions of the JC CCGs meeting to all members; and

b) Present the minutes, conflicts, matters arising, action notes and decisions to the governing bodies of the CCGs set out in paragraph 1.4 above.

12. Reporting to CCGs

The JC CCGs will make a quarterly written report to the CCG member governing bodies and the SYB ICS and hold at least annual engagement events to review aims, objectives, strategy and progress and publish an annual report on progress made.

13. Decisions

13.1 The JC CCGs will make decisions within the bounds of the scope of the functions delegated.

13.2 The decisions of the JC CCGs shall be binding on all member CCGs.

13.3 All decisions undertaken by the JC CCGs will be published by the Clinical Commissioning Groups set out in paragraph 1.4 above.

13.4 The JC CCGs agrees to make decisions by a common process for decision making with a non-member CCG. This process will apply where a non-member CCG has delegated the functions within the scope of the JC CCGs to an individual or member or employee of the non-member CCG.

14. Attendance

14.1 Voting members of the JC CCGs shall attend a minimum of at least 75% of meetings during the financial year.

15. Review of Terms of Reference

These terms of reference will be formally reviewed in **6 months** by Clinical Commissioning Groups set out in paragraph 1.4 and may be amended by mutual agreement between the CCGs at any time to reflect changes in circumstances as they may arise.

16. Withdrawal from the JC CCGs

16.1 Should this joint commissioning arrangement prove to be unsatisfactory, the governing body of any of the member CCGs can decide to withdraw from the arrangement, but has to give a minimum six months' notice to partners, with consideration by the JC CCGs of the impact of a leaving partner - a maximum of 12 months notice could apply.

List of Members from each CCG and non-voting members

Column 1 **Organisation or nomination**	**Column 2** **Representatives**
Voting members	
NHS Barnsley Clinical Commissioning Group;	The Clinical Chair, The Accountable Officer
NHS Bassetlaw Clinical Commissioning Group;	The Clinical Chair, The Accountable Officer
NHS Doncaster Clinical Commissioning Group;	The Clinical Chair, The Accountable Officer
NHS Rotherham Clinical Commissioning Group;	The Clinical Chair, The Accountable Officer
NHS Sheffield Clinical Commissioning Group;	The Clinical Chair, The Accountable Officer
Non-voting members	
JC CCGs Lay Members	Lay members X2
Nominated Director of Finance	NHS Sheffield CCG Director of Finance
Nominated Healthwatch member	Healthwatch Doncaster
South Yorkshire and Bassetlaw ICS	ICS Chief Executive or Deputy ICS Director of Commissioning ICS Communications & Engagement Lead
NHS England	Specialised Commissioning
Associate CCG member	NHS Derby and Derbyshire CCG

Appendix 3

Checklist of Statutory Duties and Protocols

Public Law Issues (including for service change)

1. Case For Change

The starting point is to have established a clear Case for Change that both commissioners and providers agree is clinically and financially sound.

2. Engagement with Public and Patients

You must comply with various statutory obligations to engage with and consult the public and patients throughout the process. That includes any determination on the viability of models of care pre-consultation and during formal consultation processes. – see s.13Q, s.14Z2 and s.242 of the NHS Act 2006 (as amended) ('the Act') and statutory guidance for CCGs and NHS England (May 2017).

3. Four Key Tests

It is important throughout the reconfiguration process to have in mind the four key tests introduced by the last Secretary of State for Health, which are:

(i) strong public and patient engagement;

(ii) consistency with current and prospective need for patient choice;

(iii) a clear clinical evidence base; and

(iv) support for proposals from clinical commissioners.

Decision makers will need to show compliance when making a final decision on service change.

4. Equality

All NHS statutory bodies must also ensure compliance with their duty under s.149 of the Equality Act 2010 that is their public sector equality duty.

5. Statutory obligations

Commissioners must also have regard to the other statutory obligations set out in the new sections 13 and 14 of the Act. In looking at CCG duties the following, amongst others, are relevant:

- 14P – Duty to promote NHS Constitution
- 14Q – Duty as to effectiveness, efficiency etc
- 14R – Duty as to improvement in quality of services
- 14T – Duty as to reducing inequalities
- 14V – Duty as to patient choice
- 14X - Duty to promote innovation
- 14Z1 – Duty as to promoting integration
- 14Z2 – Public involvement and consultation by CCGs (see above)

6. Government Consultation Principles Updated 2018

All consulting NHS bodies should consider and comply with government principles on Consultation on what needs to be done to undertake a lawful public consultation exercise.

7. Principles for consultation (2018)

- **Consultations should be clear and concise**

  Use plain English and avoid acronyms. Be clear what questions you are asking and limit the number of questions to those that are necessary. Make them easy to understand and easy to answer. Avoid lengthy documents when possible and consider merging those on related topics.

- **Consultations should have a purpose**

  Do not consult for the sake of it. Ask departmental lawyers whether you have a legal duty to consult. Take consultation responses into account when taking policy forward. Consult about policies or implementation plans when the development of the policies or plans is at a formative stage. Do not ask questions about issues on which you already have a final view.

- **Consultations should be informative**

  Give enough information to ensure that those consulted understand the issues and can give informed responses. Include validated impact assessments of the costs and benefits of the options being considered when possible; this might be required where proposals have an impact on business or the voluntary sector.

- **Consultations are only part of a process of engagement**

  Consider whether informal iterative consultation is appropriate, using new digital tools and open, collaborative approaches. Consultation is not just about formal documents and responses. It is an on-going process.

- **Consultations should last for a proportionate amount of time**

  Judge the length of the consultation on the basis of legal advice and taking into account the nature and impact of the proposal. Consulting for too long will unnecessarily delay policy development. Consulting too quickly will not give enough time for consideration and will reduce the quality of responses.

- **Consultations should be targeted**

  Consider the full range of people, business and voluntary bodies affected by the policy, and whether representative groups exist. Consider targeting specific groups if appropriate. Ensure they are aware of the consultation and can access it. Consider how to tailor consultation to the needs and preferences of particular groups, such as older people, younger people or people with disabilities that may not respond to traditional consultation methods.

- **Consultations should take account of the groups being consulted**

  Consult stakeholders in a way that suits them. Charities may need more time to respond than businesses, for example. When the consultation spans all or part of a holiday period, consider how this may affect consultation and take appropriate mitigating action, such as prior discussion with key interested parties or extension of the consultation deadline beyond the holiday period.

- **Consultations should be agreed before publication**

  Seek collective agreement before publishing a written consultation, particularly when consulting on new policy proposals. Consultations should be published on gov.uk.

- **Consultation should facilitate scrutiny**

  Publish any response on the same page on gov.uk as the original consultation, and ensure it is clear when the government has responded to the consultation. Explain the responses that have been received from consultees and how these have informed the policy. State how many responses have been received.

- **Government responses to consultations should be published in a timely fashion**

  Publish responses within 12 weeks of the consultation or provide an explanation why this is not possible. Where consultation concerns a statutory instrument publish responses before or at the same time as the instrument is laid, except in very exceptional circumstances (and even then publish responses as soon as possible). Allow appropriate time between closing the consultation and implementing policy or legislation.

- **Consultation exercises should not generally be launched during local or national election periods**.

  If exceptional circumstances make a consultation absolutely essential (for example, for safeguarding public health), departments should seek advice from the Propriety and Ethics team in the Cabinet Office. This document does not have legal force and is subject to statutory and other legal requirements.

8. Governance

As to decision making it is important that clear governance arrangements are put in place that are compliant with statute.

9. Local authorities

Equally you must comply with your obligation to consult the relevant local authorities under s.244 of the Act and the associated Regulations.

10. Clear plan

As to consulting you need to have a clear plan in place which ensures that you give the public sufficient information for them to provide informed responses.

11. Analysis and report

Once the public consultation is complete, you must be able to collate and analyse responses for the decision makers to consider, often in the form of a consolidated report. Equally, you need a clear analysis of compliance with your obligations under the public sector equality duty.

12. Compliance with statutory obligations and four Key Tests

Commissioners will also want to ensure that decisions comply with their other statutory obligations and the four Key Tests, as set out above.

13. IRP

Consideration should be given to those issues which the IRP have indicated in annual reviews cause the most concern to the public an patients. (See separate note for a list of the issues).

Procurement Issues

Commissioners are required to ensure that their decisions to procure services comply with the National Health Service (Procurement, Patient Choice and Competition) (No. 2) Regulations 2013. Key questions are set out under each heading below to assist you when considering whether you are meeting these requirements. Commissioners are also required to comply with EU/UK general procurement law but this is not covered in the list below.

1. Procurement objective

'To secure the needs of patients and improve quality and efficiency of services'.

- What have you done to assess patient need and do you have evidence to support your findings?

- How are you assessing the quality of services and the performance of the current providers? How have you assessed whether the service is offering value for money?
- Have you reviewed the current service specification to ensure it is working well and whether there is scope for further improvement? In particular, it would be helpful to have a schedule of all existing contracts and relationships, including performance monitoring on contracts.
- What steps have you taken to assess equitable access to services by all patient groups?

2. Three general requirements

I. To act transparently and proportionately and in a non-discriminatory way.

- What steps have you taken to make providers and stakeholders aware of your plans? Have you provided reasons to support your decisions?
- Are you publishing details in a timely manner and have you kept records of decision making, e.g. board minutes and briefing papers?
- Do providers understand the selection criteria you are using and are they able to express an interest in providing the services? Can you show that you have not favoured one provider over the other?
- Is your approach proportionate to the nature of the services in relation to the value, complexity and clinical risk associated with the provision of the services in question?

II. To contract with providers who are most capable of meeting the objectives and provide best value for money

- How have you identified existing and potential providers and objectively evaluated their relative ability to deliver the service specification, improve quality and meet the needs of patients?
- Are you satisfied providers are capable and robust enough to deliver a safe and efficient service and provide the best value for money in doing so?

III. Consider ways of improving services through integration, competition and patient choice

- What evidence do you have to show the steps you taken to determine whether it might be better for patients if the services are integrated with other health care services?
- Have you asked providers, patients, and other stakeholders for their views?
- Does your specification or performance monitoring process incentivise delivery of care in a more integrated manner?
- Have you considered whether competition or choice would better incentivise providers to improve quality and efficiency? Do you have evidence to support your findings?

3. Advertisements and expressions of interest

To ensure providers are able to express an interest in in providing any services which includes the requirement to publish opportunities and awards on a website

- How have you gathered evidence about the existing and potential providers on the market?
- Have you published your intentions to the market by way of commissioning intentions or publication on a website?

4. Award of a new contract without a competition

A new contract may be awarded without publishing a contract notice where the commissioner is satisfied that the services in question are capable of being provided only by that provider, e.g. A&E services in a particular area or where it is not viable for providers to provide one service without also providing another service.

- What steps have you taken and what evidence are you relying on to satisfy yourself that there is only one capable provider?

5. Conflict of Interests

Commissioners are prohibited from awarding a contract where conflicts, or potential conflicts, between the interests of Commissioners in commissioning services and the interests involved in providing the services affect, or appear to affect, the integrity of the award of the contract.

- Have you recorded how you have managed any conflict or potential conflict?

6. Anti-competitive behaviour

Not to engage in anti-competitive behaviour unless to do so would be in the interests of people who use NHS services

- Are you acting in an anticompetitive manner – for instance have you prevented new providers from entering the market or caused a provider to exit the market?

- If so, is it objectively justifiable as being in the interests of users and stakeholders? What evidence do you have to support this?

Competition Issues

1. Requirement to Notify to the Competition and Markets Authority (CMA)

Any undertakings given to the CMA or its predecessor, the Competition Commission, may prohibit a statutory transaction and should be checked. They may not apply to a merger by reconfiguration but the merger regime set out below will still apply.

2. Merger control rules

The merger control regime may apply to NHS service reconfigurations where two or more services are merged and the transaction meets the jurisdictional tests.

3. Jurisdictional Tests

The CMA has jurisdiction to examine a merger where:

1. two or more enterprises cease to be distinct (change of control)

2. and either

- the UK turnover of the acquired enterprise exceeds £70 million; or
- the enterprises which cease to be distinct together supply or acquire at least 25% of all those particular services of that kind supplied in the UK or in a substantial part of it. The merger must also result in an increment to the share of supply, i.e. the merging providers must supply or acquire the same category of services.

[**Enterprise**: NHS foundation trusts and NHS trusts controlling hospital, ambulance services, mental health service, community services or individual services or specialities may be enterprises for the purpose of merger control.

Change in control: Two enterprises (or services) cease to be distinct if they are brought under common ownership or control. There must be a change in the level of control over the activities of one or more enterprises (or services) for merger control to apply.]

4. Competition test

The CMA assesses qualifying mergers to decide whether they are likely to lead to a substantial lessening of competition ('SLC'). An SLC occurs when competition is substantially less after the merger.

5. SLC assessment

The CMA will require detailed information about the reconfiguration. This will include:

- service overlaps;
- GP referral data / catchment area analysis; and
- Hospital share of GP practice referrals.

6. CMA merger assessment timetable

The process is divided into two stages:

- Phase I: an initial 40 working day investigation; and
- Phase II: a possible 24 weeks in-depth investigation, which can be extended if the CMA considers it necessary.

Appendix 4

South Yorkshire and Bassetlaw JC CCGs Clinical Engagement and Assurance Process

The SY&B system commissioning priorities for 2019/20 have been developed by the JC CCGs, members of SYB CCG Governing Bodies and Directors of Commissioning. Individual CCGs will be responsible for leading specific priorities of work to be adopted across the ICS in order to standardise access, improve outcomes and quality of care for patients across SY&B.

It is important that JC CCGs priorities are clinically developed using best practice and evidence based and are locally clinically led to ensure an agreed SYB consensus to pathways, policies and protocols. Assurance will be sought through the JC CCGs that all SYB priorities being developed are underpinned by a robust locally managed process in each place for clinicians to engage, influence, develop and agree the work and is supported by CCG memberships.

Wider involvement of clinicians and professionals from across the system including; primary and community care, secondary care, tertiary care, mental health, cancer and specialised services will be engaged in the relevant work priorities as appropriate to inform the clinical consensus. The lead CCG will ensure that wider SYB clinical engagement has been undertaken as required.

Each CCG currently has a forum to ensure this clinical assurance takes place locally through their place:

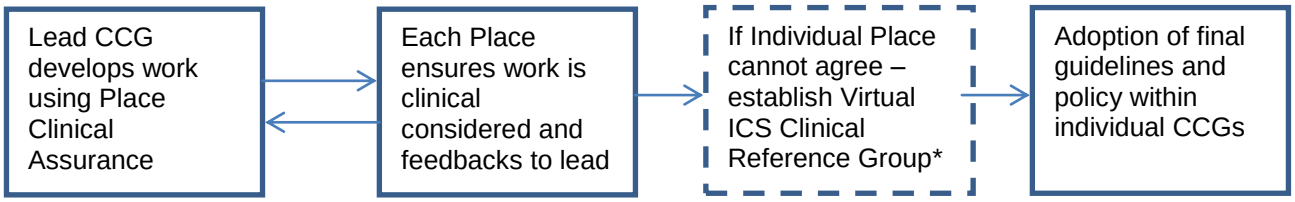
- Doncaster CCG – Clinical Reference Group
- Barnsley – Clinical Forum
- Sheffield CCG – Clinical Reference Group
- Rotherham CCG – Clinical Referral Management Committee
- Bassetlaw CCG – Service Delivery Committee

These respective groups all have the remit to ensure clinical debate and assurance is undertaken at place enabling a clinical consensus in each place for SYB system commissioning priorities throughout the work that cover the following requirements:

- Patient centred and quality driven decision making
- Local ownership and implementation of recommendations
- Consistency of guidelines and clinical pathways across the ICS
- Timely decision making to ensure implementation within agreed timeframes

SYB Clinical Engagement and Assurance Process:

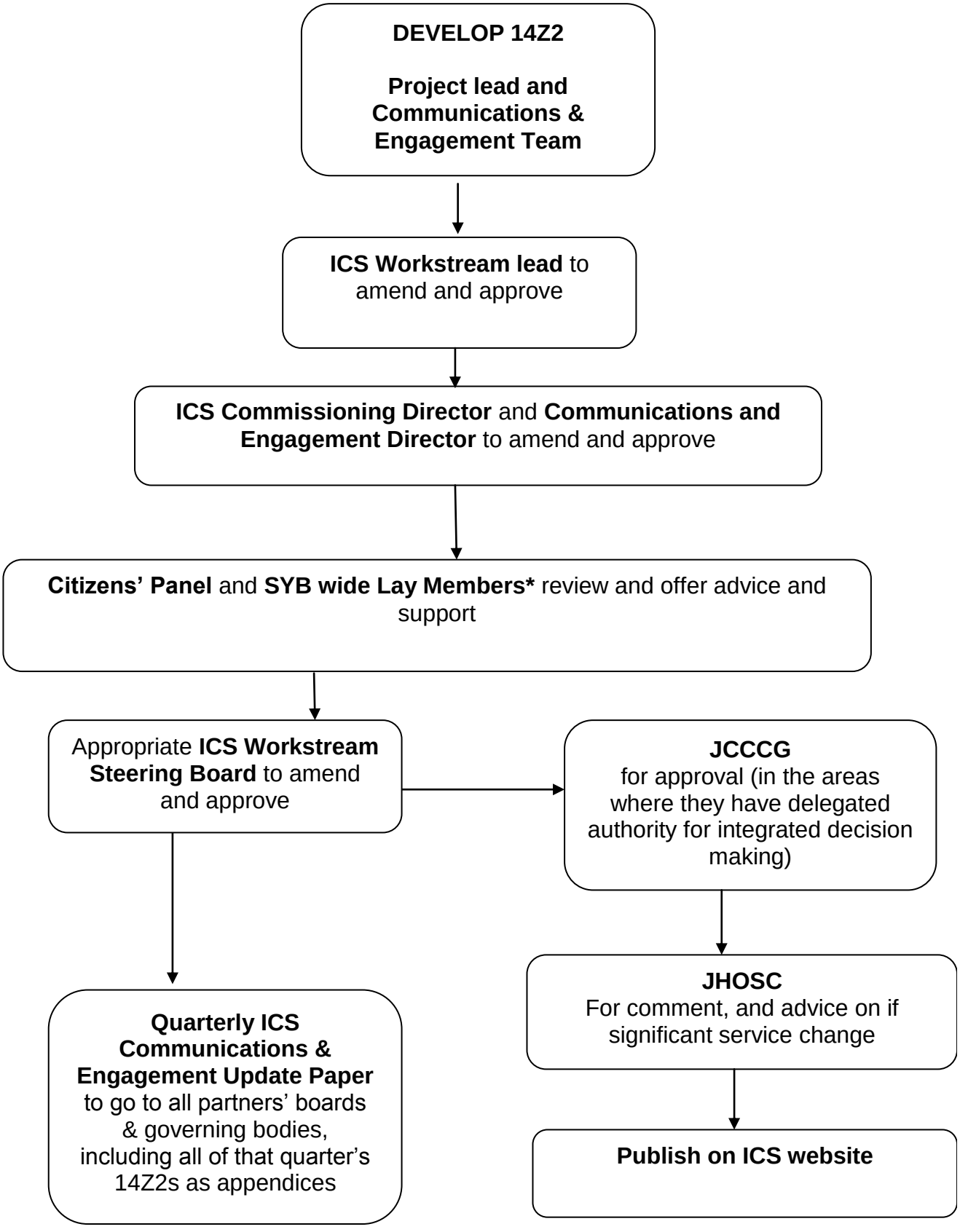
Lead CCG liaises with individual places to ensure clinical reference and agreement takes place during development of work:



*A virtual ICS Clinical Reference Group would be created to debate and reconcile clinical opinion and confirm final clinical sign off in each place. This group would be clinically tailored to the priority subject matter and have authority of clinical decision making from the ICS and place.

Appendix 5

South Yorkshire and Bassetlaw ICS Assessment Process for Section 14Z2 Duty for Public Involvement



*subject to agreement of lay members

SY&B JC CCG Clinical Engagement and Assurance Process

Options Appraisal Paper – JC CCG June 2019

Background

The SY&B system commissioning priorities and work plan for 2019/20 has been agreed by the Health Executive Group (HEG) and ratified by CCG Governing Bodies. Individual CCGs will be responsible for leading transformation work ranging from Outpatient redesign to Medicines and Prescribing. It is the intention that recommendations from the work plan will be shared, ratified and adopted across the ICS to ensure transparency and consistent quality of care for patients and staff across SY&B.

It is important that system commissioning priorities are clinically developed to ensure an agreed SYB consensus to pathways, policies and protocols. Assurance will be sought through the JC CCG that all SYB priorities being developed are underpinned by robust clinical evidence and best practice and with a locally managed process in each place for clinicians to engage, influence develop and agree the work.

Each CCG currently has a forum to ensure this assurance takes place locally (For the purposes of this paper they shall be generically referred to as "Place Clinical Assurance")

- Doncaster CCG – Clinical Reference Group
- Barnsley – Clinical Forum
- Sheffield CCG – Clinical Reference Group
- Rotherham CCG – Clinical Referral Management Committee
- Bassetlaw CCG – Service Delivery Committee

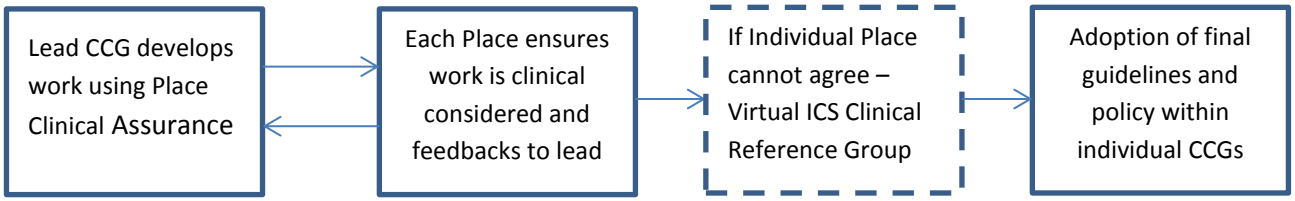
These respective groups all have the remit to ensure clinical debate and assurance is undertaken at place across a number of appropriate pathways, professionals and organisations. This paper presents 3 options for consideration on how the recommendations are agreed across the ICS. The options have been developed at Joint Directors of Commissioning Forum and the ICS Elective & Diagnostic Programme Board (using Outpatient Follow Up redesign as a working example).

The Options were subsequently presented to JCCCG Sub Group, where Option 1 was adapted and supported.

Consideration of the options should take into account the following requirements

- Patient centred and quality driven decision making
- Local ownership and implementation of recommendations
- Consistency of guidelines and clinical pathways across the ICS
- Timely decision making to ensure implementation within agreed timeframes

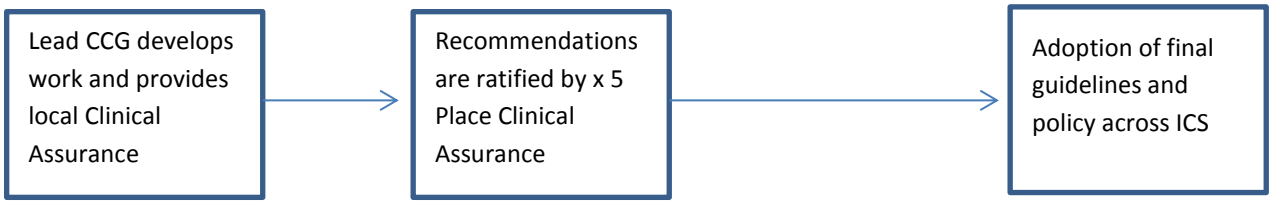
Option 1 – Lead CCG liaises with individual places to ensure clinical reference and agreement takes place during development of work



Pros	Cons
Option should allow local clinical ownership of recommendations before implementation	Labour intensive for lead CCG to ensure consistent and timely feedback from individual places during development of work
Place and ICS can be assured that each CCG has inputted into recommendation	Delays to work development if clinical disagreement across CCGs during development
Timely final sign and adoption off should be ensured once recommendations have been agreed	

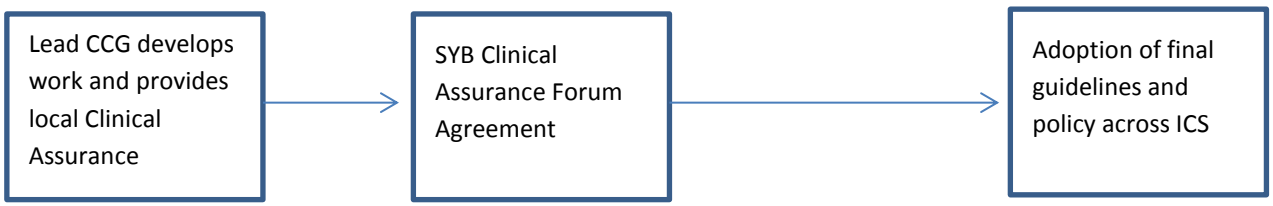
At June JC CCG Sub Group it was recommended that a **virtual ICS Clinical Reference Group** be created to debate and have final sign clinical sign off on any disagreement at Place Level. This group would be clinically tailored to the subject matter and have authority of decision making from ICS and individual Place.

Option 2 – Lead CCG develops work programme before sign off from each Place Clinical Assurance



Pros	Cons
Option will allow genuine local clinical ownership of recommendations before implementation	Inevitable delay to process through local clinical assurance across Place
Place and ICS can be assured that each CCG has inputted into recommendation	Potential for failure to agree consistent guidelines and Policy
Timely final sign and adoption off should be ensured once/if recommendations have been agreed	

Option 3 – Lead CCG develops work programme before sign off at SYB ICS Clinical Assurance



Pros	Cons
Option will ensure SYB clinical agreement on recommendations and guidelines	Local clinical speciality ownership may not be guaranteed
Timely final sign and adoption off should be	Delay in ensuring an appropriate SYB clinical

ensured once recommendations have been agreed	forum for guideline ratification

Recommendation and Next Steps

JC CCG Sub Group supported the adapted **Option 1**.

It is recommended now that further discussions be held at HEG. The clinical assurance process would need to be agreed with providers across the ICS, who would be essential to agreement and adoption of recommendations made through the work plan.

Finally whichever option is favoured; a robust agreement timeframe would need to be developed across each work plan to negate delays in the process. It is suggested that the work within Outpatient Follow up redesign be the first test for the agreed process.

NHS
Barnsley
Clinical Commissioning Group

GOVERNING BODY

11 July 2019

Local Maternity Service Update

PART 1A – SUMMARY REPORT

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

	Name	Designation
Executive / Clinical Lead	Lesley Smith	Chief Officer
Author	Patrick Otway	Head of Commissioning (Mental Health, Children's, Maternity and Specialised Commissioning)

3. SUMMARY OF PREVIOUS GOVERNANCE

The matters raised in this paper have been subject to prior consideration in the following forums:

Group / Committee	Date	Outcome
Governing Body	14/06/2018	Noted
Governing Body	10/01/2019	Noted
SY&B ICS Local Maternity Board	7/05/2019	Noted

4. EXECUTIVE SUMMARY

Governing Body have been informed of the progress made within the South Yorkshire and Bassetlaw Integrated Care System Local Maternity System (SYB ICS LMS) in transforming maternity services within the region to deliver the recommendations of 'Better Births – Improving Outcomes of Maternity Services in England – A Five Year Forward View for Maternity Care.'

The updated local plan (Appendix 1) outlines the work being progressed in Barnsley towards delivering our ambitions for improved outcomes in our Maternity services. One of the key challenges highlighted previously was our ability to achieve the March 2019 Continuing of Carer (CoC) target of 20%. Due to some excellent work by the maternity staff Barnsley achieved a March 2019

	CoC target of 32% which also enabled the SY&B ICS LMS as a whole system to achieve the 20% target. The key challenges going forward will be in sustaining and increasing upon this improvement in Continuity of Carer, reducing smoking rates in pregnancy, increasing the breastfeeding rates and developing a midwifery led unit to provide a robust third option for women to choose where they birth.
5.	**THE GOVERNING BODY IS ASKED TO:**
	• Note the contents of this report
6.	**APPENDICES / LINKS TO FURTHER INFORMATION**
	• Appendix 1 – Most recent Barnsley Place Plan for Local Maternity Services

Agenda time allocation for report:	*15 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:	4.1
2.	**Links to CCG's Priority Areas**	**Y/N**
	1 - Urgent & Emergency Care	
	2 - Primary Care	
	3 - Cancer	
	4 - Mental Health	Y
	5 - Integrated Care System (ICS)	
	6 - Efficiency Plan	
	7 - Transforming Care for People with Learning Disabilities and / or Autistic Spectrum Conditions	
	8 - Maternity	Y
	9 - Compliance with Statutory and Regulatory Requirements	
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?	
3.2	**Consultation and Engagement**	
	Has Comms & Engagement Checklist been completed?	*NA*
	Is actual or proposed engagement activity set out in the report?	
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/ BACKGROUND INFORMATION**
	Each 'Place' has been asked by the ICS to develop a local plan highlighting how the Better Births recommendations will be embedded within local practice. The Barnsley local based plan was updated at the end of January 2019 (Appendix1) and highlights the ongoing work that is currently being progressed.
2.	**DISCUSSION/ISSUES**
	The recommendations outlined in Better Births are aimed at transforming maternity services in England and cover the following: • Personalised care • Continuity of carer • Safer care • Better post-natal and perinatal mental health care • Multiprofessional working – breaking down barriers between midwives, obstetricians and other professionals • Working across boundaries to provide and commission maternity services to support personalisation, safety and choice, with access to specialist care whenever needed • A fair payment system How Barnsley is progressing against each of the areas outlined above is covered in detail within the local based plan, which is attached at Appendix 1. There remains however a number of challenges that still need to be overcome if we are to achieve the ambitions of 'Better Births'. Although Barnsley is achieving the national target for reducing still births there is still much to be done. The Saving Babies Lives Care Bundle 2 has now been launched and fully implemented in Barnsley Hospital. Further details of this national programme can be found at https://www.england.nhs.uk/mat-transformation/saving-babies/ A recommendation to help deliver the ambitions of this programme is that each LMS should appoint a Bereavement Midwife. Locally a Bereavement midwife has been recently appointed and the Bereavement midwife has identified that we do not have a good local provision for bereavement support for women who suffer a stillbirth. On-line support is offered by Sands, The Lullaby Trust and Child Bereavement UK but there is no 1:1 counselling currently offered. Both Petals.co.uk and Yorkshire Psychotherapy Ltd do provide a counselling service but at a cost and the Bereavement midwife is currently trying to identify funding sources to enable Barnsley women to access this support. The local aspirations in relation to stillbirth remain as previously reported: • Seven-day service for ANDU • A number of maternity staff to be trained to deliver Level 2 Stop smoking support

- Consultant-led preconception clinic
- Dedicated and sound-proof Bereavement Suite

Further development of the stop smoking support women receive is linked to the Maternity Stop Smoking Service and the New Continuity of Carer model. There is already a substantial action plan being progressed as part of the Maternity Stop Smoking Service.

Key challenges identified:

- Funding – the Maternity Stop Smoking Service is currently funded to October 2019. The Substance Misuse Contract is due to expire on 31 March 2019
- Refurbishment is required
- Lorenzo IT system, data collection and analysis

Barnsley Maternity Unit's continuity of carer initiative is feeding into and complimenting collaborative work with the Local Authority and Neighbourhoods Project within the Wath-upon-Dearne area of Barnsley. The Unit is currently progressing work to develop new and innovative ways of working to deliver continuity of carer to the most disadvantaged women in Barnsley.

Barnsley Maternity Unit has been able to harness quality improvement tools and drivers looking at reducing smoking in pregnancy and align this goal with that of delivering continuity of carer.

Barnsley's maternity services undertook intensive work in the early part of 2019 which resulted in Barnsley achieving a continuity of carer rate of 32%, significantly above the nationally set target of 20% by the end of March 2019. The challenge moving forward is to sustain and then surpass this achievement.

Personalised Care planning is provided by the Wellbeing Team which includes Perinatal Mental Health Midwife, Teenage Pregnancy, Substance Misuse and Bereavement Midwife. Perinatal mental health training delivered within the Yorkshire and Humber region by Tavistock and Portman has been well attended and an animation is now under development for GP's and Primary Care staff.

The target to be achieved in relation to Personalised care plans is 100% by March 2021 and the Barnsley maternity service are improving their service-user engagement and promotion of real-time feedback to inform service transformation.

Barnsley Maternity unit currently offers **two** choices for place of birth i.e. home birth and the Barnsley Birthing Centre (a Consultant-led labour suite) at Barnsley hospital. Barnsley's current rate for home births is less than 1%. However, the local based plan sets out clear aspirations:

- To have a Midwifery-led unit (Barnsley Hospital Alongside Midwifery-Led unit) - develop a Barnsley Alongside Midwifery Unit, with approximately 4 beds,
- Promote home births (where appropriate)
- Mother to Midwife direct maternity referral work-stream

	• Promote midwifery-led care settings for Barnsley women
3.	**IMPLICATIONS**
3.1	**Financial implications** As outlined within the report.
3.2	**Consultation & Engagement** Consultation in relation to the Barnsley Place Plan for Maternity Services has primarily been in conjunction with Maternity Voice Partnership and a number of public events have been held in and around Barnsley.
3.3	**Equality & Diversity** No significant issues identified.
3.4	**Information Governance**. No significant issues identified.
4.	**RISKS TO THE CLINICAL COMMISSIONING GROUP**
	The CCG needs to ensure that the transformation of maternity services in Barnsley are aligned to the recommendations within 'Better Births' and that the aspirations within the local based plan are supported.
5.	**APPENDICES TO THE REPORT**
	Appendix 1 – Updated Barnsley Place Plan for Local Maternity Services
6.	**CONCLUSION**
	Good progress continues to be made in Barnsley Maternity Services towards delivering the recommendations of 'Better Births' building on the good practice that is already embedded within the maternity services. There are a number of challenges identified within this report that we need to work to overcome but the Barnsley Maternity Services are working closely with Barnsley CCG and the SYB ICS LMS to ensure that solutions are safe, effective and of the highest quality possible.

South Yorkshire and Bassetlaw Integrated Care System: Local Maternity System

Template for Place Plans and Transformation Funding 2018-19

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Place Plan Set Up

Place Name	Barnsley	
Place Plan Lead	Laura Rumsey	Head of Midwifery/Associate Director of Nursing
Place Plan Deputy	Sarah Stables	Consultant Midwife/Clinical Lead Inpatient Maternity
Place Plan Version	DRAFT Vs 2	

When completing this template, please refer to the Guidance for Place Plans & Transformation Funding 2018-19 document.

Key Lines of Enquiry

The Place Plan is set out to cover seven agreed trajectories (or Key Lines of Enquiry):

A.1. Stillbirths and neonatal deaths
A.2. Intrapartum brain injuries
D. Number of Personalised Care Plans (PCPs)
E. Number of women able to choose from 3 places of birth
F. Number of women receiving continuity of carer
G. Number of women giving birth in midwifery settings
S. Reduction in smoking in pregnancy (SiP)

Template for Place Plans and Transformation Funding 2018-19

KLOE A.1: *Stillbirths and neonatal deaths*

Stillbirths and neonatal deaths: A 10% reduction in the number of stillbirths and neonatal deaths over the 2015-20 period.

SYB reported a rate of 4.7 stillborn babies per thousand 2013-15. This was the higher combined Stillbirth & Neonatal rate taken from 2013-15 Maternity Health Needs Data pack.

Place Plan for KLOE A.1

An outline of the current position, including previous years' quarterly figures (the annual rate for stillborn babies per 1000 births figure) is shown below for each place including the SYB average.

Year	Quarter	Barnsley	Doncaster & Bassetlaw*	Rotherham	Sheffield	SYB Average	SYB Aspiration
2015/16	Q2	4.00	2.84	3.40	7.18	4.36	-
2015/16	Q3	5.00	3.90	1.90	3.70	3.63	-
2015/16	Q4	2.90	3.10	1.87	0.00	1.97	-
2016/17	Q1	4.00	4.10	2.50	5.60	4.05	-
2016/17	Q2	4.06	4.60	3.95	4.63	4.31	-
2016/17	Q3	2.98	3.53	6.27	5.69	4.62	-
2016/17	Q4	3.60	2.79	5.57	4.96	4.23	-
2017/18	Q1	3.60	2.41	6.56	5.25	4.46	-
2017/18	Q2	3.30	2.67	5.68	5.80	4.36	-
2017/18	Q3	2.98	3.06	2.32	5.02	3.34	-
2017/18	Q4	3.01	3.24	3.86	5.88	3.99	-
2018/19	Q1						-
2018/19	Q2						-
2018/19	Q3						-
2018/19	Q4						3.95
2019/20	Q1						-
2019/20	Q2						-
2019/20	Q3						-
2019/20	Q4						3.76
2020/21	Q1						-
2020/21	Q2						-
2020/21	Q3						-
2020/21	Q4						3.48

* Doncaster and Bassetlaw figures have not yet been split to show individual Place results.

What activities are happening in your area to work towards the reduction in the number of stillbirths and neonatal deaths?

Think about those activities that have been completed, are in progress or anticipated and any additional pilots/initiatives that are being considered. Has anything been ruled out?

Who are involved in these activities? Give examples of nominated leads for the activities, service user or focus groups, clinical teams (this could be at national/regional/LMS or local levels), charities etc.

DRAFT

What timescales are you working to?

How is this linked with other areas at provider or a wider level (e.g. sharing learning/data via the clinical network, coordinated planning/training, mentoring from/to other teams, peer review, submission of abstracts etc)

For example: Have you implemented the Saving Babies Lives Care Bundle?

What are you setting as a local trajectory for this KLOE and how will you measure progress?

How are you involving MVPs and local families?

What about preconceptual care? How is Public Health and/or the Local Authority involved in, or supporting the plan?

Are there any specific Comms messages that are being developed/shared?

Current Position

- Implementation of all 4 elements of Saving Babies Lives Care Bundle
- Barnsley has recently (Nov '19) recruited a Bereavement Midwife post AFC band 7 0.8 WTE
- Collaborative work streams with Midwives and x2 Fetal Medicine Consultants
- Active participation in Saving Babies in North England (SaBiNE) project nominated lead midwife appointed June 2015.
- SaBiNE lead presented Barnsley work at the Kings Fund in November 2015,
- Participation and presentation at SPIRE Study feedback July 2018, to evaluate the Saving Babies Lives Care Bundle.
- Change to Consultant Obstetric clinics to facilitate weekly Consultant input for women having serial growth scans
- Jaxsons Gift Registered Charity contacted to collaborate and engage with Maternity services to highlight reduced fetal movements. Charity wristband "**Don't just natter, movements matter**" provided to all women at the 24 week antenatal appointment and to any women presenting with reduced fetal movements
- 100% compliance with customised growth charts for singleton pregnancies
- Reduced fetal movements patient information leaflet printed on the customised growth chart, which is added to the perinatal notes at booking.
- Updating documentation and record keeping paperwork in ANDU reflecting RCOG guidance to identify women at increased risk of stillbirth who present with reduced fetal movements. Drs review required for all at risk women.
- Extended opening hours for USS and ANDU to accommodate increase demand for growth scans.
- Modernisation and streamlining of training for SFH measurements, growth charts, plotting and referral for all midwives.
- Multidisciplinary quaterly audit meeting of all SGA babies, as a learning opportunity for midwifery, obstetrics and the USS Department.
- Changes in frequency of serial growth scans to 3 weekly from 28 weeks for babies at risk of SGA. 72 hour referral period for growth scan following a fall or static SFH.
- Streamlining admin procedures to allow community midwives quicker access for obtaining growth scans.
- Cross boundary collaboration with Rotherham and Mid Yorkshire to reduce practice variation.
- Sleep Safe Barnsley Babies initiative, initially locally now regional, discussing sleep safe, shaken baby and smoke stop. Funded by South Yorkshire Fire and Rescue targeting over 40,000 families.
- Specialist Healthcare Support Worker (HCA) delivering sleep safe, shaken baby and smoke free environment advice and support with one to one home visits
- Sleep Safe Week Service User Events
- Staff training within the Trust and at Universities (Sheffield and Bradford)
- Foster carer training re: sleep safe, smoke free environments, shaken baby
- Hand Held Maternity Records (Perinatal Institute) updated to document CO level recording at every antenatal examination (every contact matters), key information re: smoking, drug and alcohol use, sleep safe and home safety checks all from suggestions from the wellbeing team and service users.
- Midwife Sonography service for Community Antenatal Day Unit referrals launched 28th January'19
- Excellent progress working in partnership with the now established BMVP

DRAFT

Preconceptual Initiatives

- Perinatal Mental Health service provides pre-conceptual care. Barnsley Maternity Services web page has a section '*Thinking of having a baby in the future'* with a link to advice when thinking of having a baby.
- National No Smoking Day - Safe Sleep demonstration linking to smoking in pregnancy and smoke free homes
- Barnsley Maternity Services Web Page includes links to: Lullaby Trust for safe sleep advice, and links to dietary advice, smoking, weight management, for increased healthy behaviours.
- Maternity Stop Smoking Team commissioned by Barnsley Public Health to support smoking cessation two wte B 5-6 midwives, action plan in progress.
- Public Health Midwife 1.0 wte B7 leads Stop Smoking team.
- Recent audit results (Impact on maternity unit services; smokers v non-smokers) presented by PH Midwife at trust board and within the Barnsley borough at the Tobacco Alliance, Smoking group , funding for larger research project being sought.
- Public Health Midwife chairs a regional Smoking Cessation forum and attends the Yorkshire and Humber Network Smoking in pregnancy meeting.
- PH Midwife provides Smoking in pregnancy training for student midwives at SHU, year 2
- Wellbeing team refers all women (with consent) for free home safety check with South Yorkshire Fire and Rescue.
- Weight management: Women with a raised BMI - referral 'opt out' to Change 4 Life dietetic service.

Research projects undertaken in Barnsley Maternity Services led by Public Health Midwife

1. 2015 An evaluation of the impact of a Weight Management programme for obese pregnant women, delivered in an antenatal healthcare setting. Poster presentation at Brussels

2. 2015 Exploring the experiences of overweight women attempting to follow a healthy lifestyle throughout pregnancy

3. 2016 An evaluation of the impact of a midwife led obesity service on pregnancy outcomes and childhood obesity' (Research in partnership with SHU, Currently being analysed)

4. What would your baby choose? A goal setting, healthy lifestyle leaflet, research project - currently being analysed.

- 'Health Referral' scheme in partnership with Barnsley Premier Leisure offering supported activity in a gym setting for pregnant women and their partners. - Roll out in September, training for BPL staff has taken place in partnership with the obstetric physiotherapist.
- Barnsley Obesity Strategy - PH Midwife leading meeting with Public Health colleagues to discuss current and proposed pathways.

Aspirations

- Seven day service for ANDU
- Uterine Artery Doppler Clinic between 20 – 24 weeks gestation for women at risk of SGA, who do not automatically qualify for serial growth scans.
- **Raised BMI** - Weight management/Healthy Lifestyle clinic. NICE compliance with women with a raised BMI 30-35 accessing shared care now in place.
- **Smoking** - To develop the number of maternity staff trained to deliver level 2 stop smoking support (part of the continuity of care project) Consultant obstetrician lead.
- **Safe Sleep** - To provide the safe sleep resources and seek further funding form South Yorkshire Fire and Rescue when the applications for further funding - September 2018
- **Preconception** - Consultant led preconception clinic
- **Maternity Web page** - To have an interactive and more professional web page
- Dedicated and sound proof **Bereavement Suite** where bereaved women can birth their babies safely with the support of family and remain with their baby on the suite if desired.
- The development of an alongside Midwifery led unit would release space on the Labour Suite for a dedicated Bereavement Suite

Funding and resources:

Share your funding details here, linked to the activities above:
30 Apple IPads = £14,820 Public Engagement Event and Infomercial x2 60 sec £6000 15 Laptops £12,600 X3 TV's with Rasberry Pi's for ANC/ANDU/Reception to play Public Health information (including Infomercials) £3000

KLOE A.2: *Intrapartum brain injuries*

A reduction in Intrapartum brain injuries is expected as part of the outcomes for Better Births.

This measure is to be reported by all NHS neonatal units in SYB and includes all infants admitted for neonatal care (whether their home is in the same Place or not).

Place Plan for KLOE A.2
An outline of the current position should be shown below. Metrics for this are already captured through data e.g. Saving Babies Lives, MMBRACE, Each Baby Counts, NHS Resolution (HIE), Perinatal Mortality Review tool.
What are you setting as a local trajectory for this KLOE and how will you measure progress? *What is our current position? How can we measure this easily?* *How does this relate to Each Baby Counts, NHS Resolution (HIE) and the Perinatal Mortality Review tool?* *How can we involve women and families in this work?*
Current work/analyses includes review of all cases where unexpected admissions to SCBU - poster at BMFMS, also all cases where cord gases < 7.03 reviewed and any learning disseminated to all via meetings/newsletters/memos/at skills and drills. Dr Fawzy, Obstetric Consultant is the Clinical lead reporter to "Each Baby Counts" – all cases subjected to external peer review. Include our Gap analysis from NHS resolution cerebral palsy 5 years report. PMRT- Use of the national tool commenced in March 2018 for all perinatal deaths The target used in Barnsley is less than 7.0. From Jan 2017 to date (Aug 2018) Barnsley maternity services only had 2 investigations where HIE was diagnosed - one was a preterm baby with grade 2 and one was 39+4 weeks with grade 1. We have had one investigation where the baby sustained a fractured skull and brain haemorrhage following 2nd stage LSCS

How will our Place Plan contribute to a reduction in Intrapartum brain injuries?
Think about: *How local activities contribute to this aspiration.* *Which other Neonatal units will also be affected by your activities? Who is your lead on this? Have you a champion or clinician with a specialist interest in this?* *Have any specific pathways/incentives been identified or commissioned that relate to this?* *What additional resource do you need? For example data analysis, clinical input, engagement/communication specialists, marketing/infographics etc.*

DRAFT

- Maternity Safety Fund finance utilised on CTG Masterclass, and Human Factors training for Labour Suite Coordinators and Core labour suite Midwives and Consultant Obstetricians.
- Multidisciplinary annual CTG training via K2 package
- Birthrate Plus Maternity workforce review undertaken November 2018
- Maternity Services Fresh Eyes Policy, minimum 2 hourly
- Environment – relocation and modernisation of NNU now co-located closer to Labour Suite and Obstetric Theatre.
- NHSR CNST Incentive Scheme Barnsley Maternity achieved all 10 standards 2018
- Purchase of Birthrate Plus Acuity tool for Labour suite/Antenatal/Postnatal Ward to ensure consistently safe staffing and Red Flag monitoring

Aspirations :-

- Further multidisciplinary collaboration and training to share learning from incidents
- Use of Ipads to undertake staff training and education e.g. Human Factors & Situational Awareness Training, K2
- Increased use of technology and data to support transformation and real time feedback from service users

Challenges:

- IT connectivity, electronic working including remote working for Community Midwives.
- Age and quality of IT hardware
- Significant problems with data extraction including consistency of information
- Data obtained from IT Lorenzo system requires manual validation and cross referencing generating additional time and recourses
- Absence of an electronic maternity record requiring secondary data input for all maternity booking information.

Funding and resources:
Share your funding details here, linked to the activities above:

- IT hardware to improve collection and analysis of data and feedback from service users
- Improved data analytics and information collection to inform service improvement.
- Birthrate Plus Acuity tool £9000

KLOE D: *Personalised Care Plans*

All women should have Personalised Care Plans (PCPs) therefore the aspiration is 100% by March 2021. This should be supported by 'clear and credible plans to roll out personalised care planning'. PCPs should be developed based on the Better Births guidance with extensive MVP involvement throughout.

Place Plan for KLOE D
An outline of the current position should be shown below along with a trajectory that meets the aspiration: 40% of women having PCPs by March 2019 and 100% by March 2021.

Place	Baseline	March 2019	March 2020	March 2021

Barnsley		40%		100%
Doncaster		40%		100%
Bassetlaw		40%		100%
Rotherham		40%		100%
Sheffield		40%		100%

Work should be done to understand the current baseline position in each Place.

What activities are happening in your area to work towards delivering PCPs for all women?

Ask "Do we provide the type of personalised care planning envisaged in Better Births?", rather than "Do we offer personalised care plans?

How do we help women access the support available to make informed choices and develop their personalised maternity care plan? How do we help them access an NHS Personal Maternity Care Budget (where available), advocacy and interpreting?

Do our plans cover development of the PCPs with MVP involvement? What does this look like?

What about Perinatal Mental Health pathways, how are we incorporating these?

Nationally there are some areas already reporting 50% compliance with this metric – what are they doing well? Can we learn from them?

- The Barnsley Choices leaflet is available on the Maternity web page and sent to women as a link prior to the booking appointment. This action was requested by service users participating in focus groups lead by PH Midwife and her team.
- Barnsley Maternity has an integrated Maternal Mental Health Pathway in collaboration with local Mental Health services Perinatal Mental Health services and the Health Visiting service which is embedded into practice.
- Barnsley Maternity services have a whole time equivalent Perinatal Mental Health Midwife funded by the CCG. The post holder is
- Personalised care planning is provided by the Wellbeing Team which includes Perinatal Mental Health Midwife, Teenage Pregnancy, Substance Misuse and Bereavement Midwife. This plan of care is individualised and bespoke and discussed in partnership with the woman and agencies supporting
- Barnsley Maternity Services collaboration with Barnsley Maternity Voice Partnership (BMVP) is in the early stages of developing Personalised Care Plans which include modernisation of documentation and paperwork.
- Birth Thoughts Clinics facilitates Personalised Care Plans to women who feel that the usual care pathway is not fit for their current pregnancy needs or wishes. This is then documented within the woman's hospital notes to be viewed on admission to hospital. Examples of cases seen in Birth Thoughts include choosing VBAC or ECS, monitoring in labour, continuous V's intermittent or no fetal monitoring in labour, timing of IOL delayed or early. Gentle LSCS and the development of a gentle LSCS documentation. (long running audit of this clinic is in place and what it offers, could include numbers).
- Active birth sessions offer information of choices available to women and families.
- Barnsley Maternity Service's 360 Degree Virtual Tour, available from the Maternity Web page has recently been updated this was informed by feedback from BMVP.
- Patient information leaflets in various languages on web page

Aspirations:

- Improvements in service user engagement and promotion of realtime feedback to inform service transformation.
- Barnsley Maternity Services Personialied Care Plan written in partnership with BMVP now in draft.

Funding and resources:

Share your funding details here, linked to the activities above:
Funding for hardware to facilitate : 1. Collection of meaningful feedback from women and families 2. Demonstrate and share information with women and families in hospital and in community settings; Back to Sleep, safe discharge information, infant feeding fixing and positioning, well/unwell baby, administration of prophylactic VTE 3. Task and Finish Group implemented to identify,standardise information to share with women and families using electronic solutions (IT tablets).

KLOE E: *Choice*

An increase in the number of women able to choose from at least 3 places of birth.

Place Plan for KLOE E

An outline of the current position should be shown below along with the trajectory that meets the aspiration: 25% of women able to choose from 3 places of birth by March 2019 and 75%* by March 2021.

* 75% has been submitted as the SYB aspiration. This will be influenced by the Place Plans and clarity around how this is to be counted Nationally.

Place	Baseline	March 2019	March 2020	March 2021
Barnsley		25%		75%
Doncaster		25%		75%
Bassetlaw		25%		75%
Rotherham		25%		75%
Sheffield		25%		75%

Work should be done to understand the current baseline position in each Place, and how this will be evidenced or counted in the future.

How will our Place Plan contribute to an increase in the choices made available to women?

Who is your lead on this? Have you a champion or clinician with a specialist interest in this?

How will this be shown to be offered? How will it be measured and how can we evidence the current level of choice being offered? What are the plans to increase this?

Have any specific pathways/incentives been identified or commissioned that relate to this?

What additional resource do you need? For example data analysis, clinical input, engagement/communication specialists, marketing/infographics etc.

Could rates for the number of women able to choose from 3 places of birth be evaluated by mums?

Current Position

Barnsley Maternity Unit offers two choices for place of birth: home birth and the Barnsley Birthing Center(Consultant Led Labour Suite) at Barnsley Hospital. The homebirth rate is currently at or below 1%.

Women have the choice of three birthing suites with pools.

Who's Shoes Event July 2018 and subsequent action plan are now complete following partnership work with BMVP.

Short and Medium Term Aspirations

Our short term ambition(within 6-12 months) is to have one bespoke room streamlined for Midwifery Led Care, no bed, birthing cube, awaiting decor to be changed with further birthing apparatus available for women to birth in a low tech midwife led setting.

4 consultant/ shared care birthing suites (awaiting named door plates).

360 degree virtual tour of the maternity unit (on the web page) includes birthing center is in place.

Maternity choices leaflet on the maternity web page.

Maternity antenatal classes and birth drop in sessions run by midwives that include choice of place of birth.

As a service all staff promote and support home birth with home birth drop in sessions, we have identified further targeted promotion including infographics and community engagement events that would further promote the homebirth service as a choice of place of birth.

Mother to Midwife direct maternity referral work stream- implementation planned for 2019.

Webpage - Choices leaflet and 'Your Birth' section has info on options for home birth

Infographics

New maternity choices leaflet and link on webpage

Medium term Aspiration (12-24 months)

- Barnsley Hospital alongside Midwifery Led Unit to provide 3 choices of place of birth.
- Further engagement events with service users concerning choice and offers
- Engagement with all staff groups from the multidisciplinary teams and stakeholders to promote midwifery led care settings for Barnsley women

Funding and resources:
Share your funding details here, linked to the activities above:
Use of technology to engage further with service users and staff. Further development and collaboration with BMVP in the delivery of maternity transformation. Mobile telemetry for ML room £17,100 MLU room equiptment £11,000

KLOE F: *Continuity of carer*

An increase in the number of women receiving continuity of carer, measured through the whole pathway including pregnancy, birth and postnatal care. The SYB aspiration submitted as part of the local trajectory states 100% of women with continuity of carer by March 2021.

We also want to evidence where elements of parts of the pathway offer continuity (e.g. ante and postnatal). This will help us to evaluate the impact of any changes to the models of care, and evidence where good practice and continuity already exists.

Place Plan for KLOE F

An outline of the current position should be shown below.

Place	Baseline	Aspiration March 2019	Aspiration March 2020	Aspiration March 2021
Barnsley		*20%*	*50%*	100%
Doncaster		*20%*	*50%*	100%
Bassetlaw		*20%*	*50%*	100%

Rotherham		*20%*	*50%*	100%
Sheffield		*20%*	*50%*	100%
SYB	-*	20%	50%	100%

*The baseline for SYB will be calculated from Place Plan information.

Percentages in italics may be adapted, based on baseline evidence and individual Place aspirations.

How will our Place Plan contribute to an increase in the number of women receiving continuity of carer?

What is our current position? How can we measure this easily?

Do we have some continuity of carer already? What exists for pregnancy and postnatal care elements of the pathway?

What would need to be in place to change the system to deliver end to end care continuously?

How can local activities contribute to this aspiration? Who is your lead on this? Have you a champion or clinician with a specialist interest in this?

Have any specific pathways/incentives been identified or commissioned that relate to this? What plans have you in place for working with vulnerable women or young mums?

How will you avoid safety concerns? How will this look different for different cohorts of women e.g. those with previous mental health issues?

What will you do to streamline the service so women who transfer their care do not miss out?

Are there already areas of good practice?

What additional resource do you need? For example data analysis, clinical input, engagement/communication specialists, marketing/infographics etc.

Current Position

Teenage Pregnancy Midwife delivers high levels continuity throughout the antenatal and postnatal period but not in the intrapartum period.

Substance Misuse Midwives (x2) have high levels of antenatal and postnatal continuity with women on their caseloads not including intrapartum care. Care is bespoke to vulnerable women, and streamlined following discharge if in drug treatment services (commissioned by Humankind)

Pregnancy liaison service where the most vulnerable and those raising concerns to the midwife can be discussed rather than following the social care pathway for pregnancy.

Care streamlined when in HMP Newhall Women's Prison by the Substance Misuse Midwives.

Strong links with Vulnerabilities teams within the locality and Nationally for those women transferring care or may be seen as at risk of moving away from the area.

Community Midwifery teams currently facilitate good levels of antenatal and postnatal continuity of carer which in general does not include intrapartum care.

Aspirations, Direction of Travel

Women who have a planned CS (Barnsley 9% of births) could have their named Community Midwife as the attending midwife when having their CS increasing the continuity of carer,experience and outcomes for this cohort of women. Work to support this change in practice will require women identified as having a high chance of an ELCS being highlighted following Consultant antenatal clinics.

Work is currently progressing to develop new and innovative ways of working to deliver continuity of carer to the most disadvantaged women of Barnsley who declare themselves to be smokers at the initial booking appointment or earlier. Participation in the Maternal Neonatal Safety Collaborative Wave 2 initiative, Barnsley Maternity Unit has been able to harness quality improvement tools and drivers looking at *reducing smoking in pregnancy* and align this goal with that of delivering continuity of carer.

Our vision is to dramatically reduce our current high levels of smoking in pregnancy by delivering continuity of carer.

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Barnsley Maternity Units continuity of carer intiative will feed in and compliment collaborative work with the Local Authority, Neighborhoods Project focused in the Wath-Upon-Derne area of Barnsley. This is a new model of working between community health, social care, the voluntary and community sector, primary care and the Acute Trust. The primary purpose of this is to design an approach which delivers a comprehensive community service focussed on the health and care needs of individuals, families and communities, unconstrained by current barriers such as different employing organisations, systems and labels.

The current pathway to support women to quit smoking has been demonstrated to reduce the percentage of smokers at birth, particularly when investment has been made in the service offered, however progress is slow. Our rates of smoking at birth, whilst reducing over recent years, continues to be one of the highest rates nationally. From a recent review of Barnsley Maternity unit acuity our unit was found to have a particularly high levels of complex women. It could reasonably be argued that this, in some part, is derived from the high levels of smoking in pregnancy and postnatally. Reduction in the levels of smoking in pregnancy would lead to a reduction in poor outcomes for mothers and babies and which may also reduce current demands on the service. Improvements would be measurable over an 18 month period.

Measurables: IOL rates, USS demand, antenatal admissions , emergency CS rates, neonatal admission rates

Support from the Stop Smoking midwives presently in post offer support to women alongside that of the community midwife. Whilst this support is valuable, evidence suggests that if the same midwife not only delivers all routine care but also that of stop smoking support, smoking cessation rates are significantly improved.

Women participating in the CoC pilot will be from a disadvantaged area of Barnsley,from 3 identified GP practices. Six WTE midwives will work as a small team in this area and carry caseloads of up to 35 women. To work within the proposed envelope of the pilot project, Work within the current continuity of carer task and finish group work includes:

- Development of a clear pathway which will encompass the booking appointment all through to discharge within the postnatal period. Stop smoke support will be woven into this pathway to deliver the optimal impact.
- Co-production of the pathway will be enable by working closely with the MVP and other focus groups of women who currently smoke in pregnancy.
- Development of an on call service from this small team that will not lead to Midwife burn out or impact negatively on the modern midwives work life balance.

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Challenges in achieving 20% CoC by March 2019

Currently challenges to the midwifery workforce resource may not be able to deliver the entire ambition of 20% . Initiatives to pilot CoC are in progress as described above, the appetite for change and CoC in the unit is positive. The initiatives in progress balance the need to deliver safe high quality maternity care to the remaining women choosing to birth their babies in Barnsley.

Funding and resources:
Share your funding details here, linked to the activities above:
Support required for this pilot will include data collection and analytics, e-rostering changes to reflect a new patterns of working. IT hardware as discussed earlier in Plan. Backfill 0.4 wte Band 5 for 4 months – approx £8000 Drager bilirubinometer £5000

KLOE G: *Midwifery settings*

An increase in the number of women in midwifery-led settings: homebirth (planned), Standalone Midwifery Led Units (SMLUs), Alongside Midwifery Led Units (AMLUs).

Place Plan for KLOE G

Template for Place Plans and Transformation Funding 2018-19

An outline of the current position should be given below. This needs to show a planned overall increase in the numbers of women giving birth in midwifery settings.

Year	Barnsley	Doncaster & Bassetlaw		Rotherham	Sheffield		SYB Total	SYB Aspiration
		Doncaster	Bassetlaw		Homebirth	AMLU		
2016/17	207 (2015/16 data)					1257	1470*	-
2017/18							-	
2018/19							-	1500
2019/20							-	2100
2020/21							-	2500

* For 2016/17 the estimated total women giving birth in midwifery-led settings across the SYB footprint was approx. 1470.

Actual figures need to be established to project appropriate increases in midwifery-led settings.

How will our Place Plan contribute to an increase in the number of women giving birth in midwifery-led settings?

How can local activities contribute to an increase in the number of women choosing to have homebirths or using a local MLU?

How is the midwifery to birth ratio being improved to support this? What impact is expected? How does this fit with other plans? (E.g. staff turnover/succession or CIP.)

Who is your lead on this? Have you a champion or clinician with a specialist interest in this?

Have any specific pathways/incentives been identified or commissioned that relate to this?

What additional resource do you need? For example data analysis, clinical input, engagement/communication specialists, marketing/infographics etc.

Current Position:

Barnsley Maternity Unit offers homebirth as the primary place of birth in midwifery settings. A newly refurbished and modern Labour Suite with 3 birthing pools is the primary place of birth for women in Barnsley. Whist women experience low risk midwifery led care on the unit there is not a separate midwifery led unit.

Future ambitions

Short Term (6-12 months: a birthing room with pool on the Labour Suite which is named following partnership working with BMVP and refurbished to reflect a home from home environment. Women will be offered the choice of this additional environment as a place of birth antenatally.

Longer Term (12-24 months):

A Barnsley alongside Midwifery Led Unit approximately 4 beds offering a third choice for place of birth. Early discussions have been undertaken with the Trust Executive team to model this ambition taking into account recommendations from the recent Hospital Services Review.

Funding and resources:

Share your funding details here, linked to the activities above:

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Infographics/public engagement forums and further engagement/collaboration with BMVP to elicit the views and feedback from women and families.

Decoration and refurbishment of new MLC room

KLOE S: *Smoking in pregnancy*

A reduction in the number of women smoking in pregnancy measured at booking and at birth as a percentage of the total number of women.

Nationally the aim, by end of 2022, is to reduce the prevalence of smoking in pregnancy from 10.7% to 6% or less. Our suggested aspiration would be to reduce SYB by a similar 5% margin, or better.

Place Plan for KLOE S

An outline of the current position should be added below.

The initial data below shows the number of women smoking at booking and is taken from HES/MSDS data.

Some data is not complete and is shown as 'missing data' on the HES report.

Rotherham did not submit any figures, therefore it is blank.

Year	Barnsley		Doncaster & Bassetlaw		Rotherham		Sheffield	
	Number	%	Number	%	Number	%	Number	%
2016/17	605	21	450	23	-	-	55	1
(missing data)	(165)	(6)	(40)	(2)	-	-	(2035)	(30)

Rates for smoking can be taken from existing data as shown for Q4 below.

Date	Measure	Barnsley	Doncaster & Bassetlaw	Rotherham	Sheffield	SYB Ave	Y&H Ave
Q4 2017/18	% of women smoking at booking	15.7%	23.3%	19.7%	12.4%	17.5%	17.0%
Q4 2017/18	% of women smoking at time of delivery	17.7%	16.2%	17.2%	13.6%	15.6%	14.7%

How will our Place Plan contribute to a reduction in smoking in pregnancy?

What is our current position compared with other areas? Do we have 'pockets' of challenge? How can we measure this easily at a local level?

Smoking at time of delivery current position 2017-18: Barnsley 16.8% Yorkshire and Humber 14.2% England 10.8% National ambition 6% or less by 2022

In the North of England commissioning region, only 1 out of 64 CCGs achieved the national ambition.

Pockets of challenge: Areas of deprivation across Barnsley. We can measure this via the number of women smoking at booking, number smoking at time of delivery, number of referrals into the Maternity Stop Smoking Service, number of women lost to follow up, number of women who quit, and number of women CO validated.

How can local activities contribute to this aspiration? Who is your lead on this? Have you a champion or clinician with a specialist interest in this?

The further development of the stop smoking support women receive linked to the Maternity Stop Smoking Service and the NEW Continuity Carer model. We already have a substantial action plan as part of the Maternity Stop Smoking Service and to further compliment this yearly mandatory training would be optimal for all staff including Medical and USS staff. The clinical lead and champion is the Public Health Midwife. A lead consultant would be ideal; we have a champion in ANC/ANDU and the ANPN Ward.

Have any specific pathways/incentives been identified or commissioned that relate to this? Are there other initiatives in place working with the key cohorts or women? This might be work with vulnerable groups or local areas/community hubs.

The Maternity Stop Smoking Service has been commissioned for 1 whole time equivalent (WTE) B6 Midwife and 1(WTE) HCSW with an SLA and a pathway which is currently under review. The Maternity Stop Smoking Team has direct links to all maternity clinical areas. One of the team (HCA) works with the Teenage Pregnancy Midwife and also supports teenagers to stop smoking on the Stop Smoking Programme. Both of the stop smoking midwives (job share posts) also undertake booking clinics as part of their community role and will support and refer any of the women they see at the appointments on the Stop Smoking Programme.

All women are CO tested at every antenatal appointment and the midwives are trained in very brief advice.

What additional resource do you need? For example data analysis, clinical input, engagement/communication specialists, marketing/infographics etc.

Barnsley Maternity Services continuously supports all staff to receive good quality, regular (yearly) training and updates to deliver consistent messages to women and families and to undertake VBA (very brief advice). This needs to include medical and support staff. Motivational interviewing techniques are a valuable tool to use for all staff.

Further training on how to talk to women would be very beneficial and essential to reduce smoking rates in Barnsley

Data analysis:

Accurate data input into the Lorenzo IT system and accurate reports in a timely manner as these are crucial. Smoking at time of delivery (SATOD) data is consistently missing and /or inaccurate.

Early referral is needed into the Maternity Stop Smoking Service via the GP receptionists

Info graphics and access to I Pad's as a resource for staff and women

Support for the action plan already in place for the maternity stop smoking team.

Public Health via Barnsley Council are the commissioners for the Maternity Stop Smoking Service there is an additional subcontract via SWYPT. The Public Health Midwife attends the Tobacco Alliance and Barnsley Smoking Group where Public Health is involved.

Regionally we are represented at the Smoking in Pregnancy Clinical Network and the Public Health Midwife chairs the operational regional stop smoking meeting.

BMVP and other service users are consulted on use of new resources/leaflets/logos.

Funding and resources:

Share your funding details here, linked to the activities above:

None required as Barnsley Maternity Stop Smoking service received additional end of year funding.

Supporting Elements of the Place Plan

Risks & Issues

What are the key risks and issues that relate to this and how are you managing them?
This might be availability or management of time/resources, communication gaps, workforce maturity or instability, local health and welfare issues, staff engagement and ownership, political sensitivities, data collection and quality challenges, conflicting priorities, insufficient senior leadership engagement/interest, expected impact from HSR etc. *Do you have a risk register specifically related to the Better Births activities?* *What processes do you have in place for escalating or sharing visibility of risks?* *What risks or issues are likely to impact the SYB plans? Or those of neighbouring Places?*
Maternity Stop Smoking Service is funded until October 2019 Lorenzo IT system, data collection and analysis O block(Maternity, Gynecology, Paediatric services) schedule of refurbishment Hospital Services Review recommendations and subsequent regional initiatives. Human Kind Service SLA in place until 2019

Interdependencies

What are the key interdependencies?
What are you dependent on? Is anything reliant on your achievement of the plans? Who else has a vested interest in your success? *Think about Perinatal Health (Wave 1 & 2), preconceptual care, children's services and also workforce demands, succession planning and local changes to training and qualification programmes.* *What about the local area? Is there re-generation in the local housing market? Have you an increasing number of families or growing younger population?* *What about immigration or job creation locally? Will this impact your workforce or local socioeconomic dynamics?*
Human Kind currently commissioned to provide Substance Misuse Services in Barnsley Barnsley Clinical Commissioning Group Neonatal Unit opening of new unit October 2018 Paediatric services Public Health Services Local Authority Services: Neighborhoods

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Template for Place Plans and Transformation Funding 2018-19

Stakeholders

Who are your key stakeholders?
Think about staff members (clinical or not and in frontline or parallel/peripheral services), mums and wider family members, neonatal and children's wards, transport services, mental health services etc. *How have you identified their interests and involvement? How are you managing communication and engagement?* *Who else has a vested interest in your success?* *Have you got a communication plan? Or support for updating social media messages/trust website information?*
BMVP *Human Kind* currently commissioned to provide Substance Misuse Services in Barnsley Barnsley Clinical Commissioning Group Neonatal Unit opening of new unit October 2018 Paediatric services Public Health Services Local Authority Services: Neighborhoods

Place-based MVPs

How is the local MVP being supported?
MVPs are vital stakeholders. How are they being supported and engaged throughout these Place Plans? *How is this being developed? How are they being funded?* *What activities are they involved in and how are these being commissioned? How are they being (or going to be) involved in development of the plans?* *What help do you need to develop your local MVP?* *What help do they want or need?*
Engagement and collaboration from Midwifery services; teams, leadership, specialist services, Comms, Patient partnership services. Regular meetings with BMVP and CCG BMVP engagement and feedback essential component of Barnsley Place Plan Support from maternity services in recruitment and signposting to BMVP Support for resources to enable functionality of BMVP Feedback from BMVP is awaited for the Place Plan

Funding and resources:
Share your funding details for stakeholders and MVPs here:

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Funding from Transformation monies £5000 this money will be held back by Barnsley CCG and provided to BMVP.

Anything else?

Other things you might think about:
Have you developed any local resources you could share? Templates, training packages, links to 3rd sector organisations, academic institutions etc. *Are there local champions, either in the NHS, community or charity settings that are active in supporting/leading your aspirations?* *Have any specific pathways/incentives been identified or commissioned that relate to this?* *What additional resource do you need access to? For example data analysis, clinical input, engagement/communication specialists, marketing/infographics etc.* *Is there anything you'd like to investigate/explore? For example: visiting a Maternity Unit with a similar demographic or set up or developing leaflets to support staff awareness or families.* *The local community (often through the MVP) has links to advocates and charities in our SYB footprint e.g. 4Louis and Healthwatch. How are we engaging with these charities to work toward a shared interest?*

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NHS
Barnsley
Clinical Commissioning Group

Governing Body Meeting
11 July 2019

Diabetes Transformation Funding Evaluation

PART 1A – SUMMARY REPORT

1.	**THIS PAPER IS FOR**

Decision		*Approval*		*Assurance*	x	*Information*	

2.	**REPORT OF**

	Name	Designation
Clinical Lead	Dr Krishnasamy	Associate Medical Director
Senior Responsible Officer	Jeremy Budd	Director of Commissioning
Author	Siobhan Lendzionowski	Lead Commissioning and Transformation Manager

3.	**SUMMARY OF PREVIOUS GOVERNANCE**

The matters raised in this paper have been subject to prior consideration in the following forums:

Group / Committee	Date	Outcome
CCG Diabetes Transformation Steering Group	December 2018/February 2019	Agreed process for evaluation and indicators
Clinical Forum	4th May 2019	Provided view on evaluation outcomes and future priorities
Management Team	26 June 2019	Approved the report's recommendations and content; to add that post mobilisation gaps in provision to be addressed prior to transfer of ongoing governance and management to the

			CCG contracting department

4.	**EXECUTIVE SUMMARY**
	The purpose of this paper is to provide the Governing body with a summary of the evaluation undertaken, to ascertain if the Diabetes Transformation Funding objectives and deliverables have been met and to identify the future priorities for the diabetes programme. The evaluation findings are that: • Improving waiting times; access and the locations of services remains a priority for patients • The majority of patients were aware of the services available and valued them • The provision of structured education groups and ensuring patients are able to self-manage their care had made a difference to patients • Ensuring there is a seamless service and continuity of patient care across the services is a priority for both clinicians and patients • Diabetes care and treatment has improved but needs to be maintained and variation in care reduced • GP Practices value having specialist support available and training to improve their skills and knowledge • A patients and clinicians experience of how easy it was to access and the availability of the service impacted on their view of the effectiveness of the transformation funding. For the full report refer to appendix1. In summary the evaluation demonstrated that the CCG has successfully delivered the transformation funding objectives via the commissioning of a diabetes integrated service and by working with GP Practices, Barnsley Healthcare Federation and SWYPFT. The CCG will continue to embed the deliverables and objectives during 2019-20 via its ongoing work with providers and in partnership with patients and carers.
5.	**GOVERNING BODY IS ASKED TO:**
	Governing body are asked to: 1. To take note of the evaluation report recommendations. 2. To note that post mobilisation gaps in provision by the Diabetes Integrated Service will be addressed, prior to the transfer of ongoing governance and management to the CCG contracting department.

6.	**APPENDICES / LINKS TO FURTHER INFORMATION**
	Appendix 1: Evaluation Report Diabetes Transformation Fundir

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:	
2.	**Links to CCG's Priority Areas**	**Y/N**
	1 – Urgent & Emergency Care	N
	2 – Primary Care	Y
	3 – Cancer	N
	4 – Mental Health	N
	5 – Integrated Care System (ICS)	N
	6 – Efficiency Plan	N
	7 – Transforming Care for People with Learning Disabilities and / or Autistic Spectrum Conditions	N
	8 – Maternity	N
	9 – Compliance with Statutory and Regulatory Requirements	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?	N
3.2	**Consultation and Engagement**	
	Has Comms & Engagement Checklist been completed?	*N*
	Is actual or proposed engagement activity set out in the report?	*Y*
3.3	**Equality and Diversity**	
	Has an Equality Impact Assessment been completed and appended to this report?	*N*
3.4	**Information Governance**	
	Have potential IG issues been identified in discussion with the IG Lead and included in the report?	*N*
	Has a Privacy Impact Assessment been completed where appropriate (see IG Lead for details)	*N*
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/ BACKGROUND INFORMATION

Barnsley currently has 16,166 people who are either Type one or Type 2 diabetics. This equates to 7.4% of people in Barnsley who are diabetic with the highest number of diabetics being people who are Type two, which can be prevented or complications reduced by self-management and education.

To address this challenge and ensure people who were diabetic were given the care and treatment needed the CCG applied and was awarded Diabetes Transformation funding from NHS England. This was for the period November 2017- April 2019.

Patients views were collected before the bid was submitted and their feedback was that:

They had poor understanding of their condition, despite in many cases having had the condition for many years

The need for structured patient education was clearly identified as a priority and praised by those who had received it

Patients and carers also reflected on the differences in the quality of care that they received and the importance of high quality primary care

An evaluation has been undertaken to assess if the transformation funding objectives have been met and to identify future priorities or the programme and commissioning intentions for the CCG.

The evaluation has comprised of three parts:

- Identification of data to demonstrate quantitative measures have been met
- Evaluation survey distributed to services and clinicians to gain evaluation from their perspective and experience and future priorities
- Evaluation survey distributed to patients/carers to gain evaluation from their perspective and experience and future priorities

Please refer to appendix 1 for the full evaluation report.

The evaluation indicates that the CCG has made great progress over the funding period to deliver the transformation objectives.

This has been achieved in a number of ways:

- By the CCG commissioning from April 2018 a Diabetes Integrated service that is led by BHNFT but works across secondary care, SWYFT and primary care GP Practices. This service ensures that patients receive a seamless service across all services; provides diabetes care closer to home via 6 integrated hub clinics; and works jointly with GP's and Practices to improve patient's treatment targets via joint clinics and via case based discussions with the Diabetic specialist Nurse and/or Consultant
- The CCG has worked with GP practices to ensure 100% of practices are

now participating in the National Diabetes Audit (it was 83.3% in 2016)

- The CCG via the GP practice development agreement has worked with practices to ensure that 41.3% of diabetic patients are meeting their three NICE treatment targets. 29 practices are now achieving the target of 41.3% or are above it. During 2019 via the local contract GP practice agreement the CCG will continue to ensure people with Type 2 diabetes are invited annual review to complete 3 treatment targets.
- Barnsley Health Care Federation has employed a Primary Care Diabetes Improvement Nurse to work more intensively with 10 practices which has reduced the variation of treatment targets in these practices. This work will continue in 2019-20 and extend to further practices.
- Improved the Diabetes management skills and abilities of GP's and Practice Nurses by delivering the Warwick Diabetes course to date to 30 staff. A further course will be take place in September 2019 and at least 8 staff will take part.
- Met the target to be accurately recording of attendance and coding on Primary Care Systems

This has been delivered as Practices are :

- Using the four recommended READ codes to code attendance and outcomes on the Providers systems
- Included recording of these codes on GP clinical systems in primary care incentive schemes and local clinical system template
- by reducing the number of admissions and OPD appointments that people attend at the hospital via commissioning a Diabetes Integrated Service, which has measures in place to reduce admission and OPD appointments. Further monitoring over the next year will identify further efficiencies.
- Improved Specialist diabetic Multi-disciplinary team working - This is being delivered by the commissioning of a Diabetes Integrated Service
- There has been increase in referrals from health care professionals (primary care and others) of patients with diabetes to the structured patient education programme. This is being delivered by the CCG commissioned Diabetes Integrated Service and SWYPFT.

In March 2018-19 524 patients have been offered a course place compared to 200 in 2015-16. During 2018-19 28 EXPERT courses were run for T2 diabetes people and 6 DAFNE courses for T1 diabetics. In 2016 only 30% of patients referred attended the course compared to 66% attendance at the end of 2018. Feedback from people who have attended the courses has been positive. Refer to the evaluation report for further details.

- by implementing a pilot digital structured Diabetes education programme - During 2019-20 the CCG will continue to pilot a digital structured Diabetes education programme, to ascertain if this option would be an effective alternative choice for people who are T2 diabetes, but are unable to attend a group session.
- The CCG has been working with SWYPFT to increase the uptake of structured education and treatment target for people who have a Learning

	Disability, by testing a SE offer with 10 people who have a Learning Disability. It will continue this programme during 2019/20. • Reduced Cost and Improved Efficiencies- This has being delivered by the commissioning of a Diabetes Integrated Service, which has measures in place to reduce admission and OPD appointments. Further monitoring over the next year will identify further efficiencies
2.	**SUMMARY OF EVALUATION**
	In summary the evaluation has demonstrated the CCG has successfully delivered the transformation funding objectives via the commissioning of a diabetes integrated service and by working with GP Practices, BHF and SWYPFT. It will continue to embed the deliverables and objectives during 2019-20 via its integrated partnership and commissioning intentions and responsibilities The evaluation highlighted a number of points as future priorities and improvement actions. These were: • Improving access points and the locations for care and treatment is a priority for both clinicians and patients • It is a concern for both clinicians and patients about the waiting times to access care and services • Structured education and ensuring patients are able to self-manage their care remains a priority for both clinicians and patients. People reported that this provision had made a difference to patients ability to self- manage their diabetes and treatment outcomes • Ensuring there is a seamless and continuity of patient care across the services involved in diabetes care is a priority for both clinicians and patients. This work has begun but needs to continue to be viewed as attained by all • Improving the care and treatment outcomes for people who have diabetes has improved but needs to maintained and variation reduced • GP Practices value having specialist support available and training to improve their skills and knowledge • Ensuring patients experience of the care and service receives remains a priority for both services and people who are diabetic or a carer • There was a difference of opinion and perception about the effectiveness of the transformation funding impact given via clinicians and patient's feedback. This appear to be depended on the person experience of how easy to was to access and availability of care or services • The majority of patients were aware of the services available and valued them.
3.	**RECOMMENDATIONS**
	It is recommended that the:

	1. The CCG continue to embed the deliverables and objectives during 2019-20 and via its ongoing work with providers and patients/carers. **2.** Services working to improve diabetes care in Barnsley incorporate the priorities highlighted in this report into their improvement plans as appropriate.
4.	**CONCLUSION**
	In conclusion: • Governing body is asked to approve this evaluation and recommendations outlined in this assurance report.

NHS
Barnsley
Clinical Commissioning Group

Diabetes Transformation Funding Evaluation

Louise Exley

Contract and Commissioning Support Manager

3 June 2019

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1.0 Introduction

This report will begin by providing context and background to the evaluation taking place. Thereafter, it will outline the aims and objectives of the evaluation and provide an explanation of the approaches used. It will then present the findings of the approaches and will conclude by presenting a conclusion and making recommendations to inform the future priorities for the diabetes programme.

The report will evaluate the Diabetes Transformation Funding deliverables and impact. The evaluation was undertaken by the CCG between February and early June 2019.

2.0 Context and background

Following a successful bid, in 2017 NHS England awarded the CCG with Diabetes Transformation Funding. This funding was initially allocated for a period of 18 months and was awarded to the CCG for the following purposes:

- To transform access to structured education for people with both Type 1 and Type 2 Diabetes in Barnsley
- To improve the achievement of the target key treatment measures and to reduce the unwarranted variation in outcomes for these measures across GP practices in Barnsley
- To improve patient experience and clinical outcomes for children and adults

Before the CCG submitted the successful bid to NHS England, patient's views were collected. The following feedback was received:

- Patients had poor understanding of their condition, despite in many cases having had the condition for many years
- The need for structured patient education was clearly identified as a priority and praised by those who had received it
- Patients and carers reflected on the differences in the quality of care that they received and the importance of high quality primary care

As a result of the initial funding period coming to a close, the CCG has chosen to evaluate the Transformation Funding to ascertain if the objectives and deliverables have been met and to identify the future priorities for the diabetes programme.

3.0 Aims and objectives

The aim of the report is to evaluate the Diabetes Transformation Funding which was allocated to the CCG to use between November 2017 and April 2019.
The above aim will be met by the following objectives:

1. Identify the data to demonstrate quantitative measures and assess if the funding deliverables were met

2. Identify clinical views on diabetes services within Barnsley to provide a an evaluation position and future priorities from this perspective
3. Identify patients/carers views on diabetes services within Barnsley to identify from their perspective the programme evaluation and future priorities
4. Analyse the objectives and deliverables of the Diabetes Transformation Funding against the findings to identify gaps
5. Make recommendations to inform the future priorities of the diabetes programme

4.0 Methodology

After researching both qualitative and quantitative approaches, it was decided to address the evaluation using a mixed methods approach. In its most basic sense this is using a combination of both qualitative and quantitative research collection methods.

This was chosen as it will allow the evaluation to successfully achieve its aim and objectives. Qualitative data will provide an insight into how the participants who took part in the delivery of the diabetes services within Barnsley. It will be able to involve a larger sample size by using quantitative data methods which will provide statistics to aid with displaying the results of the research in section 5.0.

4.1 Data collection

The data collection has been structured to ensure that three of the objectives outlined in section 3.0 are addressed. This section will address objectives one (Identify quantitative data), two (Identify clinical views) and three (Identify patient/cares views).

The evaluation used two data collection methods; Collecting secondary data and two questionnaires; one for clinicians and service staff and the other for patients and carers.

The secondary data will be completed first and will answer objective one - Identify the data to demonstrate quantitative measures. The first questionnaire will answer objective two – Identify clinical views on diabetes services within Barnsley. The second questionnaire with answer objective three- Identify patients/carers views on diabetes services within Barnsley.

This section will now explore the two chosen data collection methods in greater detail.

4.1.1 Secondary data

The evaluation collected secondary data from the CCG; this was achieved by looking at previous reports, NHS England returns and monitoring data that is already available to the CCG.

4.1.2 Questionnaires

Two questionnaires were designed and undertaken in order to obtain views from local patients, and carers and clinicians on their experiences of accessing, using, referring into and delivering Diabetes services locally.

Information and links to both questionnaires were posted online on the 'Get involved' section of the NHS Barnsley CCG website (www.barnsleyccg.nhs.uk/haveyoursay) and also kindly circulated by local partners working across the health and social care economy. The link to the patient and carer survey was also circulated, to members of the NHS Barnsley CCG Patient Council and to members of the OPEN (Our Public Engagement Network) Database.

Over 200 paper copies of the patient survey were circulated to Diabetes Service Leads for them to be able to disseminate to their staff and contacts that have direct patient contact through clinics both out in the community and within the Diabetes Centre at Barnsley Hospital. Posters promoting the surveys were also developed and circulated. Paper copies were also available on request and respondents were also able to feedback over the telephone.

In addition to the above, two CCG staff members also attended clinics at Woodland Drive Medical Centre and Chapelfield Medical Centre on Tuesday 28 May and three times at the Diabetes Centre at Barnsley Hospital in May and June in order to gain additional feedback via the patient survey.

Notification of the engagement phase and the opportunity for people to have their say has been promoted on social media via the CCG Facebook and twitter pages on a regular basis throughout the engagement period and also shared by local partners including Barnsley Hospitals NHS Foundation Trust.

Clinicians Questionnaire

At close, 23 responses were received in response to the clinician's questionnaire.

A copy of the clinician's questionnaire can be found in Appendix 1.

Patients/ Carers Questionnaire

At close, 57 completed responses to the patient/careers questionnaire have been received.

A copy of the Patient/carers questionnaire can be found in Appendix 2.

5.0 Findings

This section will present the results gained following the application of the methodologies outlined within section 3.0. It will display the findings produced from the secondary data and highlight the results of the questionnaires.

5.1 Secondary data

The below information was sourced using data that has been previously submitted either to the CCG (from providers) or by the CCG (to NHS England or committees). It is structured using the programme deliverables.

1. Structured Education and Self-Management deliverables:

Measure	Status
Increase provision of nationally accredited structured patient education programmes	Target met
by 10 point increase per year in the percentage of newly diagnosed patients attending structured education	Target on track to be met
20% of all patients with diabetes attending structured education over the next 5 years	On track
STH- 2017/18- Fully train one DSN and one dietitian as educators for DAFNE	Target met
2019-19 Link worker role/roles increased uptake of structured education and treatment target by vulnerable people (e.g. LD, MH).	10 people targeted – SWYPFT are piloting a specific SE offer for people with a LD

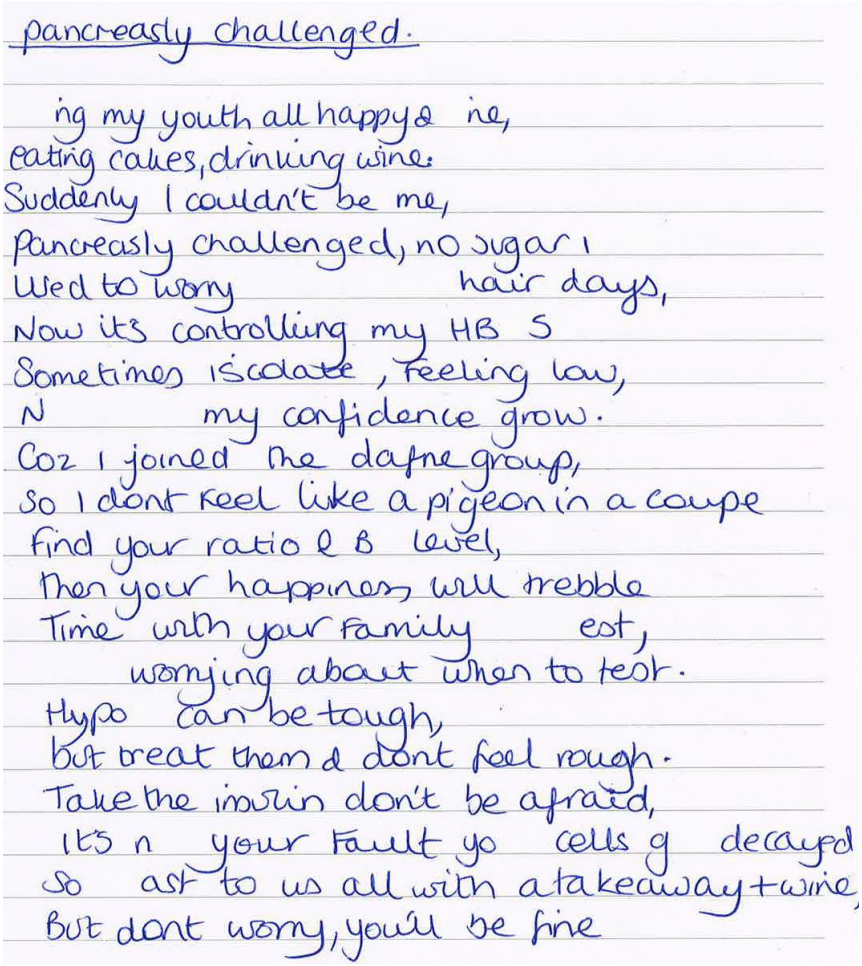
2. Increase referrals from health care professionals (primary care and others) of patients with diabetes to the structured patient education programme

Measure	Status
Increase patients understanding of the importance of structured patient education	This is being delivered by the commissioning of a Diabetes Integrated Service and inclusion within the PDA indicators
Increase accessibility of the programmes	This is being delivered by the commissioning of a Diabetes

	Integrated Service. In March 2018-19 266 patients have been offered a course place compared to 200 in 2015-16. 28 EXPERT courses were run for T2 patients and 6 DAFNE courses for T1 diabetics. In 2016 only 30% of patients referred attended the course compared to 66% attendance at the end of 2018

2.1 Patient feedback from Structured Education Courses

A sample of Patient feedback collected from the DAFNE course for people with Type 1 Diabetes:



pancreasly challenged.

ing my youth all happy & ine,
eating cakes, drinking wine.
Suddenly I couldn't be me,
pancreasly challenged, no sugar 1
Wed to worry hair days,
Now its controlling my HB S
Sometimes isolate, feeling low,
N my confidence grow.
Coz I joined the dafne group,
so I dont feel like a pigeon in a coupe
find your ratio & B level,
then your happiness will trebble
Time with your family est,
worrying about when to test.
Hypo can be tough,
but treat them & dont feel rough.
Take the insrin don't be afraid,
its n your fault yo cells g decayed
so ast to us all with a takeaway + wine,
But dont worry, you'll be fine

The DAFNE course has been brilliant, I've honestly never learnt as much about diabetes as I have here. t has elped me so much in one week and it will help me in the rest of y life. I've had so much support and help, I / lt that I could voice any wo nes and not be judged. The info mation given was incredible and the reso ces/activities ave been so much fun and helped us to understand diabetes better.
Thankyou so much to Pauline, Carolin and the team fc all of your help and suppor! Lauren ☺

What can say about AFNE?
The words life-changing, mind blowing & empowering come to mind, but, more the safe environment and free-speaking that has been amazing.
The morning round-up of the previous days BGLs was initially very scary but actually it turned out to be more helpful than I could have ever imagined.
The course is intense but everything is relevant and ~~also~~ allows us to have the knowledge & feel empowered to treat ourselves.
Thanks go to Pauline & Carolin for being non-judgemental friendly & approachable. They created a safe environment for us to explore our condition.
Going on this course & forcing my work give me the week off has been the best decision of my life.

3. Improve the achievement of the target key treatment measures and specifically reducing the unwarranted variation in outcomes for these measures across GP practices in Barnsley

Measure	Status
National Diabetes Audit - Increase the number of participating practices to 100% by 2018 - 83.3% of primary care practices in Barnsley participated in the National Diabetes Audit in 2016, leaving 5 practices that did not participate	Target met
Aim for 41.3% of diabetic patients to be meeting their three NICE treatment targets	Q3 PDA local results for 2018 are : • 29 practice are at 41.3% or above • 3 practices are below 41.3% • 1 Practice no results On track. Practices will continue to improve target via 2019-20 PDA indicator for Type 2 people. National Diabetes Audit: Core Report 1 – Care Processes and Treatment Targets. Type 2 is 42.2% at April 2018

4. Accurate Recording of Attendance and coding on Primary Care Systems

This has been delivered as practices are:

- Using the four recommended READ codes to code attendance and outcomes on the Providers systems
- Included recording of these codes on GP clinical systems in primary care incentive schemes and local clinical system template

5. To work closely across primary and secondary care providers to establish and maintain best practice for transition into adult diabetes services

Measure	Status
Develop and initiate strategies to effectively communicate key messages and information about paediatric diabetes to enable informed choices	On track – via BHNFT CYP Diabetes Service offer
Develop and evaluate counselling	Delayed – BHNFT working on meeting

strategies and provide support to children, young people and families	this objective.
Deliver SE for transition WICKED	Action was changed due to STHT evaluation of courses not showing expected outcomes. BHNFT staff undertaken WICKED training and incorporating principles into their practice and trialling 1 day course and working on having closer working relationships with youth and voluntary sector services.

6. Specialist diabetic MDT

Measure	Status
Specialist diabetic MDT	This is being delivered by the commissioning of a Diabetes Integrated Service
Undertake joint clinics within primary care, some of which may be virtual. These will be a mix of diabetic specialist nurse and diabetic consultants with practice nurses and GPs. They may take the form of consultations with patients within primary care or may be case based discussions without the patient	• This is being delivered by the commissioning of a Diabetes Integrated Service (BIDS) • Undertaken joint clinics in; Dearne, Grimethorpe & at Kakoty practice. Working with GP practices on diabetes case management reviews as alternative offer. • 6 Hub clinics established by BIDS

7. Improve the outcomes of patients registered in the lower performing practices to the level of achievement of our highest performing practices

This on track and is continuing to be delivered by Barnsley Healthcare Federation Diabetes Improvement Primary Care Nurse.

- BHF Diabetes Improvement Primary Care Nurse during 2018-19 has been supporting 6 practices. There have been improved outcomes reported at practice level since following this input. In 2018-19 the nurse supported:

1. Dr Kakoty's
2. BHF Brierley
3. The Grove Medical Practice
4. Lakeside Surgery
5. Hoyland Medical Practice
6. St Georges Medical Practice

8. Improve the control of patients with Type 1 diabetes and in younger patients with Type 1 and Type 2 diabetes

This has been delivered via the CCG commissioned BHNFT run service.

9. Enhancing the skills/knowledge of practice nurses to deliver one to one education

This has been delivered by offering Warwick Diabetes course- to date 30 staff from Primary Care has been trained in the WARWICK CIDC Course. This comprises of GP's and Practice Nurses. A further course will be taking place in 2019/20 to start in September to provide this opportunity to the practices that have not taken part. Practice nurses have also been upskilled via joint clinics/case management discussions with the Diabetes Integrated service. These will increase in number over the 2019-20.

10. Implement a pilot digital structured Diabetes education programme

The CCG is implementing this pilot during 2019 via commissioning Changing Health to offer 50 places to type 2 diabetes patients at the GP practices the BHF Nurse is working with and the CCG Governing body Diabetes Clinical Lead practice. The aim of the pilot is to evaluate if a digital offer will be a successful alternative for people who cannot attend a face to face group.

11. Reduced Cost and Improved Efficiencies

This has being delivered by the CCG commissioning from April 2018 a Diabetes Integrated Service, which has measures in place to reduce admission and Out Patient Department appointments. Further monitoring over the next year will identify further efficiencies.

Current performance is:

To decrease, over two years, the number of hospital admissions in people aged over 18 years at Barnsley Hospital with a diagnosis of Diabetes or Specifically Related Conditions by 10% each year (compared to 2016/17 baseline)			
	Number of Admissions		
	Baseline	Threshold	Actual YTD

Key Performance Indicator	2016/17	2018/19	2019/20	Actual 18/19
Ketoacidosis	141	127	114	62
Hypoglycaemia	14	13	11	2
Hyperglycaemia	104	94	84	6
Combined	259	233	210	70

5.2. Clinicians questionnaire

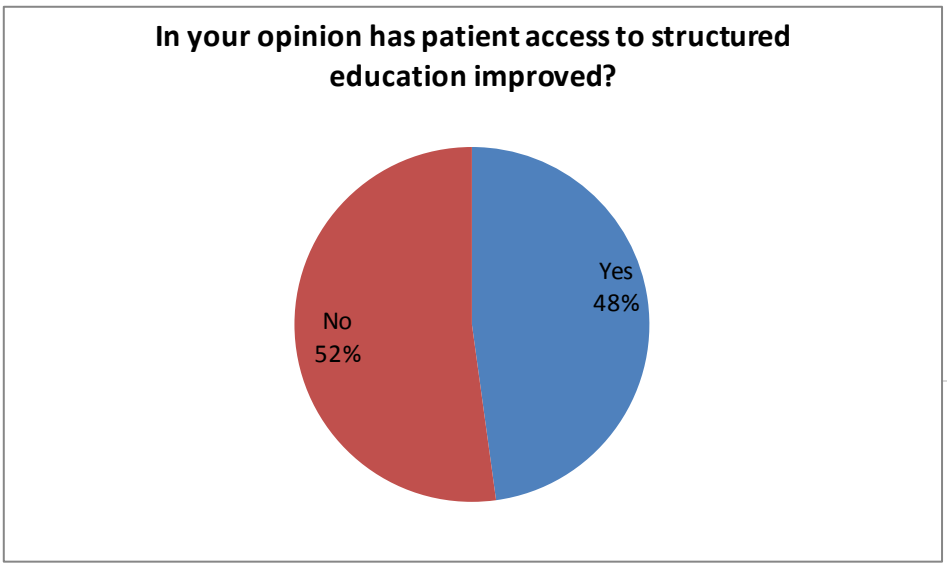
A total of 23 responses were received for the survey. The CCG Clinical Forum also gave their views. In total 30 people views were obtained. This section will now explore the survey responses in greater detail.

Question 1: What is your role in the treatment of people with diabetes?
Table 1: Responses to Question 1

Role	Number
GP	**4**
Diabetes Specialist Nurse	**1**
Practice Nurse	**13**
Service Manager	**1**
Advanced Nurse Practitioner	**2**
Management Support	**1**
Declined to answer	**1**

Question 2: In your opinion has patient access to structured education improved?

Figure 1: Responses to Question 2



Question 2a: Please tell us the reason for your response

Table 2: Responses to question 2a

In your opinion has patient access to structured education improved? Please tell us the reason for your response	
Representative quotes	
Waiting lists	Waiting lists are extremely long lots of patients do not like education in big groups
Access	Improved - Increased awareness, access to education, a variety of dates and 6 venues available to patients. Patients contacted by the SPA team to talk through the sessions
Location	There are now courses for type 1 and 2 available, could be improved further by more clinics based in different areas of the community
Location	More sessions - more acceptable locations
Waiting times/ Venues	Both yes and no, longer waiting times for access to structured education. (A positive aspect is that it has now become available locally, more venues available)
Waiting times	Long waiting times for patients. Practice unaware of wait times until patient declines

Question 3: Given your experience of diabetes services, please tell us what aspects of local services have improved over the past 2 years? (Please refer to the aims of the programme)

Figure 2: Responses to Question 3

Question 3a: Please tell us the reason for your response

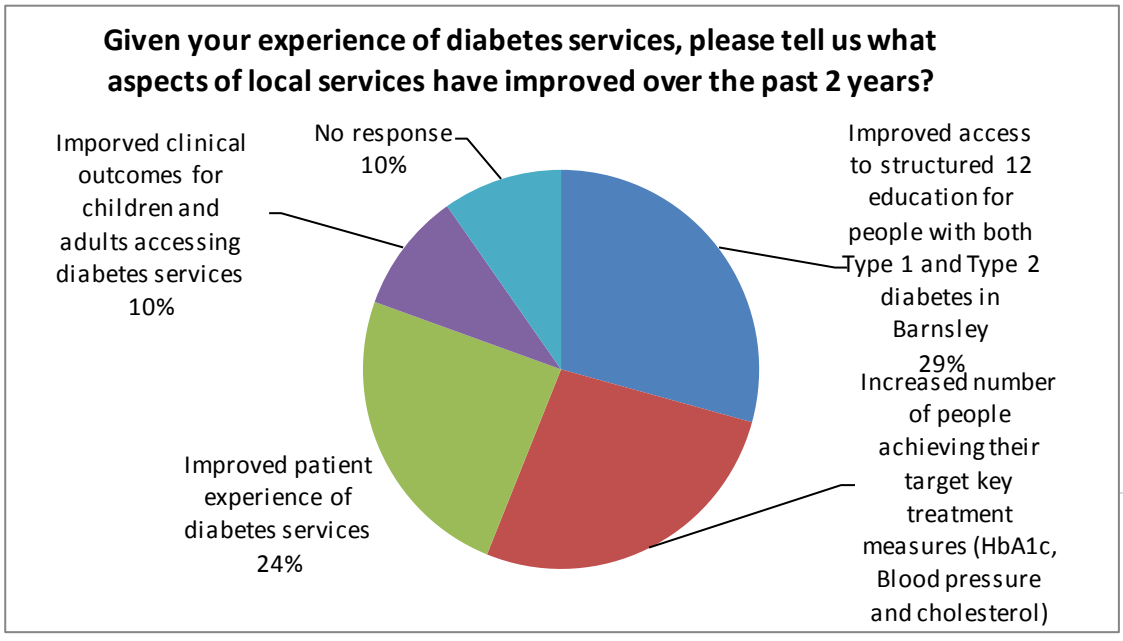
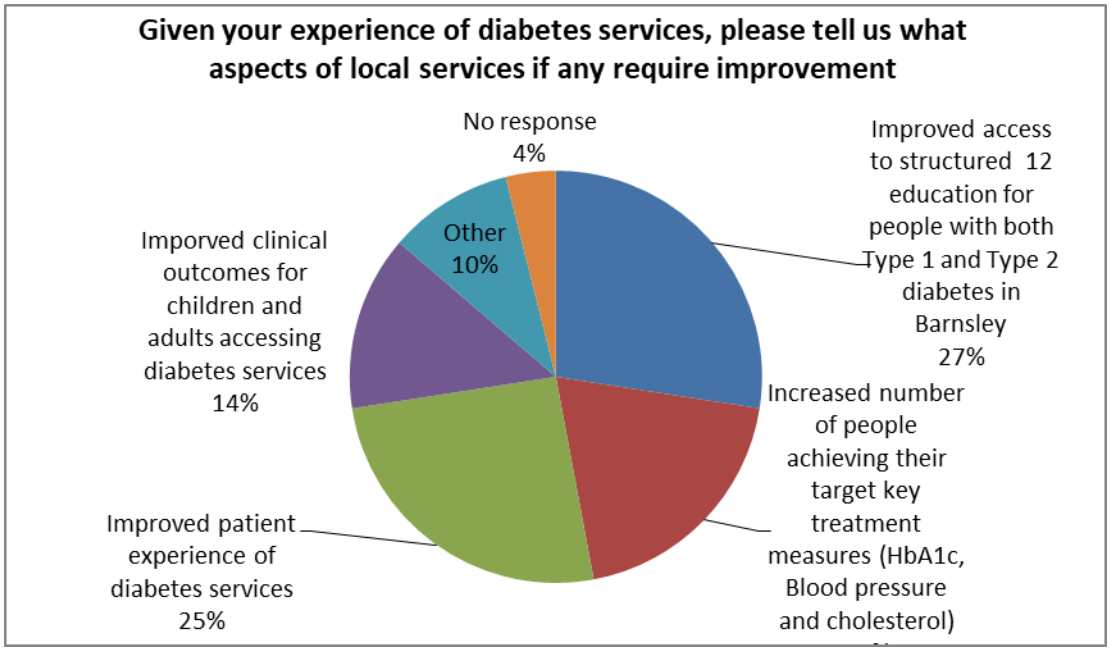


Table 3: Responses to Question 3a

In your opinion has patient access to structured education improved? Please tell us the reason for your response	
Representative quotes	
Improved Support	Improved -Assistance and support in our practice to do clinics by primary care diabetes lead nurse
Access	Access to structured education has been improved, but I have not noticed any significant change to people achieving Key targets. People are finding it harder to speak to a Diabetic specialist when needed. So patient experience not improved.
Disjointed	Disjointed no one has seen us to improve joined up care
Support / Joint surgeries	Better working relationship with our community DSN who is very approachable. We had joint surgeries at the practice to upskill our practice nurses Also I have undertaken the Warwick course which has been a great learning experience and I feel more confident in initiating certain therapies such as SLGT2 inhibit and GLP1RAs
Patient Experiences	Patients we see tell us of experiences and it would appear experiences improved Patients respond by actually attending appointments when have good experience.

Question 4: Given your experience of diabetes services, please tell us what aspects of local services if any require improvement? (Please refer to the aims of the programme)

Figure 3: Responses to question 4



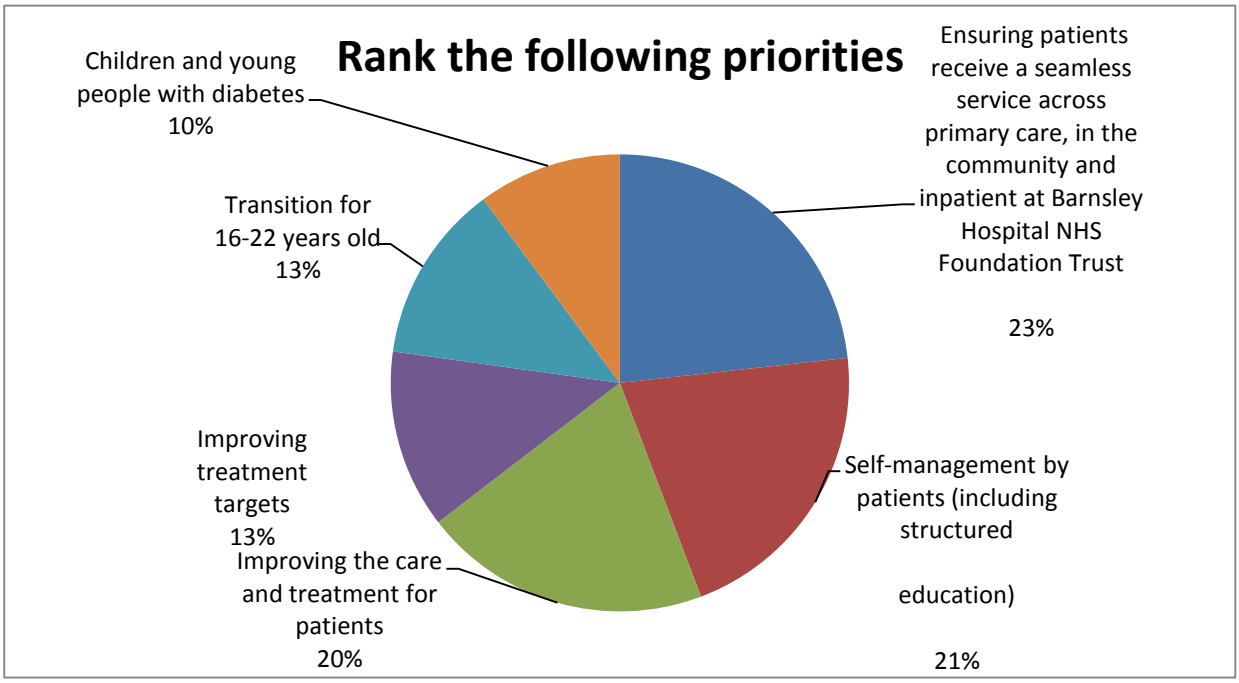
Question 4a: Please tell us the reason for your response

Table 4: Responses to Question 4a

Given your experience of diabetes services, please tell us what aspects of local services if any require improvement Please tell us the reason for your response	
Representative quotes	
Working together	Improved working together
Access	We need to look at why people are not achieving key targets, We need to improve access to specialist Nurses quicker
Location	Better locations and timings for people who work or have to use public transport
Access	Out of hours access to diabetes services also leaflets in other languages such as Chinese
Access / Support	Access to DSN support is limited and the integration of services is not present. Patients are quickly discharged by DSN even when they have not achieved their target treatment measures. This is putting extra pressure of GP practices and causing patient dissatisfaction. More in house education and training support is required for GP practices for difficult diabetic patients.

Question 5: Please help us to decide the key areas that we need to focus on going forwards, by ranking the following list of priorities from 1 - 6 (1 = highest/ 6 = lowest)

Figure 4: Responses to question 5



Question 5a: Please tell us the reason for your response

Table 5: Responses to Question 5a

Please help us to decide the key areas that we need to focus on going forwards Please tell us the reason for your response	
Representative quotes	
All a priority	No one is deemed higher than the other, they all interlink and therefore improving care is a priority
Self-manage	Diabetes is a disease that affects individuals of every age and hence I do not necessarily believe we should focus on specific age groups (might be considered ageist). Improving treatment targets is more about the service than those using it. We need to focus on improving the capability to self-manage and focus more time on those who clearly cannot
Children's	Children's services already seem quite good

Question 6: Any other comments

Table 6: Responses to Question 6

Any other comments	
Representative quotes	
Demand	The DSN's provide an excellent resource but are over stretched for the demand of the local population with current resources
Structured education options	It would be great to have information re diabetes in languages such as Chinese. We have a lady who only speaks Chinese and is newly diagnosed with diabetes. She would benefit from structured education but family can't attend with her as they are working full time. It would be helpful to have options for patients in situations such as this one.
Working together	There were lots of promises of working together and nobody has come to see us in spite of frequent invitations

5.3 Patient/carers questionnaire

A total of 57 responses were received. This section will now explore the responses in greater detail.

Question 1: Which of these best describes you? I am...

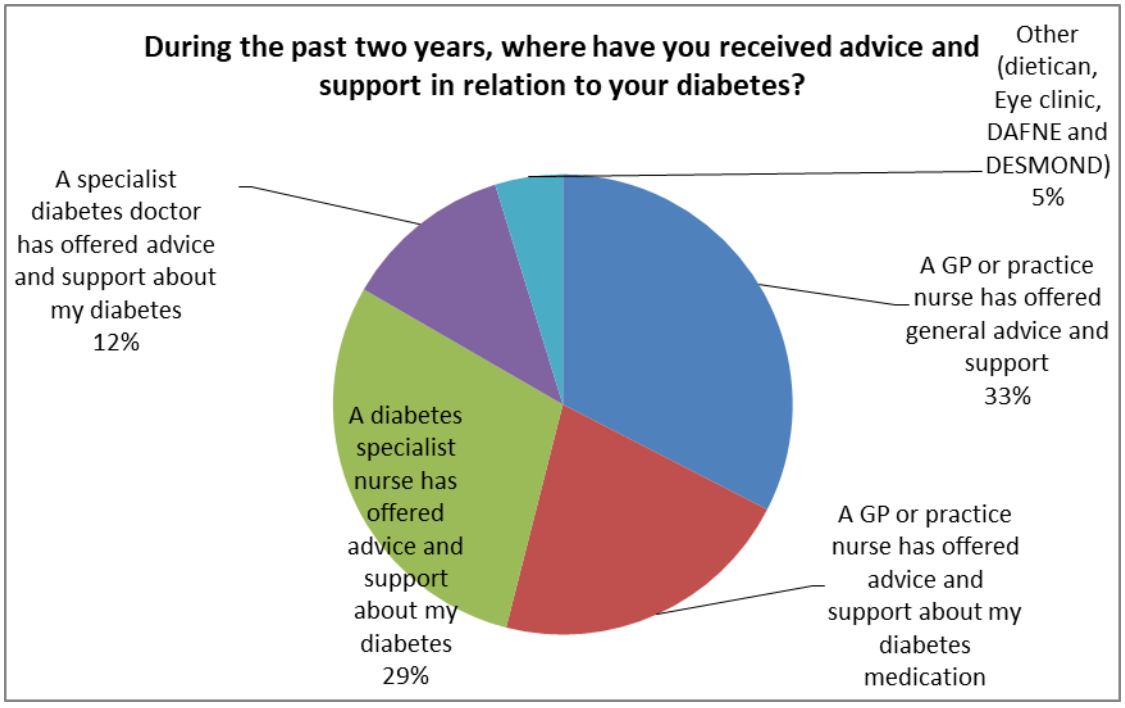
Table 7: Responses to Question 1

I am…	Number
Living with Type 1 diabetes	10
Living with Type 2 diabetes	40
Living with another type of diabetes	1
Someone who has been diagnosed as being at risk of developing Type 2 diabetes	2
Unsure what type of diabetes I have	1

A family member / friend or carer or a person living with diabetes	3

Question 2: During the past two years, where have you received advice and support in relation to your diabetes?

Figure 5: Responses to question 2



Question 3: Some of the funding has also gone towards providing self-management education courses. (DAFNE is aimed at people with Type 1 diabetes and X-PERT is aimed at people with Type 2 diabetes.)

Figure 6: responses to Question 3 (DAFNE)

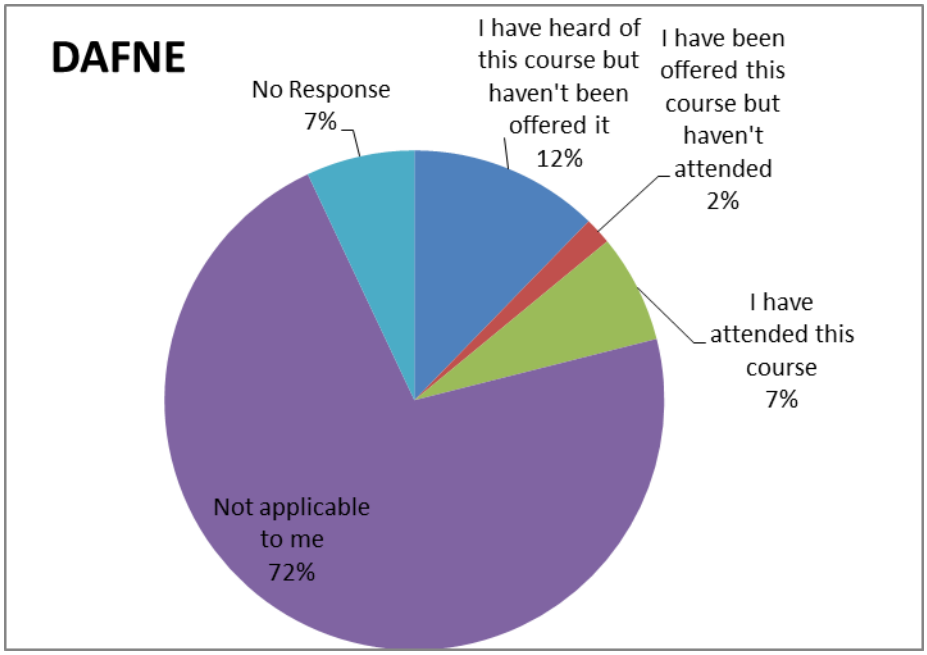
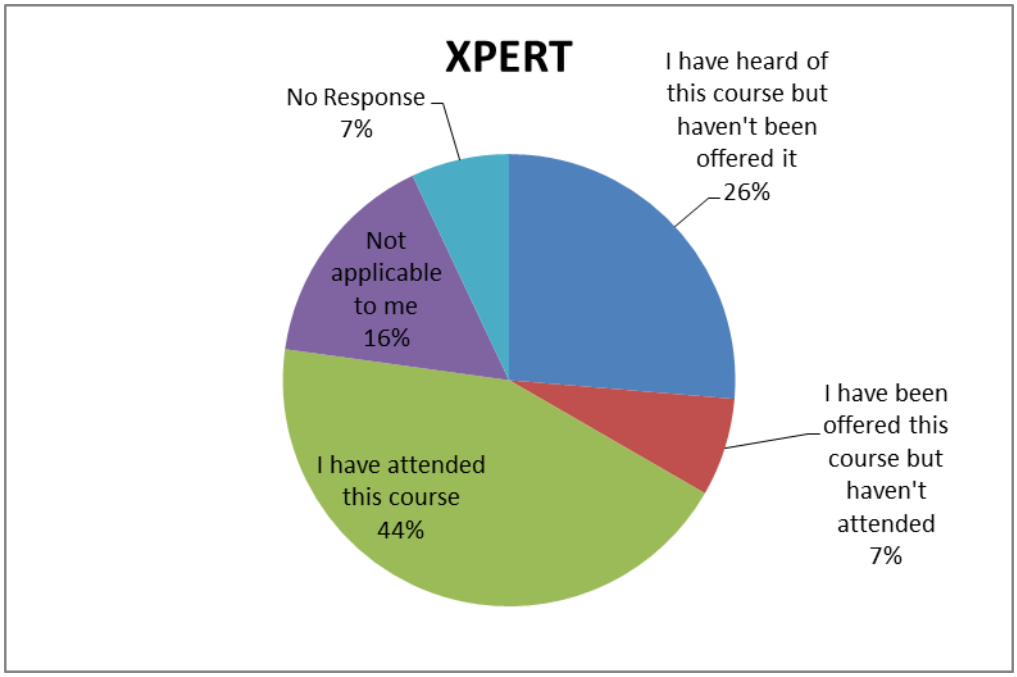


Figure 7: responses to Question 3 (XPERT)



Question 4: From your experience over the past two years, how useful did you find the advice and support you received from the following services to help manage your diabetes?

Figure 8: Responses to Question 4 (Diabetes Doctors at the hospital)

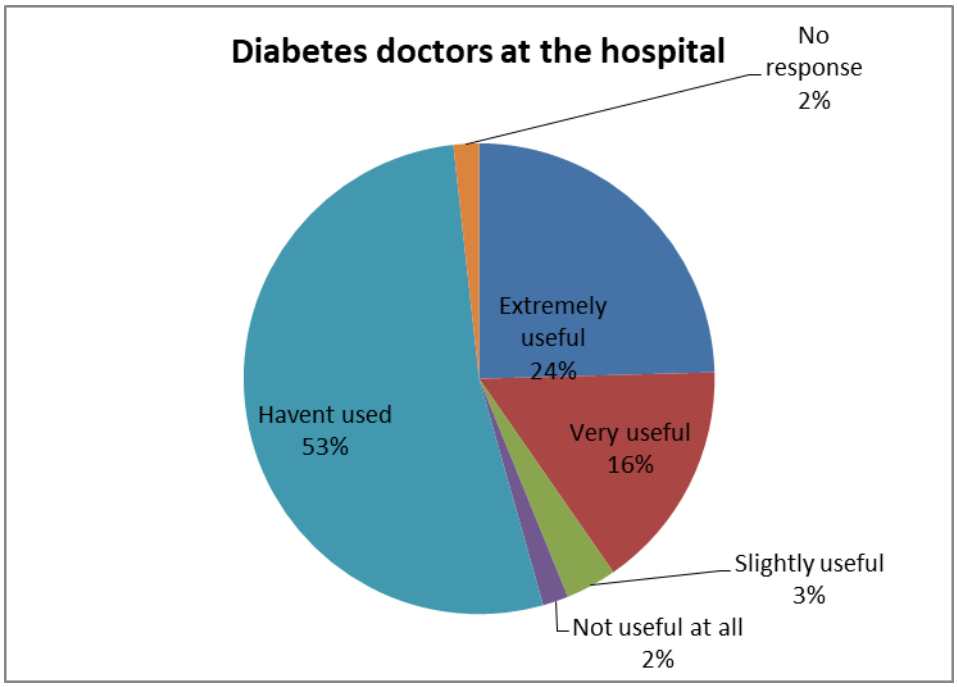


Figure 9: Responses to Question 4 (Your GP)

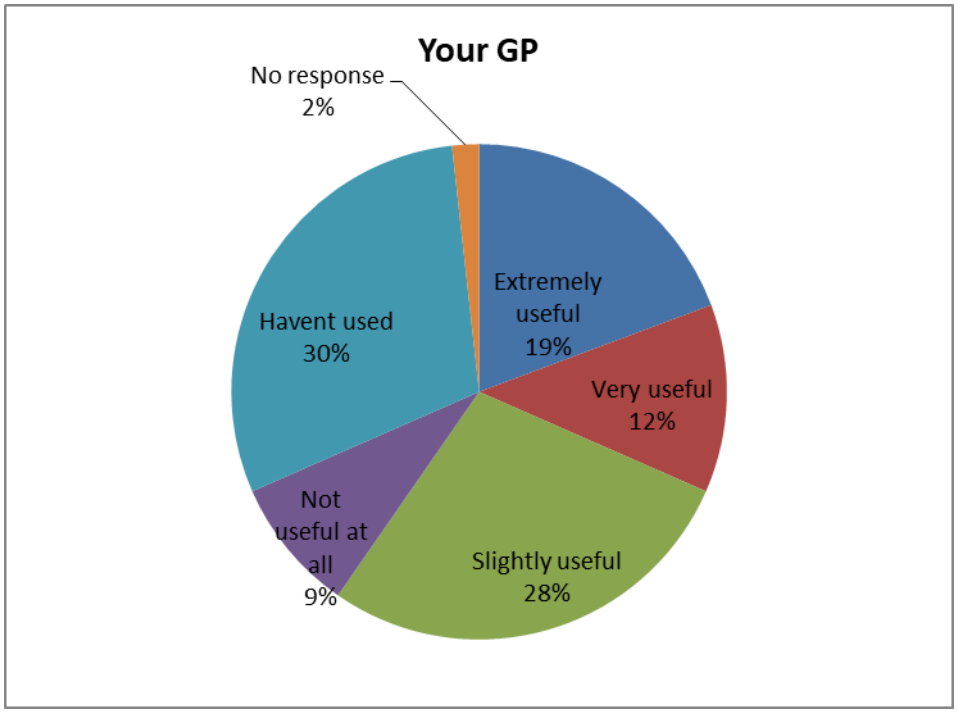


Figure 10: Responses to Question 4 (Your Practice nurse)

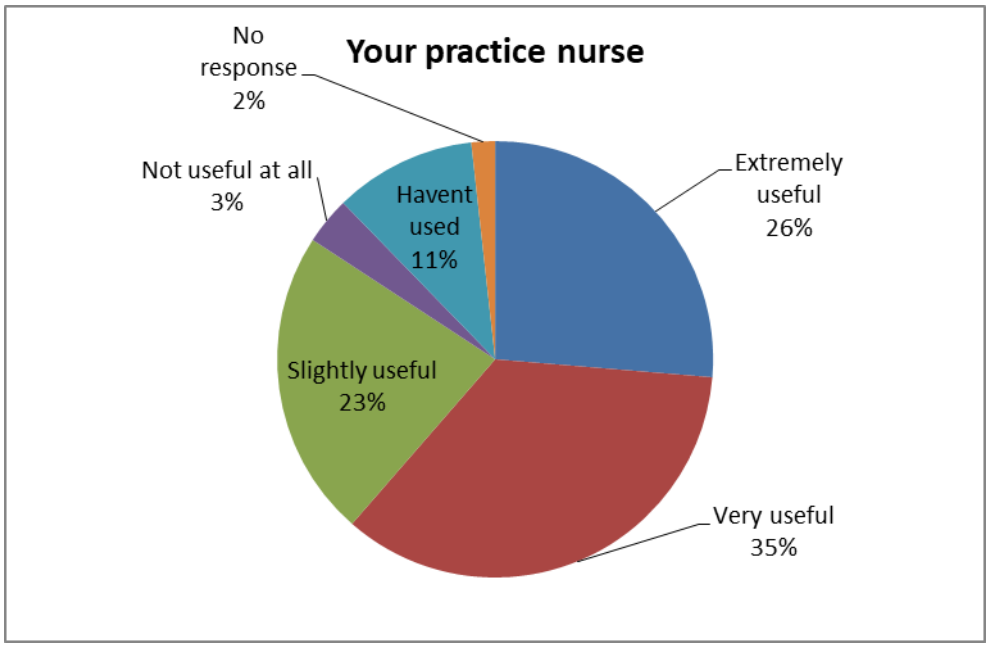


Figure 11: Responses to Question 4 (Diabetes specialist nurses)

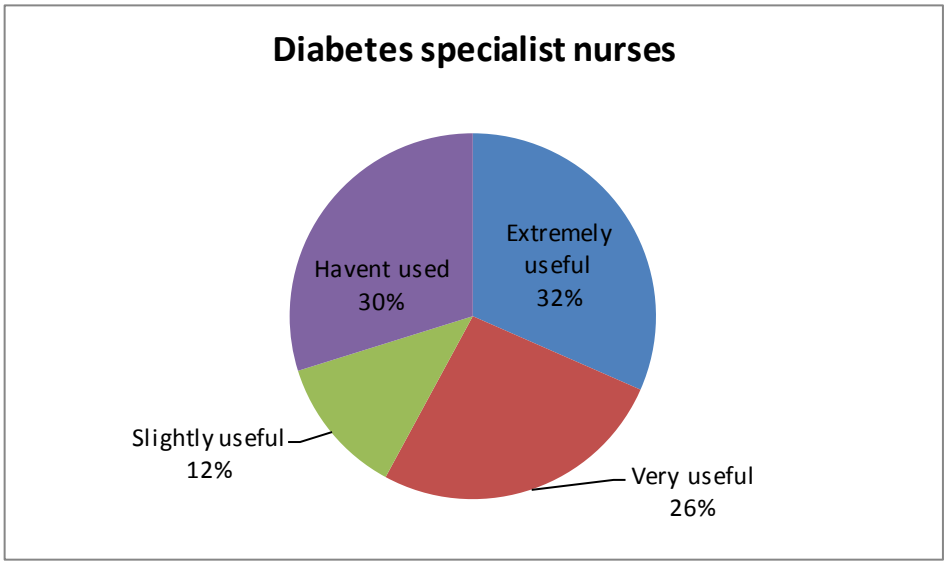


Figure 12: Responses to Question 4 (Dietician)

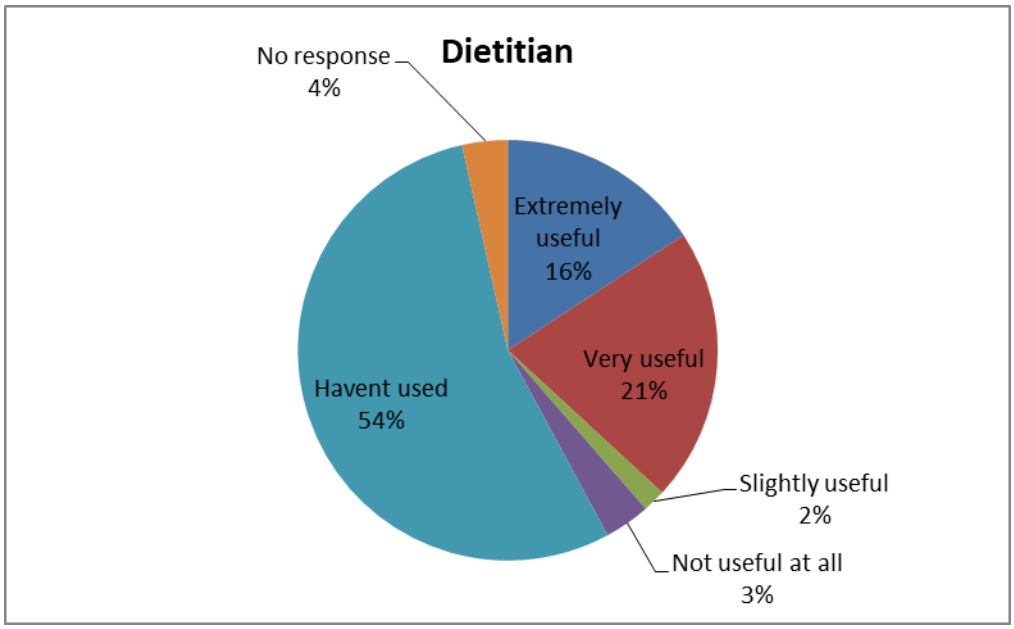


Figure 13: Responses to Question 4 (DAFNE structured education)

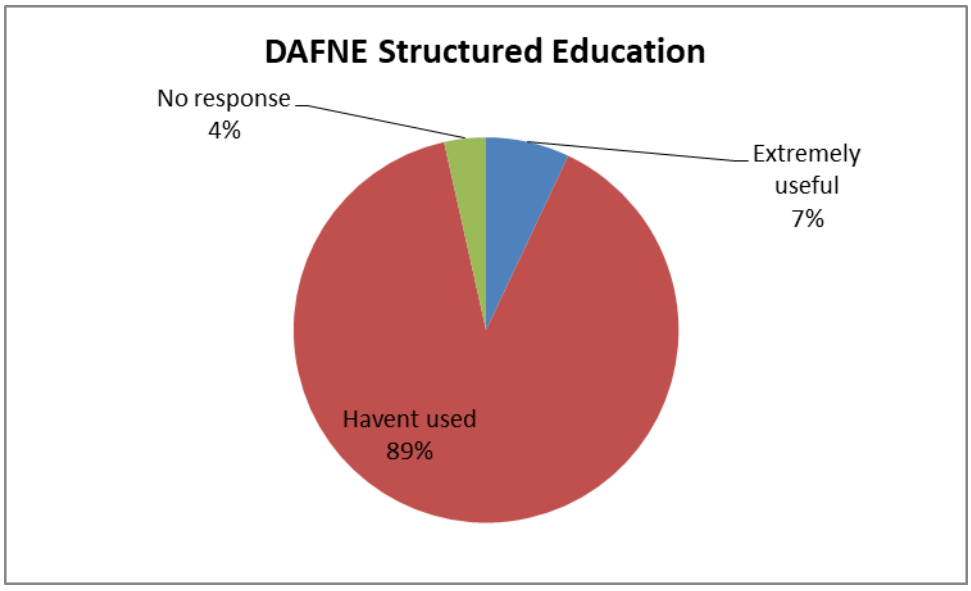
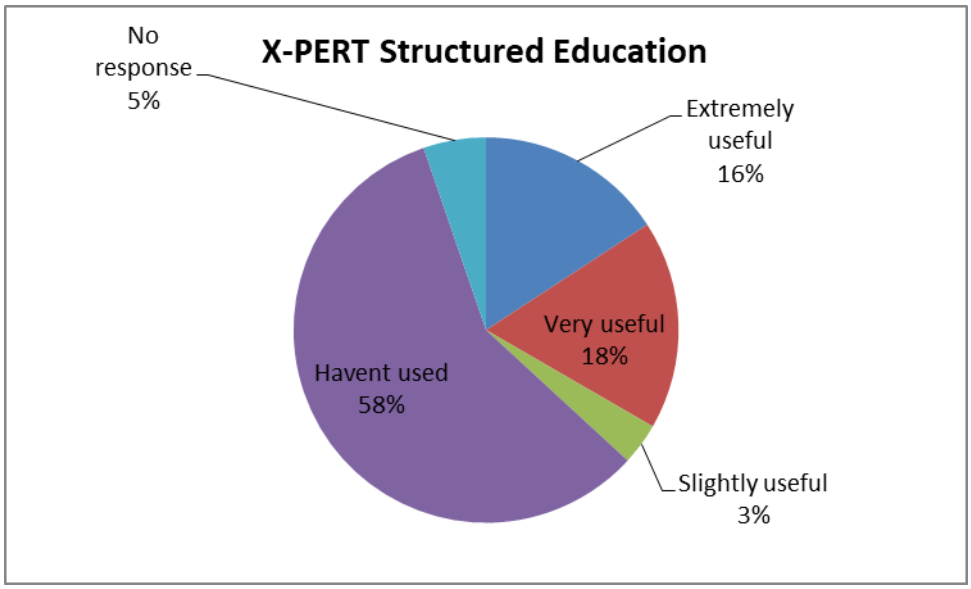
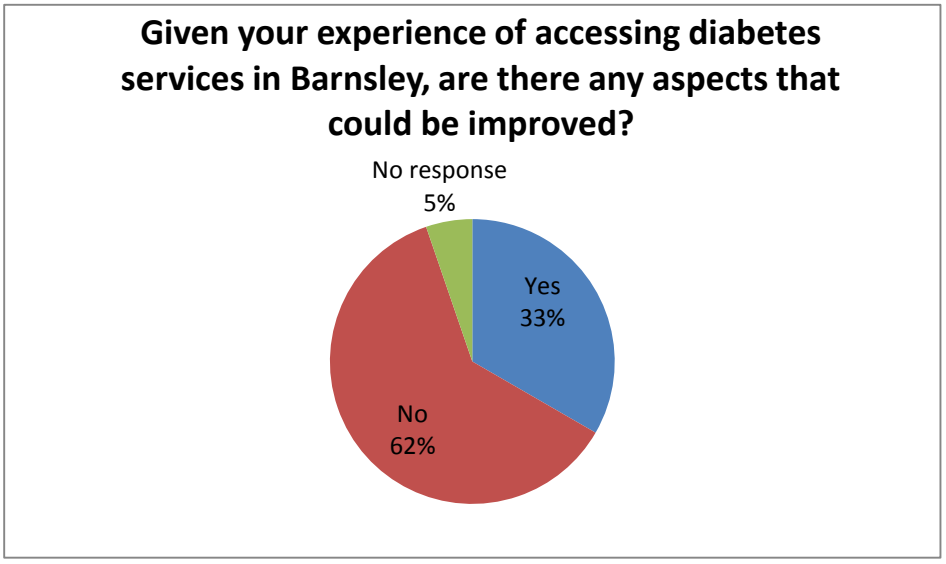


Figure 14: Responses to Question 4 (X-PERT structure education)



Question 5: Given your experience of accessing diabetes services in Barnsley, are there any aspects that could be improved in your opinion?

Figure 15: responses to question 5



Question 5a: Please tell us the reasons why:

Table 7: Responses to question 5a

Given your experience of accessing diabetes services in Barnsley, are there any aspects that could be improved? Please tell us why	
Representative quotes	
Limitations	Due to recent changes in GP I no longer see them and only get practice nurse which feels limited in depth and experience.
Reason – not access support	I've always been offered lots of support but I have chosen not to take it up as of yet but I know it is there when I am ready to access it.
Increase Structured education and support	More structured education from the outset of diagnosis & then at regular intervals, say yearly, thereafter. Improved access to both Diabetes specialist nurses, but more so the specialist diabetes doctors at the hospital - having not been seen for over two years by a diabetes specialist doctor due to repeated admin errors at the hospital, I finally got to see someone that resulted in my going on the DAFNE course, however it now appears that I'm going to be subjected to the same delays with seeing a doctor as before.
Access to Appointments	Access to service i.e. appointments, availability and continuity
Dietician Referral pathway	Patient self-referral to dietitian as the healthcare professionals don't always refer on for specialist help
Increase GP Support/Access	More support from your GP and getting an appointment - even when told by the nurse in my appointment to go and make an appointment with the receptionist to see my GP, I can't get in often for 3 weeks or I'm told to ring which is frustrating.
Waiting times	X- PERT course availability - Had to wait too long for a course to become available

Question 6: We would like to know what you think the three priorities are in relation to diabetes care, advice and support in Barnsley over the next year and beyond.

Table 8: Responses to question 6

We would like to know what you think the three priorities are in relation to diabetes care, advice and support in Barnsley over the next year and beyond.
Representative quotes

Self-management	People being given support to look after their diabetes themselves for all ages
Self-management	1. Providing information to help me manage my diabetes 2. Simplified RAG {Red, Amber, Green} indicators on key goals and data 3. Access to talking therapy to help with mental health issues related to being diabetic
Increase testing - Blood sugars	Would like my blood sugars testing more frequently as I get tired
One access point	One stop shop to include eye screening
Improve Foot checks	Improving foot checks
Increase Services	Range of services being made available - not one size fits all!
Hours of services	Self-management and access to wider range of services that aren't just available during traditional working hours.

Question 7: Is there anything else you would like to feedback?

Table 9: Responses to question 7

Anything else you would like to feedback	
Representative quotes	
Education	Education is key! from identifying the signs of type 1 diabetes, to educating adults who have had the condition for many years, schools, employers and even parents in terms of prevention (type 2 patients) and diet (type 1 and type 2).
Staff Contact	Regular contact and continuity of staff is important
Support older people	Older people need a bit of help to manage at home
Great support	Everyone is and has been really helpful over the past ten years since my diagnosis. It's reassuring to know the support is there if and when I need It.
Access-MDT	Please can you make it easier to be seen by the wider MDT like the dietitians as currently the SPA referral system does not work well for this speciality and I haven't been able to access dietetic care
Good service	Barnsley Diabetes Service is very good and I do not know what I would have done without them to talk to.

6.0 Summary

In summary the CCG has successfully delivered the transformation funding objectives via the commissioning of a diabetes integrated service and by working with GP Practices, BHF and SWYPFT. It will continue to embed the deliverables and objectives during 2019-20 via its integrated partnership and commissioning intentions and responsibilities

The evaluation highlighted a number of points. These were:

- Improving access points and the locations for care and treatment is a priority for both clinicians and patients
- It is a concern for both clinicians and patients about the waiting times to access care and services
- Structured education and ensuring patients are able to self-manage their care is a priority for both clinicians and patients. People with diabetes who had attended a course had found it a positive experience and the number offered this provision has considerably improved
- Ensuring there is a seamless and continuity of patient care across the services involved in diabetes care is a priority for both clinicians and patients. This work has begun but needs to continue to be consistent and considered improved by all
- Improving the care and treatment outcomes for people who have diabetes has improved but needs to continue to be consistent and variation in outcomes reduced in some areas
- GP Practices value having specialist support available and training to improve their skills and knowledge
- Ensuring patients have a positive experience of the care and service they receives remains a priority for services and patients/carers
- There was a difference of opinion and perception about the effectiveness of the transformation funding impact given via clinicians and patient's feedback. This appeared to be a positive or negative opinion based on ease of access to the service or person
- The majority of patients were aware of the services available and valued them

7.0 Recommendations

It is recommended that:

1. The priorities highlighted within this report are addressed via the CCG ongoing work with provider.
2. Services working to improve diabetes care in Barnsley incorporate the priorities highlighted in this report into their improvement plans as appropriate.

Appendix 1: Clinician's questionnaire

Diabetes Transformation Evalu

Appendix 2: Patient/carers questionnaire

Diabetes Transformation Evalu

NHS
Barnsley
Clinical Commissioning Group

GOVERNING BODY

11 July 2019

Treatment of Tobacco Dependency in Acute and Mental Health Secondary Care

QUIT Business Case – NHS Barnsley CCG

PART 1A – SUMMARY REPORT

1. THIS PAPER IS FOR

Decision	X	*Approval*	X	*Assurance*		*Information*	

2. REPORT OF

	Name	Designation
Executive Lead	Jeremy Budd	Director of Commissioning
Author	Lynsey Bowker	Lead Commissioning and Transformation Manager

3. SUMMARY OF PREVIOUS GOVERNANCE

The matters raised in this paper have been subject to prior consideration in the following forums:

Group / Committee	Date	Outcome
Acute Federation Chief Executives	March 2019	The SYB QUIT programme (which is based on the Ottawa model) endorsed for implementation
Accountable Officers of CCGs	April 2019	
Chief Finance Officers Meeting (SY&B)	20.05.19	Discussion on financial implications of proposed model.
Management Team	26.06.19	Noted the SY&B ICS programme and CCG implications. Request for paper to be considered at July Governing Body meeting.

4. EXECUTIVE SUMMARY

The purpose of this paper is to ask Governing Body to agree funding to support implementation of the QUIT programme. The estimated financial contribution from Barnsley CCG is outlined in the 'Commitment Table', see Table 1, page 6.

	QUIT is the systematic implementation at scale of the treatment of tobacco dependency in secondary care and the provision of on-going support for people who quit smoking from community stop smoking services. The ambition is the QUIT programme will be implemented at scale in all Acute and Mental Health Trusts in SY&B, starting in January 2020. The QUIT programme is in line with commitments made in the NHS LTP that; by 23/24 all people admitted to hospital will smoke will be offered Ottawa style NHS funded tobacco treatment services.
5.	**THE GOVERNING BODY IS ASKED TO:**
	- Approve to the financial contribution as set out in the financial commitment Table, see Table 1, page 6, - Support the prescribing of tobacco dependency pharmacotherapy drugs in primary care, - Champion the programme at a local level, - Contribute to a Place implementation plan, that is submitted to the ICS demonstrating how the partners at Place will work together to implement QUIT, - Contribute towards QUIT comms and engagement, - Contribute to the evaluation and monitoring of the programme
6.	**APPENDICES / LINKS TO FURTHER INFORMATION**
	Appendix 1: QUIT briefing NHS BCCG This briefing provides summary information of the key implications of the QUIT business case to enable organisations to understand their part in the quit programme and estimated financial implications. **Appendix 2:** Yorkshire Cancer Research (YCR) submission v3 **Appendix 3:** YCR health initiative and service application supplication – final

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:	9.1
2.	**Links to CCG's Priority Areas**	**Y/N**
	1 - Urgent & Emergency Care	Y
	2 - Primary Care	Y
	3 – Cancer	Y
	4 - Mental Health	Y
	5 - Integrated Care System (ICS)	Y
	6 - Efficiency Plan	Y
	7 - Transforming Care for People with Learning Disabilities and / or Autistic Spectrum Conditions	N
	8 - Maternity	Y
	9 - Compliance with Statutory and Regulatory Requirements	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?	*Y*
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?	*N*
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

Treatment of Tobacco Dependency in Acute and Mental Health Secondary Care

QUIT Business Case

1. Purpose

The purpose of this paper is to ask Governing Body to agree funding to support implementation of the QUIT programme. The estimated financial contribution from Barnsley CCG is outlined in the 'Commitment Table' see Table 1, page 6.

2. Introduction

The NHS Long Term Plan gives a commitment that all people admitted to hospital who smoke will be offered NHS-funded tobacco treatment services based on the Ottawa model; And additionally, a new universal smoking cessation offer will also be available as part of specialist mental health services for long-term users of specialist mental health, and in learning disability services. NHSE funding for this is expected to be phased in from 2021/22.

Treating tobacco dependency in the secondary care setting is:

- Evidenced based
- Highly clinically effective – saves lives and reduces the incidence of cancer
- Saves money

The CURE programme in Greater Manchester has shown that the Ottawa model can be delivered in NHS acute trusts and has shown positive results. South Yorkshire and Bassetlaw has the opportunity to be the forerunner to demonstrate that the model can be adapted for use in NHS secondary care and mental health settings and to share this learning across the country.

The SYB QUIT programme (which is based on the Ottawa model) was endorsed for implementation by the Acute Federation Chief Executives in March 2019 and by the Accountable Officers of the CCGs in April 2019.

While there is good commitment from the Trusts, implementation is being hindered by lack of resources. Yorkshire Cancer Research (YCR) have expressed an interest in funding the specialist stop smoking advisors needed within trusts to implement the QUIT programme in 2019/20 and 2020/21.

Before taking a paper to their Strategy Impact Group in July and Board in September, the ICS needs to demonstrate that the ICS, Trusts, CCGs and Local Authorities will make an interim investment until the NHSE funding is available:

- To cover the costs of other elements needed to implement QUIT (e.g. coordination and management of the programme and specialist stop smoking advisors, release of staff for training, pharmacotherapy, specialist stop smoking support post discharge)
- To cover costs of the specialist advisors from 21/22 if there is a delay to, or a shortfall in, the national NHSE funding that is due in 2021/22.

What are the financial commitments of CCGs in the QUIT Programme?

The estimated financial contribution from Barnsley CCG is shown below in Table 1.

2019/20 and 2020/21 to fund:

- **One week of the four week take home medication** for tobacco dependency pharmacotherapy given by acute and mental health trust post discharge from an admission
- The **increased pharmacotherapy and dispensing costs** above the **local community SSS's current pharmacotherapy budget**/commissioned activity level
- The **pharmacotherapy and dispensing costs of patients with severe mental illness** being supported in the community by the mental health SSS Advisors

From 2021/22 NHSE funding will start to come on line (see Appendix 1, pages 3 and 4). The current working assumption within the ICS is this funding will probably come to CCGs as part of their baseline allocation.

- The ICS proposal assumes that in light of the reductions in admissions expected due to people stopping smoking, CCGs growth forecast for acute admissions for 21/22 onwards will reduce, 'releasing' the funding to commission the Trust based specialist stop smoking service managers, advisors, admin support and inpatient and community pharmacotherapy costs. This will be part funded by the NHSE funding as it is incrementally introduced.
    - CCGs picking up these costs are dependent on Trusts having demonstrated good levels of implementation during 2020/21.
    - If Trusts continue to have a CQUIN that covers NRT costs, this would need to be factored in.
- Trusts pick up the funding of the Healthy Hospital Programme Managers.
- LAs continue to ensure and fund sufficient capacity within community stop smoking services but with their share of the NHSE funding as this is incrementally increased.

Table 1: Estimated financial contribution from Barnsley CCG

Estimated financial contribution from Barnsley CCG							
Barnsley		**2019/20**	**2020/21**	**21/22**	**22/23**	**23/24**	**All costs given at 2019/20 values, NB:- This is only a guide to likely drug costs**
CCG funded	1 week TTA - Acute	9,835	41,386				**19/20 and 20/21** one week of inpt TTA plus community stop smoking drugs and dispensing costs. Hospital drug costs based on CURE costs and 3 months prescribing in 2019/20. Community SSS drug costs based on prorate of current com SSS drug costs and 2/12 drug costs for 2019/20. Any underspend on current community SSS drug budget not taken into account in these figures, so actual costs may be less. **From 21/22** Outpt and community MH SSSAs
	Com SSS drugs/dispensing	33,801	202,804				
	Acute outpt SSSA & MH com SSSA			93,134	93,134		
	Total	43,635	244,189	93,134	93,134		
CCG/NHSE funded				646,608	646,608		Inpt drug costs, community drug costs and inpt SSSA and SSS manager Acute and MH Trusts
Total		43,635	244,189	739,742	739,742	NHSE funded	NB:- Drug costs for pts having support from community mental health SSSAs, and any increase in referrals to community SSSAs from outpatients have not been estimated and will be additional to the costs given

APPENDIX 1

South Yorkshire and Bassetlaw Integrated Care System

Treatment of Tobacco Dependency in Acute and Mental Health Secondary Care

QUIT Business Case Briefings by Organisation – Barnsley

June 2019

Dr Lisa Wilkins, Consultant in PHM, Caroline Burrows, QUIT Programme Manager, Karen Smith, Prevention Programme Manager, QUIT Project Manager

South Yorkshire & Bassetlaw Integrated Care System

Aims of the briefing pack

This pack provides summary information by organisation of the key implications of the QUIT business case to enable organisations to understand their part in the QUIT programme and the estimated financial implications.

The pack brings together the personalised briefings for all of the organisations in each Place in South Yorkshire and Bassetlaw, to facilitate understanding at a place level as to who is responsible for what elements.

We have also listed the areas where Places need to make some urgent decisions / take immediate action.

All organisations should read section A before reading the briefing for their organisation. This pack should be read in conjunction with the full QUIT business case.

Contents

		Page
A.	Introduction and Overview of the QUIT programme	2
B.	Briefing Paper for Acute Trusts	6
C.	Briefing paper for Mental Health Trusts	10
D.	Briefing paper for Local Authorities	15
E.	Briefing paper for Clinical Commissioning Groups	18

Abbreviations:

CCGs – NHS Clinical Commissioning Groups
DPH – Director of Public Health
HHPM – Healthy Hospital Programme Manager
GM CURE – the Greater Manchester version of QUIT
ICS – Integrated Care System
LAs – Local Authorities
Inpt – In patient
MH – Mental health
Outpt – Out patient
SSM – Stop Smoking Manager
SSS – Stop Smoking Service
SSSA – specialist stop smoking advisor
SYB – South Yorkshire and Bassetlaw
T&F – task and finish groups
TTA – drugs to take home from hospital
WTE – whole time equivalence
YCR – Yorkshire Cancer Research

A. Introduction and Overview of the QUIT programme – Applicable to all organisations

What is the QUIT programme all about?

- QUIT is the **systematic implementation, at scale, of the treatment of tobacco dependency in secondary care** and the provision of ongoing support for people to QUIT smoking from community stop smoking services or the specialist mental health stop smoking advisors.
- The QUIT programme recognises that **tobacco dependence is a chronic, relapsing clinical condition** that prematurely kills at least half of people who smoke. **Smoking is seen as a medical condition that can be treated, rather than as a lifestyle choice.**
- The QUIT programme will be implemented at scale **in all Acute and Mental Health Trusts** in South Yorkshire and Bassetlaw, starting in January 2020.
- The QUIT programme is the first element in a broader **Healthy Hospital Programme**, that will encompass the **other prevention priorities within the Long Term Plan** that relate to Trusts eg alcohol care teams, active transport and air pollution, healthy hospital standards.

The QUIT programme is in line with commitments given in the **NHS Long Term Plan** that:

- By 2023/24, **all people admitted to hospital who smoke will be offered Ottawa style NHS-funded tobacco treatment services** (ie the QUIT programme), with a modified programme for **expectant mothers**, and their partners.
- There will be a new universal smoking cessation offer as part of **specialist mental health services** for long-term users of specialist mental health, and in **learning disability services.** On the advice of PHE, this will include the option to switch to **e-cigarettes while in inpatient settings.**

Why are we doing this?

- Tobacco dependence is a **chronic, relapsing clinical condition** that prematurely kills at least half of people who smoke
- It is a **major cause of health inequalities** in SYB and accounts for much of the 15 – 20 year **gap in life expectancy** between the general population and people with **severe mental illness**
- SYB Clinical Commissioning Groups currently **spend over £26m** a year on smoking related admissions
- There is a really **strong evidence base** on how to treat tobacco dependency – we have very effective drugs & methods to support people to stop smoking
- Helping people stop smoking **saves lives** and **decrease NHS and care demand**, including a decrease in non-elective admissions
- Treating tobacco dependency has an **immediate positive impact** on a person's health and risk of further admissions
- It **saves money**
- **And it's a Long Term Plan 'Must Do'**
- Greater Manchester's CURE programme has shown the Ottawa model **can be successfully delivered in the current NHS**
- **SYB** has opportunity to be the **forerunner for adapting the model for NHS secondary care mental health services**
- **Strong clinical support – "the right thing to do"**
- It provides a strong statement that we as an ICS are **committed to prevention**
- The QUIT programme will form a central pillar to **NHS Long Term Plan response on health inequalities**
- **It's a tangible demonstration of what the ICS is about and can achieve that involves a wide range of front line staff**

Treating Tobacco Dependency is Our Business

The **Royal College of Physicians:**

- sees **preventing smoking** as the **highest priority in medicine**

and

- **the failure of clinicians and systems to offer the cost effective stop smoking treatments as unethical and negligent.**

As doctors we must recognise that **treating** tobacco dependence effectively and routinely **is our business.** Smoking cessation should be incorporated, as a priority, as a systematic and opt-out component of all NHS services, and delivered in smoke free settings. It **is unethical to do otherwise.** Prof Jane Dacre, President, RCP

Health service commissioners & practitioners have a responsibility to ensure that cost effective smoking interventions are provided and properly implemented. Failure to identify and treat smokers is **no less negligent that failure to identify & treat patients with cancer**. System failure is no less negligent in this respect than individual failure. RCP Hiding in Plain Sight

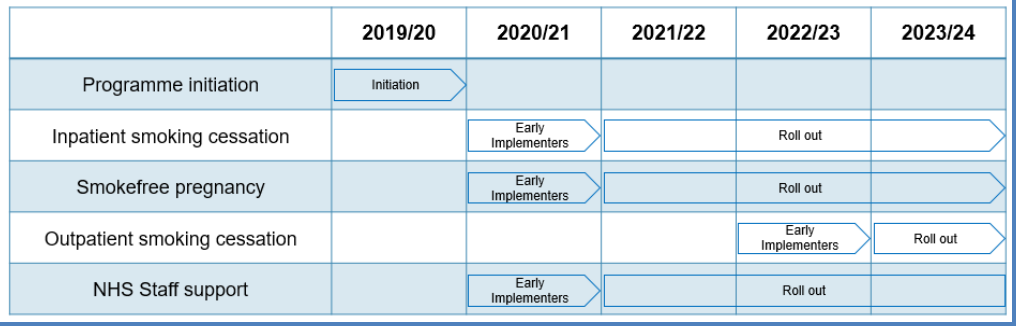
Anticipated outcomes in SYB if the Ottawa outcomes are replicated in SYB for patients who have an admission in an Acute Trust by CCG.

(1) Non elective admissions, transfers and elective admissions, LOS 0 and ≥1, (Day cases and Maternity excluded), aged > 15 years, Assumes 20% spells smokers, full year activity, SYB CCG patients only	Reduction by CCG					
(2) The 2017/18 Department of Health Reference Costs state that an average non-elective hospital admission costs £1,603 and A&E attendance £160.	**Barnsley**	**Bassetlaw**	**Doncaster**	**Rotherham**	**Sheffield**	**Total**
Estimated number SYB spells who are smokers (1)	7,081	2,666	8,412	6,385	13,310	37,853
Mortality at 1 year	425	160	505	383	799	2,271
Mortality at 2 years	**510**	**192**	**606**	**460**	**958**	**2,725**
Readmission at 30 days	439	165	522	396	825	2,347
Readmission at 1 year	828	312	984	747	1,557	4,429
Quit rates at 6 months	1,062	400	1,262	958	1,996	5,678
ED attendances	319	120	379	287	599	1,703
Saving on readmission costs at one year	£1,327k	£500k	£1,578k	£1,198k	£2,496k	£7.1m
Saving on ED costs at 30 days	£51k	£19k	£61k	£46k	£956k	£273k
Total savings from admissions within a year and ED within 30 days (gross)	£1.4m	£519k	£1.6m	£1.2m	£2.6m	£7.4m

When is the Long Term Plan NHSE funding for this going to become available?

NHSE funding will be available in future years in line with the timetable that will be published in the Long Term Plan Implementation Framework. Our understanding is that the funding will go to commissioners, probably as part of the CCGs baseline allocation.

The national NHSE programme manager has given an indicative timeline for when it is anticipated that the NHSE funding will be available. Within the roll out periods the amount of funding will increase for that programme area in an incremental manner. The amount of funding that will be available in each of the years has not yet been confirmed.



Who will be paying for the different elements of the QUIT programme? See table 16 and 17 in the b'ness case for details		
	19/20 and 20/21	**21/22 onwards**
SYB QUIT Programme Manager SYB QUIT Clinical Leads	Cancer Alliance	ICS
SYB part time Project Manager for 15 months	ICS	-
SYB Comms and Engagement part time post	Yorkshire Cancer Research	-
Set up costs for development of the online training modules and shared materials	ICS	-
Contribution in kind for senior communications and engagement advice/supervision, admin support, input from the Consultant in Public Health Medicine and analytical support via the Hosted Clinical Networks.	ICS	ICS
Healthy Hospital Programme Manager for each Acute and Mental Health Trust	ICS	Acute and Mental Health Trusts
Hospital based Stop Smoking Manager for each Trust Admin support for the Healthy Hospital Programme Manager and Hospital Stop Smoking	ICS	CCGs / NHSE
Hospital based specialist stop smoking advisors: • Acute Trusts (including Sheffield Children Hospital) - inpatient and outpatients • Mental Health Trusts - Covering inpatients, community and home-based support services, community mental health and learning disability teams	Yorkshire Cancer Research	CCGs / NHSE
Inpatient pharmacotherapy and 3 weeks of a 4 week TTA	Acute / Mental Health Trusts	CCGs / NHSE
Week four of the TTA	CCGs	CCGs / NHSE
Contributions in kind - areas such as: • Clinical and managerial leadership • Comms and engagement expertise, Staff training • Pharmacy staff time • IT support • Staff asking smoking status, recording CO levels, provision of very brief advice, offering and providing NRT, referral and liaison with specialist stop smoking advisors	Acute / Mental Health Trusts	Acute / Mental Health Trusts
Increase in community stop smoking advisors	Local Authorities	Local Authorities / NHSE
Community pharmacotherapy and dispensing fees – increase in costs above current SSS drug budget	CCGs	CCGs / NHSE
	CCGs need to agree with LA a baseline figure above which they will fund the extra drug costs	
Community pharmacotherapy and dispensing fees for pts having support from mental health SSSAs post discharge/in community	CCGs	CCGs / NHSE

When will we know if the Yorkshire Cancer Research Application has been successful?

	Date
Application form submitted	14 June
Any amendments requested would need to be made by	11 July
Date of Strategy Impact Group	24 July
Timeline within which to make any requested amendments	23 Aug
YCR Board meeting	11 Sept

What support will be available from the central ICS team?

Key contacts are:

Caroline Burrows – QUIT Programme Manager
caroline.burrows@nhs.net

Karen Smith – QUIT Project Manager

k.smith60@nhs.net

Dr Lisa Wilkins – Consultant in Public Health Medicine
lisa.wilkins2@nhs.net

Sally Barber – Admin Support

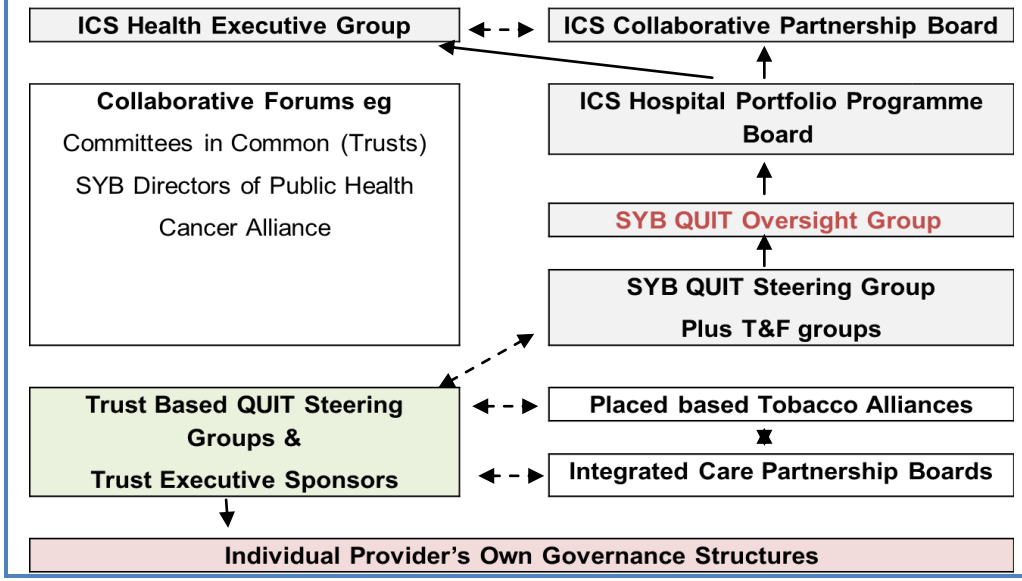
Sally.barber6@nhs.net

QUIT Clinical Leads - TBA

The QUIT project team are writing a detailed **project plan**. **Initial** areas of focus for the team include:

1. **Liaison with Yorkshire Cancer Research -** Submission of YCR funding application. If application successful, negotiation of award agreement including KPIs, monitoring and comms/marketing arrangements
2. **Liaison with all relevant partners** (CCGs, LA, Trusts, current SSSs) **and updating of senior committees**
3. **Establish and support short term task and finish groups** – eg evaluation; comms; clinical pathways/guidelines inc pharmacy; e-learning; mental health
4. **Writing of service specification for Trusts** and discussion with **CCGs and LAs re commissioning, contracting & finance arrangements**
5. Co-development with Trusts**, LA & SSS standard job descriptions for HHPM, Trust based SSS, Trust based SSSAs**
6. **Appointment of SYB clinical leads**
7. Continue to **support Trust based QUIT steering groups**

What is the ICS Governance for the QUIT Programme?



Oversight Group	Steering Group
SRO - Dr Richard Jenkins (chair)	SYB QUIT Clinical Leads - TBA
Lead DPH – Julia Burrows	Trust Health Hospital Programme Managers/QUIT leads
QUIT Exec Sponsors	
SYB QUIT Clinical Leads - TBA	LA Tobacco Leads
CCG CFO – Jackie Mills	Stop Smoking Service reps
Cancer Alliance Programme Director – Julia Jessop	? A CCG representative
Yorkshire Cancer Research Rep	
SYB ICS QUIT Programme Manager – Caroline Burrows	
SYB ICS Consultant in PHM – Dr Lisa Wilkins	
SYB QUIT Project Manager – Karen Smith	
3 – 4 monthly	6 weekly

B. Briefing for Acute Trust – Barnsley Hospital NHS Foundation Trust (BHNFT)

What is the role of Acute Trusts in the QUIT Programme?

Admissions (7 day service)

- Systematically ask pts on admission if they smoke & check CO level
- To offer smokers very brief advice and NRT on admission
- To automatically refer patients who smoke to Trust based specialist stop smoking advisors (SSSAs) for specialist support while an inpatient
- To provide pharmacotherapy while the patient is in hospital and a four week TTA
- To ensure the smoker has a clear tobacco dependency treatment plan and post discharge follow up arranged including an initial FU phone call by the Trust based advisor
- To provide a post discharge SSSA call to smokers who were discharged before they had been seen by the SSSA
- To offer advice to parents of children who have been admitted who smoke and signpost to community based stop smoking services

A&E, outpatients and day cases

- To systematically ask pts if they smoke, offer very brief advice & signpost to community stop smoking services
- For selected high priority care pathways eg preoperative clinics, respiratory, cardiology and pts having cancer treatments, refer to Trust based SSSAs. Trusts have flexibility as to how they prioritise the use of the outpatient SSSA capacity

Maternity services

- Smoking support in pregnancy and for partners is covered in the better birth work stream and not included in the QUIT business case

Trust staff who smoke

- Staff policies **support all hospital staff to quit** or remain tobacco-free during working hours
- Offer **tobacco dependency treatment** including smoking cessation support and appropriate short-term medication

Smoke free sites

- All the hospitals in SY&B be truly **smoke free zones**

Which patients does the QUIT programme apply to?

- **Elective and non-elective admissions of any length of stay** (excluding maternity – smoking in pregnancy pathways apply)
- **Priority outpatient pathways** – Trusts have flexibility on how they best use the outpt SSSA capacity. It is suggested that this could be focused to eg surgical, cancer, respiratory and cardiology pathways
- **Parents of children who have been admitted** – initial advice and signposting to community SSSs
- **Day cases** – have **not been included within the modelling.** These patients should have their smoking status asked by GPs at time of referral. Surgical patients should be signposted to community stop smoking services or the Trust based stop smoking advisors during their work up for surgery
- **All patients in all settings should be asked whether they smoke, offered very brief advice including sign posting to community SSS** if they do not fall into one of the above cohorts

What staffing is included in the business case for our Trust to support the QUIT Programme?

- **Healthy Hospital Programme Manager (HHPM) – funding from 1 Sept 2019**
- **Band 8a 1 wte**
- Standard SYB job description, that will be developed collaboratively
- To be **employed by the Trust**
- First priority QUIT, but then responsibilities broaden out to include the other healthy hospital programme areas eg alcohol care teams, active transport, healthy hospital standards
- Page 24 of the QUIT b'ness case details key elements of the role

Trust Based Stop Smoking Manager (SSM) - funding from 1 Dec 2019

- **Band 6, 1 wte**
- Standard SYB job description, that will be developed collaboratively
- Could be **employed by the Trust or be an in-reach service from local community SSS**
- Key role in staff training and management of Trust base SSSAs
- Page 25 of the QUIT b'ness case details key elements of the role

Trust Based Stop Smoking Specialist Advisors (SSSAs) - Funding from 1 Dec 2020

- **Band 3, total 4.27 wte**
  - Inpatients, including one phone call post discharge – 3.07 wte
  - Outpatients – 1.2 wte
- Could be **employed by Trust or be an in-reach service from local community SSS**
- 7 day service for inpatients
- Standard SYB job description, that will be developed collaboratively for Trusts wishing to employ their own SSSAs

Administrative Support – Funding from 1 Sept 2019

- **Band 3, 1 wte**
- To support the Healthy Hospital Programme Manager and Trust based SSS

Modelling predictions for BHNFT

We estimate that there are just under 30,000 **admissions to BHNFT in the QUIT pt cohorts**, of which about 20% - 6,000 **- will be smokers**. Based on GM CURE data, we predicted that just over 4,000 **inpts will take up the offer of NRT** and **600 varenicline** as an inpatient. 3,335 pts **will see a stop smoking advisor during their admission** and a further 910 who were discharged prior to seeing SSSA will have a call from a SSSA post discharge.

An estimated **1,567 will QUIT smoking at four weeks.**

From Table Five in the b'ness case - Modelling of QUIT Pathway for Acute Trusts Inpatient Adult Activity: Number of Smokers, Uptake of QUIT Pathway and Number of Quits

	Assumptions		**BHNFT**	**Notes**
Number of spells	Non elective, transfers &, elective, with LOS 0 and ≥1, excluding day case and mat, > 15 yrs age, Dec 17 - Nov 18, HES, Dr Foster	**Total**	**29,910**	
		0 LOS	7,679	
		≥ 1 LOS	22,231	
Number Smokers	Assumes 20% spells smokers	**Total**	**5,982**	BTS estimates 25% of spells are smokers. SYB CQUIN finding about 14% self-reported smokers - lower than our population prevalence. We will be doing CO monitoring that will identify more than the self-reported numbers. 20% is a conservative estimate but some spells will be readmissions of pts who are already taking NRT products and having SSS support etc.
		0 LOS	1,536	
		≥ 1 LOS	4,446	
Seen by stop smoking advisor as inpt	Assumes 75% of all smokers with LOS ≥1	≥ 1 LOS	3,335	Pts will be referred automatically but some patients will be discharged before being seen, others will be too unwell (eg end of life care, ITU, severe dementia)
Number of smokers taking up NRT	54% of all smokers admitted (all LOS)	Total	4,038	Based on GM CURE three months figures, breakdown by 0 and ≥1 not available
Numbers of smokers having varenicline	10% of all smokers admitted	Total	598	From GM CURE data, breakdown by LOS not available
Receives one post discharge phone call from hospital based team	Assumes 65% of smokers with LOS ≥ 1	≥ 1 LOS	2,890	
0 LOSs Contacted post discharge by hospital based SSSA as not seen while inpt	Assumes 60% of smokers with LOS 0	0 LOS	921	
Number of inpt smokers referred on to Community Stop Smoking Services	Assumes:	Total	2,377	
	10%	0 LOS	154	
	50%	LOS ≥ 1	2,223	
Number of referrals per week			46	
Number of 4 week quits (for pts who had had an inpt admission)	47%	**Total**	**1,567**	From GM CURE 5 month data - 47% of those who see specialist stop smoking advisor in hospital

What are the financial commitments for the Acute Trust? See page 4 for an overview of who is paying for the different elements of the QUIT programme

BHNFT All costs given at 2019/20 values	**19/20**	**20/21**	**21/22 onward**
Inpt pharmacotherapy costs plus 3 weeks of a 4 week TTA*	£31,603	£126,411	CCG/NHSE
Contributions in kind areas such as: ▪ Clinical and managerial leadership, Comms and engagement expertise ▪ Staff training ▪ Pharmacy staff time, IT support ▪ Staff asking smoking status, recording CO levels, provision of very brief advice, offering and providing NRT, referral and liaison with specialist stop smoking advisors	BHNFT	BHNFT	BHNFT
Health Hospital Programme Manager and Health Hospital Programme Officer (1 wte band 8a mid point plus on costs)	Funded by ICS		£58,225
*Estimated costs based on pro-rata GM CURE actual pharmacotherapy costs, 3 months costs for 19/10 Figures do not take into account existing pharmacotherapy costs, so actual increase in cost will be less **NB:- 2019/20 CQUIN includes provision of NRT. Value of the BHNFT CQUIN for two tobacco elements of the CQUIN for 19/20 is £253,982**			

Note: CCGs picking up the inpt drug costs and 3 weeks of the TTA from 21/22 onwards is dependent on Trusts having demonstrated good levels of implementation during 2020/21. If Trusts continue to have a CQUIN that covers NRT costs, this would need to be factored in. **CCGs will also pick up the ICS / YCR costs of the SSSM, SSSAs and admin from 21/22, assuming good levels of implementation in 2020/21.**

What other commitments will the Acute Trust have?

- **Trust's Exec Sponsor for QUIT to be on QUIT Oversight Group**
- **To submit an implementation plan** to the ICS demonstrating how the **partners at Place will work together** to implement QUIT
- **To work collaboratively across SYB to co-design and implement the same core QUIT clinical pathway,** clinical guidelines and supporting resources such as e-learning package
- To **deliver the programme in line with the QUIT service specification** (to be written in line with the b'ness case and milestones & KPIs TBA with YCR). CCGs are being asked to include the service specification in Trusts contracts, with a contract variation being made for this year
- To collect an **agreed SYB / YCR data set** and participate in the **monitoring/evaluation of the programme**
- **Abide by the (to be agreed) YCR communications and marketing requirements, including staff funded by them being recognisable as funded by YCR eg lanyards, badges**
- **Healthy Hospital Programme Managers** will have a **common job** description and will all take a **lead for the system** for certain aspects of the programme
- **To identify a Trust clinical lead for QUIT and free up time in their job plan to undertake the role**
- **Support a culture shift that** views smoking as a chronic relapsing medical condition **– tobacco dependency - that can be treated**

Key timelines – see table 4 page 36 of B'ness case for more information

The current timelines given in the business case for BHNFT are:

	Post commences	Funding available from	Comments
Healthy Hospital Programme Manager and Healthy Hospital Programme Officer (band 7	Sept – Nov 2019	Sept 2019	
Admin support (for HHPM & Trust based SSS)	Sept – Nov 2019	Sept 2019	
Trust based stop smoking managers (band 6)	Dec 2019	Dec 2019	The timeline currently in the QUIT B'ness case is the same as for STH, SCH and DBTH and a month earlier than for TRFT.
Trust based SSSAs	Dec 2019	Dec 2019	
QUIT patient intervention rolled out at scale	Starting Jan 2020		

What do we need to be doing / considering now?

- Take the QUIT **business case** through the Trust's **internal Governance** and let the ICS know your support by 5th **July**
- Also by 5th July:
  - Agree with your **Local Authority DPH** whether the Trust will **employ the Trust based Stop Smoking Manager and SSSAs or whether you would like an in reach service** from the community stop smoking service
  - Workout **what implementation timeline** will work for the Trust and community stop smoking service. **Let ICS know** when you would want the funding for the Trust based posts / in reach SSSAs to start.
- Establish a **Trust based QUIT steering group** if you do not already have one and agree **internal governance structure** for QUIT
- Identify an **overall clinical lead for QUIT** for your Trust and free up time in their **job plan** to undertake the role
- Identify a **line manager** for the Healthy Hospital Programme Manager and consider whether you would like to have a **collaborative recruitment process** for the post
- Identify **directorate / specialty leads for QUIT – both clinical & programme management**
- **Identify an office base for the HHPM and Trust based SSS**
- **Contribute to the SYB collaborative work** eg development of clinical pathway, clinical and prescribing guidelines, e-learning package
- **Begin to think about** how you would like to **utilise the outpatient SSSA capacity**
- Will need to have negotiations with relevant pharma companies for **discounts on varenicline and NRT products** - agree SYB prescribing guidelines first and then ? do we do this collaboratively or each Trust individually

C. Briefing for Mental Health Trusts – South West Yorkshire Partnership Foundation Trust (SWYFT)

What is the role of Mental Health Trusts in the QUIT Programme?

Smoke free site – be **truly smoke free on all sites**

Supporting staff to quit:

- Staff policies **support all hospital staff to quit** or remain tobacco-free during working hours
- **Provide tobacco dependency treatment to staff who wish to quit**

Inpatients – all ages

- Provide support to **reduce harm from tobacco** and assist patients with being smoke free during an inpatient admission (**temporary abstinence**) and if they wish **support to quit**
- Provide an option for patients to switch to an **e-cigarette** whilst in MH **inpatient settings** (over 18s), in line with the NHS Long term Plan
- Facilitation of **smoke free environments**, including attention to wider elements of physical health promotion, and activities to help to take the place of smoking
- **Role of the specialist advisors within mental health will differ from those in acute care,** in that as well as providing **smoking cessation assessment and interventions,** they will also:
    - **Provide advice and support to ward staff** – many patients with SMI will be too unwell to interact with the SSSAs for much of their inpatient stay. The SSSA will advise ward staff on appropriate pharmacotherapy and the pts tobacco dependency treatment plan. This may focus on **temporary abstinence** during an admission (for people who do not or may not want to quit at that stage).
    - Ensure **robust discharge planning** for the pts ongoing specialist stop smoking support for patients wishing to quit or have an ongoing harm reduction programme.
    - Reinforce the training provided to inpatient teams by the Healthy Hospital Programme Manager and Stop Smoking Manager to reduce harm from tobacco and the **promotion of smoke free settings**.

Community and home-based support services, community mental health and learning disability teams

- For people with severe mental ill health the **stop smoking specialist support** (assessment and intervention), both while an **inpatient and in community settings** will be delivered by **Trust specialist mental health smoking cessation advisors.**

Admissions

- Systematically ask pts on admission if they smoke & check CO level if feasible to do so
- Offer smokers NRT or e-cigs on admission
- Automatically refer patients who smoke to a Trust based specialist stop smoking advisors (SSSAs) for specialist support while an inpatient
- Provide pharmacotherapy / e-cigs while the patient is in hospital and a four week TTA
- Ensure the smoker has a clear tobacco dependency treatment plan and post discharge follow up arranged with the MH SSSAs if they wish to continue a harm reduction or quit attempt
- To offer advice to parents of children who have been admitted who smoke and signpost to community based stop smoking services

Community and home-based support services, community mental health and learning disability teams

- To systematically ask pts if they smoke, offer very brief advice &:
    - Refer to mental health SSSAs if pt has SMI and would like harm reduction or quit support
    - Signpost to community SSS is pt has low level mental health problems
-

Which patients does the QUIT programme apply to?

- **Elective and non-elective admissions of any length of stay** to the mental health trust
- **Community and home-based support services, community mental health and learning disability teams**
- **Parents of children who have been admitted** – initial advice and signposting to community SSSs

What staffing is included in the business case for our Trust to support the QUIT Programme? These are for Barnsley patients

Healthy Hospital Programme Manager (HHPM) – funding from 1 Sept 2019

- **Band 8a 0.4 wte**
- Standard SYB job description, that will be developed collaboratively,
- **Employed by the Trust**
- First priority QUIT, but then responsibilities broaden out to include the other healthy hospital programme areas eg alcohol care teams, active transport, healthy hospital standards
- Page 24 of the QUIT b'ness case details key elements of the role

Trust Based Stop Smoking Manager (SSM) - funding from 1 Dec 2019

NB:- The Trust may prefer to combine the band 8a and band 6 roles into one post with more wte

- **Band 6, 0.4 wte** (30% pt contact, 70% training, management, coordination)
- Standard SYB job description, that will be developed collaboratively
- Could be **employed by the Trust or be an in-reach service from local community SSS**
- Key role in staff training and management of Trust base SSSAs
- Page 25 of the QUIT b'ness case details key elements of the role

Trust Based Stop Smoking Specialist Advisors (SSSAs) - Funding from 1 Jan 2020

- **Band 3, total 2.5 wte,** 5 day service
- To be used flexibly as to what proportion of this capacity will be needed for inpts and what proportion for pts post discharge/community based MH referrals, until the pathways bed in and it becomes clearer the relative demands of the different elements of the pathway.
- Could be **employed by Trust or be an in-reach service from local community SSS**
- Standard SYB job description, that will be developed collaboratively for Trusts wishing to employ their own SSSAs

Administrative Support – Funding from 1 Sept 2019

- **Band 3, 0.2 wte**
- To support the Healthy Hospital Programme Manager and Trust based SSS

Modelling for Mental Health Trusts – SWYFT

Warning about modelling data: Unlike for the Acute Trusts, we do not have any comparator studies to help inform the inpatient mental health pathways. For number of QUITs in the community we have extrapolated results from SCIMITAR but that trial recruited patients with mental health conditions who were in the community who had expressed an interested in stopping smoking. Hence, their results may not be directly transferable to the QUIT programme. NHS digital also gives a warning about the data quality of the mental health commissioning data, so baseline data on number of admissions may not be accurate.

An estimated 186 Barnsley CCG mental health pts who smoke are admitted to SWYFT each year. The business case allocated 2.5 wte stop smoking advisors to SWYFT. If 30% of this capacity is used to cover inpatien that is 0.8 wte. That leaves 1.8 wte SSSAs to work with pts with severe mental illness post discharge or through referrals from community based mental health services. Assuming an average of 7.3 hrs of SSSA time per pt, 335 pts could be supported in the community per year. Assuming a QUIT rate of 15.2% (as per the SCIMITAR trail) this would give 51 quits per year.

Table six Numbers of people in contact with or admitted to secondary care mental health services and estimated number of smokers

Source: NHS Digital via PHE Severe Mental Illness dashboard. NB: NHS Digital gives a warning about the data quality of these data sets

	Time period	Barnsley CCG
Number of people on GP QOF Severe Mental Illness Registers (schizophrenia, bipolar affective disorder and other psychoses, all ages)	2017/18	2,056
Number of people in contact with adult secondary care mental health services (18 yrs +, excludes learning disability services)	End quarter 3 2018/19 snap shot	5,350
Number of Adult Inpt Admissions to Secondary Mental Health Services (all ages, includes learning disability services)	Quarter 4 2017/18 to Quarter 3 2018/19	310
Estimated number of people admitted who are smokers	Assumes 60% are smokers	**186**

Note: RDASH, SWYFT and Notts Health Care also cover non SYB patients so data given by CCG rather than by Trust

Number of stop smoking advisors, number of patients supported and estimated number of QUITs (from table 7 in business case) – Barnsley pts		
1. Total WTE SSSAs SWYFT	2.5	
2. Capacity for support in the community If 70% of total capacity for community based support, WTE SSSA	1.8	
Num pts supported in the community (assuming average of 7.3 hrs each)	335	Assumes 192 pts per yr can be supported by 1 wte, average of 7.3 hrs of support per pt, see table 7a of QUIT b'ness case for details of suggested FU protocol/staffing time
Capacity for support for inpatients If 30% of total capacity for inpts, WTE SSSA	0.8	
3. Number quits at 12 months assuming 15.2% quit rate	51	Quit rate as per in the SCIMITAR trial, assumes all patients who quit who were an inpt were referred on to community mental health SSSAs and no other quits.

What are the financial commitments for the Mental Health Trust? See page 4 for an overview of who is paying for the different elements QUIT

SWYFT All costs given at 2019/20 values	19/20	20/21	21/22 onward
Inpt pharmacotherapy +/- e-cigs costs plus 3 weeks of a 4 week TTA	Not yet estimated		Paid by CCG / NHSE
Contributions in kind areas such as: ▪ Clinical and managerial leadership, Comms and engagement expertise ▪ Staff training ▪ Pharmacy staff time, IT support ▪ Staff asking smoking status, recording CO levels, provision of very brief advice, offering and providing NRT, referral and liaison with specialist stop smoking advisors	SWYFT	SWYFT	SWYFT
Healthy Hospital Programme Manager and Healthy Hospital Programme Officer (0.4 wte band 8a mid point plus on costs)	Funded by ICS		18,532
Would be 3 months drug costs for 19/10, assuming Jan start date NB:- 2019/20 CQUIN includes provision of NRT. Value of the SWYFT CQUIN for two tobacco elements of the CQUIN for 19/20 **is** £69,519 from Barnsley CCG			

Note: CCGs picking up the inpt drug costs and 3 weeks of the TTA from 21/22 onwards is dependent on Trusts having demonstrated good levels of implementation during 2020/21. If Trusts continue to have a CQUIN that covers NRT costs, this would need to be factored in. **CCGs will also pick up the ICS / YCR costs of the SSSM, SSSAs and admin from 21/22, assuming good levels of implementation in 2020/21.**

What other commitments will the Mental Health Trusts have?

- **Trust's Exec Sponsor for QUIT to be on QUIT Oversight Group**
- **To submit an implementation plan** to the ICS demonstrating how the **partners at Place will work together** to implement QUIT
- **To work collaboratively across SYB to co-design and implement the same core QUIT clinical pathway,** clinical guidelines and supporting resources such as e-learning package
- To **deliver the programme in line with the QUIT service specification** (to be written in line with the b'ness case and milestones & KPIs TBA with YCR). CCGs are being asked to include the service specification in Trusts contracts, with a contract variation being made for this year
- To collect an **agreed SYB / YCR data set** and participate in the **monitoring/evaluation of the programme**
- To explore different ways of **increasing access to e-cigs for inpatients, including exploring provision of free NRT**, and participate in an **evaluation** of this
- **Abide by the (to be agreed) YCR communications and marketing requirements, including staff funded by them being recognisable as funded by YCR eg lanyards, badges**
- **Healthy Hospital Programme Managers** will have a **common job** description and will all take a **lead for the system** for certain aspects of the programme
- **To identify a Trust clinical lead for QUIT and free up time in their job plan to undertake the role**
- **Support a culture shift that** views smoking as a chronic relapsing medical condition **– tobacco dependency - that can be treated**

Key timelines – see table 4 page 36 of B'ness case for more information

The current timelines given in the business case for SWYFT are:

	Post commences	Funding available from
Healthy Hospital Programme Manager	Sept – Nov 2019	Sept 2019
Admin support (for HHPM & Trust based SSS)	Sept – Nov 2019	Sept 2019
Trust based stop smoking managers (band 6)	Dec 2019	Dec 2019
Trust based SSSAs	Jan 202	Jan 202
QUIT patient intervention rolled out at scale from	Starting Feb 2020	

Timelines for SH&SC for commencement of the SSM, SSSAs and Quit roll out is currently given in the b'ness case as one month ahead of the other mental health trusts.

What do we need to be doing / considering now?

- Take the QUIT **business case** through the Trust's **internal Governance** and let the ICS know your support by **5th July**
- Also by 5th July:
  - Agree with your **Local Authority DPH** whether the Trust will **employ the Trust based Stop Smoking Manager and SSSAs or whether you would like an in reach service** from the community stop smoking service
  - Workout **what implementation timeline** will work for the Trust and community stop smoking service if opting for an in reach service. **Let ICS know** when you would want the funding for the Trust based posts / in reach SSSAs to start.
- Establish a **Trust based QUIT steering group** if you do not already have one and agree **internal governance structure** for QUIT
- Identify an **overall clinical lead for QUIT** for your Trust and free up time in their **job plan** to undertake the role
- Identify a **line manager** for the Healthy Hospital Programme Manager and consider whether you would like to have a **collaborative recruitment process** for the post
- Identify **directorate / specialty leads for QUIT – both clinical & programme management**
- **Identify an office base for the HHPM and Trust based SSS**
- **Contribute to the SYB collaborative work** eg development of clinical pathway, clinical and prescribing guidelines, e-learning package
- **Begin to think about** how you would **utilise the outpatient SSSA capacity**
- Will need to have negotiations with relevant pharma companies for **discounts on varenicline and NRT products** - agree SYB prescribing guidelines first and then ? do we do this collaboratively or each Trust individually

D. Briefing for Local Authorities - Barnsley

What is the role and non-financial commitments of LAs in the QUIT Programme?

- To ensure **that sufficient capacity has been commissioned within the community stop smoking** services to meet the **increased demand:**
  - **a)** of **referrals from secondary care** from Acute Trusts for **ongoing stop smoking support post discharge from hospital**
  - b) of **outpatients** who have been sign posted to community stop smoking services
  - c) of patients with **low level mental health problems** who have been sign posted from community mental health services eg IAPTs
  - d) **of parents** of children who have been admitted
  - e) in **self-referrals** of **family members** of patients trying to quit and **general public** following the publicity about QUIT.

  (Patients with severe mental illness ongoing support will remain with the mental health trust based SSSAs)
- To ensure that community SSS enable **consistency** of pathways between all the SYB hospitals & community SSSs regarding **at what point patients are handed over from hospital to community services**, (to prevent pts who receive their hospital care in a different Place from 'falling through the net').
- To ensure that community SSS contracts include the collection of an **agreed SYB / YCR data set** and that they participate in the programmes **monitoring/evaluation**
- To provide **public health tobacco expertise** (via LA Tobacco leads) to the **SYB and local Trust QUIT steering groups and to help coordinate the place plan and implementation.**
- **To contribute to a Place implementation plan,** that is submitted to the ICS demonstrating how the **partners at Place will work together** to implement QUIT.
- **To contribute to the collaborative SYB work to co-design and implement the same core QUIT clinical pathway,** clinical guidelines and supporting resources such as e-learning package.
- **To contribute to the QUIT comms and abide by the (to be agreed) YCR communications and marketing requirements**
- **Integrate** the QUIT programme in to **wider local tobacco control programmes/**work of local Tobacco Alliances.
- **To support a culture shift to viewing smoking as a chronic relapsing condition that can be treated, rather than lifestyle choice**
- **To have a lead DPH on the QUIT oversight group** (Julia Burrows, DPH for Barnsley Council)

What are the financial commitments of LAs in the QUIT Programme?

- **2019/20 and 2020/21 - To fund the additional specialist stop smoking advisors** needed in the **community stop smoking service** to meet the increased demand

NB:- The increased pharmacotherapy costs above the SSS's current pharmacotherapy budget/commissioned activity level **will be met by the NHS**

- **Trusts** will fund **inpt drug costs plus 3 weeks of a 4 week TTA. CCGs** will fund the **fourth week of the TTA**
- **CCGs will fund** the **additional costs incurred by Community Stop Smoking Services due to an increase in referrals from secondary care** from acute Trusts.
- CCGs will also fund the **associated additional dispensing costs.**
- As:
  - There is some secondary care activity currently occurring (to varying degrees between Trusts/community stop smoking services)
  - Some Stop Smoking Services have an underspend on existing pharmacotherapy budgets

  it is suggested that **CCGs who no longer hold the tobacco prescribing budget agree with their local stop smoking services and Local Authority tobacco leads a baseline sum, above which the CCGs would fund the additional drug and dispensing costs** incurred.
- **From 2021/22 NHSE funding will** start to come on line (see page 3). **LAs** will continue to **commission increased capacity** from the community SSS and **fund the community SSSA but LAs will receive their share of the NHSE funding** to help support this. CCGs will continue to fund the increase in pharmacotherapy costs as above
- **Contribution in kind:**
  - **Tobacco Lead time** to support local and SYB QUIT **implementation**
  - **Tobacco Lead, commissioning and contracting time** to amend service specification and contracts of SSS

Modelling for QUIT Referrals to Barnsley Community Stop Smoking Service

Referrals to Barnsley community stop smoking service (following inpt admission at an Acute Trust)		
Number of referrals per year (full year)	2,824 (54 per week)	See modelling for Acute Trusts for assumptions made for the number of referrals made by Trusts to community stop smoking service – page 7. NB:- The number of referrals made by the Trust to community SSS will be different to the number received by their local stop smoking service as some of the Trust patients will be from neighbouring Places and referred to other SSSs. Number of referrals to the community SSS, assumes community SSS catchment area is coterminous to CCG and thus prorata by the % all SYB spells that were from your local CCGs (excluding children, maternity and day cases). This figure will include patients who are already being referred to the community stop smoking service from acute trusts and thus will overestimate the new activity.
Number of 4 week QUITs	1,864	From GM CURE 5 month data - 47% of those who see specialist stop smoking advisor while inpt in hospital QUIT by 4 weeks.
Number WTE community SSSA needed	2.32	Assumes average of 1 hr of direct pt support plus 20 mins admin per referral Some patients will default from follow up, so the mean number of hours per patient who actually completes the programme will be higher than the 1 hr above. This number assumes that all of the referrals require additional capacity. Some community SSS are functioning below full capacity at the moment and some SSSA activity may be able to be redirected away from other activities to direct patient contact. Some SSSs may be able to switch to less intensive follow up U protocols to currently. Thus some increase in referrals may be able to be accommodated within current capacity.
Cost SSSA	To be locally determined	But if the stated number of WTE of SSSA were needed, based on top of band 3, (with no OOH supplements) it would be £59,059 pa

No modelling has been done for the:

- **Number of referrals from outpatients, low level community mental health services, self-referrals of family members or general public**

What is the estimated increase in pharmacotherapy costs for the community SSS? See above re **NHS funding for this NB- this is a guide only**

Estimated for referrals to Barnsley community stop smoking service following inpt admission at an Acute Trust – see tables 10 to 13 in b'ness case			
Current Community SSS:	**2019/20**	**20/21**	2 months costs for 2019/20 – assumes three months activity but one month being TTA **All costs given at 2019/20 values**
a) Drug spend / number pts setting quit date		£102.70	
b) Mean drug £ per pt per day		£1.22	12 weeks supply
Additional community SSS drug cost - Assuming pt has had a 4 week TTA and 2,546 referrals		**£178,446**	Based on the estimated drug cost per day of the current community SSS applied to estimated number of additional patients, taking account that the first few weeks of therapy will be provided by the Trust. These estimates do not take account of any activity already generated by secondary care referrals or any underspend on current community stop smoking drug budgets. They may thus be an **overestimate of additional cost**. 2 month drug costs in 2019/20.
Additional community dispensing fees		£24,357	Prorata from Barnsley dispensing costs for 2018, 2 month for 2019/20

No modelling has been done for the:

- **Drug costs from referrals from outpatients, low level community mental health services, self-referrals of family members or general public**

What do LAs need to be doing / considering now?

- Take the QUIT **business case** through the LAs **internal Governance** and let the ICS know your support by 5th **July**
- Also by 5th July let the ICS know:
  - Agree with your **Local Acute and Mental Health Trusts,** whether the Trusts will **employ the Trust based Stop Smoking Manager and SSSAs or whether they would like an in reach service** from the community stop smoking service
  - Workout **what implementation timeline** will work for the Trust and community stop smoking service. See timeline given for BHNFT and SWYFT in their sections above.
- **Work out with community stop smoking services how many additional referrals for ongoing support could be accommodated within existing commissioned Community SSS and how many additional community SSSAs will be needed**. Take in to consideration factors such as:
  - Current under performance compared to contracted activity levels
  - Whether some SSSA capacity could be redirected to direct patient contact
  - Whether the current support regimen could be streamlined to use less SSSA direct patient contact time eg greater use of phone calls, on line and text support
  - That patients referred after an admission in an acute Trust will already have had their initial assessment and one follow up call post discharge from the Trust based SSSAs
- **Ensure community SSS is aware of the implications of the QUIT programme** for them.
- **Amend service specifications for community SSS.**
- **Seek procurement advice** on whether the expansion in community SSSA activity +/- delivery of in reach service to the Trusts can be accommodated within a contract variation. If not, let Trusts and ICS know of likely reprocurement time lines as this will delay implementation of QUIT in the Trusts.
- **If the CCG does not currently hold the tobacco dependency budget, agree with the CCG a baseline sum above which the CCG will fund the additional pharmacotherapy and dispensing costs**
- **Contribute to the SYB collaborative work** eg development of clinical pathway, clinical and prescribing guidelines, e-learning package
- **Support local QUIT steering group and help co-ordinate actions at a local level across the acute and mental health Trusts, SSS, CCG and LA**
- **Reframe discourse around stopping smoking support as treating tobacco dependency** and view smoking as a chronic relapsing medical condition that can be treated

E. Briefing for CCGs - Barnsley

What is the role of CCGs in the QUIT Programme?

- To **champion the programme** at a local level
- **To contribute to a Place implementation plan,** that is submitted to the ICS demonstrating how the **partners at Place will work together** to implement QUIT.
- To **fund your contribution** of the programme as set out in the financial commitment box plus **continue to fund the national tobacco and alcohol CQUIN**
- **To have a lead CFO on the QUIT oversight group** (Jackie Mills)
- To include the **SYB QUIT service specification for Acute and Mental Health Trusts in their contracts**, undertaking a contract variation for 2019/20
- **Sheffield CCG will host the YCR funding** and **distribute to other CCGs / LAs for onward payment of providers** (subject to them meeting agreed milestones)
- To agree how we are best to **performance monitor implementation**, taking account of need to agree monitoring requirements and KPIs with Yorkshire Cancer Research if funding application successful
- **To contribute to the QUIT comms and engagement**
    - Utilising shared **common messages** co-developed with the ICS so that we get **better consistency in how QUIT is promoted and understood.**
    - **To take a lead on engaging with your partner practices and Primary Care Networks about QUIT**
    - **Abide by the (to be agreed) YCR communications and marketing requirements**
- **To contribute to the collaborative SYB work to co-design and implement the same core QUIT clinical pathway,** clinical guidelines and supporting resources such as e-learning package. Eg through provision **of medicines optimisation expertise**
- To contribute to the **evaluation and monitoring of the programme** eg through the provision of prescribing and other data, getting public feedback via your existing engagement channels
- **To support the prescribing of tobacco dependency pharmacotherapy drugs in primary care**
    - There may be some patients who commence NRT / varenicline while in hospital who would like to continue their quit attempt and pharmacotherapy post discharge but do not wish to have support from the community stop smoking service.
    - NICE guidelines recommend that if people opt out of a referral to local stop smoking support, that they are referred to a professional who can offer pharmacotherapy and very brief advice.
- CCGs may also like to encourage PCNs to ensure that their new post holders as **the additional roles are recruited all undertake training in the provision of Very Brief Advice** and where appropriate training in the prescribing of smoking cessation pharmacotherapy.

What are the financial commitments of CCGs in the QUIT Programme?

- **2019/20 and 2020/21** To fund:
  - **One week of the four week TTA** for tobacco dependency pharmacotherapy given by acute and mental health trust post discharge from an admission
  - The **increased pharmacotherapy and dispensing costs** above the **local community SSS's** current pharmacotherapy budget/commissioned activity level
    - It is suggested that **CCGs who no longer hold the tobacco prescribing budget agree with their local stop smoking services and Local Authority tobacco leads a baseline sum, above which the CCGs would fund the additional drug and dispensing costs** incurred.
  - The **pharmacotherapy and dispensing costs** of patients with **severe mental illness** being supported **in the community by the mental health SSSAs**
- **From 2021/22 NHSE funding will** start to come on line (see page 3). We understand that this will probably come to the CCGs as part of their baseline allocation.
  - In light of the reductions in admissions expected due to people stopping smoking, CCGs **growth forecast for acute admissions for 21/22 onwards will reduce**, '**releasing' the funding** to commission the **Trust based specialist stop smoking service managers, advisors, admin support and inpatient and community pharmacotherapy costs**. This will be **part funded by the NHSE funding** as it is incrementally introduced.
    - **CCGs picking up these costs is dependent on Trusts having demonstrated good levels of implementation during 2020/21.**
    - If Trusts continue to have a CQUIN that covers NRT costs, this would need to be factored in.
  - **Trusts** pick up the funding of the **Healthy Hospital Programme Managers**.
  - **LAs** continue to **ensure and fund sufficient capacity within community stop smoking services** but with **their share of the NHSE funding** as this is incrementally increased.

Estimated financial contribution from Barnsley CCG **(NB:- These are revised figures compared appendix 6 of the b'ness case. These more specifically individualise the costs to each CCG taking account of different SSS drug costs and different mental health staffing levels compared to appendix 6 that just prorated based on % of hospital admissions from that CCG)**

Barnsley		**2019/20**	**2020/21**	**21/22**	**22/23**	**23/24**	**All costs given at 2019/20 values, NB:- This is only a guide to likely drug costs**
CCG funded	1 week TTA - Acute	9,835	41,386				**19/20 and 20/21** one week of inpt TTA plus community stop smoking drugs and dispensing costs. Hospital drug costs based on CURE costs and 3 months prescribing in 2019/20. Community SSS drug costs based on prorate of current com SSS drug costs and 2/12 drug costs for 2019/20. Any underspend on current community SSS drug budget not taken into account in these figures, so actual costs may be less. **From 21/22** Outpt and community MH SSSAs
	Com SSS drugs/dispensing	33,801	202,804				
	Acute outpt SSSA & MH com SSSA			93,134	93,134		
	Total	43,635	244,189	93,134	93,134		
CCG/NHSE funded				646,608	646,608		Inpt drug costs, community drug costs and inpt SSSA and SSS manager Acute and MH Trusts
Total		43,635	244,189	739,742	739,742	NHSE funded	NB:- Drug costs for pts having support from community mental health SSSAs, and any increase in referrals to community SSSAs from outpatients have not been estimated and will be additional to the costs given

What do CCGs need to be doing / considering now?

- Take the QUIT **business case** through the CCGs **internal Governance** (if needed / not done so already) and let the ICS know your support by 5th **July**
- Consider whether you would like to have a **CCG representative on your local Trust QUIT steering groups** (communication to date has been via CQUIN leads)
- Consider whether the CCGs collectively would like a **representative on the SYB QUIT steering group**
- **If the CCG does not currently hold the tobacco dependency budget, agree with the LA a baseline sum above which the CCG will fund the additional pharmacotherapy and dispensing costs**
- **Contribute to the SYB collaborative work** eg development of clinical pathway, clinical and prescribing guidelines, e-learning package. The ICS team will ask for advice / support as needed
- **Reconsider and support the provision of tobacco dependency pharmacotherapy by primary care**
- **Reframe discourse around stopping smoking support as treating tobacco dependency** and view smoking as a chronic relapsing medical condition that can be treated

South Yorkshire and Bassetlaw Integrated Care System

Embedding the Treatment of Tobacco Dependency in Acute and Mental Health Secondary Care

QUIT Business Case

Yorkshire Cancer Research Funding Application Submission

June 2019

Dr Lisa Wilkins, Consultant in PHM

Caroline Burrows, QUIT Programme Manager

South Yorkshire & Bassetlaw Integrated Care System

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We would like to thank all of our colleagues on the SYB QUIT Steering Group, Local Authority Tobacco Leads, QUIT leads in the acute and mental health Trusts, Stop Smoking Service Managers and CQUIN leads in the CCGs for their support and input into the development of this business case. Also thanks to ICS colleagues, SYB medicines management leads, Jackie Mills, Deputy CFO of Sheffield CCG and Julia Burrows, Director for Public Health, Barnsley Council, for their input.

Abbreviations

A&E	Accident and Emergency
AOs	Accountable Officers
BHNFT	Barnsley Hospital NHS Foundation Trust
CCGs	Clinical Commissioning Groups
CEs	Chief Executives
CiK	Contribution in Kind
CQUIN	Commissioning for Quality and Innovation
DBTH	Doncaster & Bassetlaw NSH Foundation Trust
DGHs	Directorate General of Health Services
DPH	Director of Public Health
ED	Emergency Department
HEG	Health Executive Group – the decision making body of the ICS
Inpt	Hospital inpatient
LA	Local Authority
LOSs	Length of Stay
LTP	NHS Long Term Plan
NRT	Nicotine Replacement Therapy
NHSE	NHS England
OMSC	Ottawa model for smoking cessation
QOF	General Practice Quality and Outcome Framework
PHE	Public Health England
Pt	Patient
QUIT	Question, Understand, Inform, Treatment
RDASH	Rotherham, Doncaster and South Humber NHS Foundation Trust
SCH	Sheffield Children's Hospital
SH&SC	Sheffield Health & Social Care Trust
SSSA	Specialist Stop Smoking Advisers
STH	Sheffield Teaching Hospital
SYB ICS	South Yorkshire and Bassetlaw Integrated Care System
SWYPFT	South West Yorkshire Partnership NHS Foundation Trust
TRFT	Rotherham NHS Foundation Trust
TTA	To Take Away (drugs given on discharge from hospital)
WTE	Working Time Equivalent

Executive Summary

Introduction

Smoking is the **biggest cause of premature death and health inequalities** in South Yorkshire and Bassetlaw (SYB). It accounts for **half of the health gap** between the poorest and most affluent communities and is a major contributor to the **15 – 20 years gap in life expectancy** between people with a **severe mental health illness** and the general population.

Smoking is the single **biggest avoidable risk factor for cancer**. Tobacco smoke is estimated to be responsible for 15% of cancers in the north of England and 27% of all cancer deaths. For South Yorkshire, Bassetlaw and North Derbyshire Cancer Alliance this is **1,670 cancers** and **1,432 cancer deaths attributed to smoking each year**.[1]

Smoking cost SYB Clinical Commissioning Groups (CCGs) **£26.6 million** in **smoking attributable admissions** in 2016/17.[2]

Reducing the number of people smoking has a **very quick positive impact on both people's own health and on NHS and social care budgets.**

Supporting people to stop smoking is the quickest and most effective thing within the power of the NHS to do to support a reduction in health inequalities. It is also one of the **key actions** that the **NHS can do to reduce the incidence of cancer.**

Reducing the prevalence of smoking is **one of the most effective demand management measures for the NHS – with risk of hospital admission falling as soon as someone stops smoking.**

The British Thoracic Society estimates that **25% of patients admitted to acute hospital are smokers.** Smoking rates for people admitted to or using mental health secondary care are even higher **(approximately 60% of those admitted and 40% of people on the severe mental illness register smoke).**

There is a strong evidence base that the contact with secondary care provides an **ideal opportunity to support people to stop smoking**. When patient contacts in A&E, outpatients and community mental health services, as well as the opportunity to support staff who smoke are also considered, acute and mental health trusts have **contact with a high proportion of the local population who smoke each year**.

The NHS **Long Term Plan** gives a commitment that **all people admitted to hospital who smoke will be offered NHS-funded tobacco treatment services** based on the Ottawa model; And additionally, a new universal smoking cessation offer will also be available as part of **specialist mental health services** for long-term users of specialist mental health, and in learning disability services. On the advice of PHE, this will include the option to **switch to e-cigarettes while in mental health inpatient** settings

NHSE funding for this is expected to be **phased in from 2021/22.**

Treating tobacco dependency in the secondary care setting is:

- **Evidenced based**

[1] Source – NCRAS. Figures for SYBND cancer alliance do not include data for Bassetlaw, North Derbyshire and Hardwick CCG areas as it has not been possible to disaggregate data to this population level.

[2] PHE Local Tobacco Profile

- **Highly clinically effective – saves lives and reduces the incidence of cancer**
- **Saves money.**

The **CURE programme** in Greater Manchester has shown that the Ottawa model is 'doable' in NHS acute trusts and has shown impressive results.

South Yorkshire and Bassetlaw has the opportunity to be the **forerunner to demonstrate that the model can be adapted for use in NHS secondary care mental health settings** and to share this learning across the country. We will also **explore ways of increasing the use of e-cigarettes** as an aid to quitting smoking or as harm minimisation in **inpatients who smoke who have severe mental illness.**

The **SYB QUIT programme** (which is based on the Ottawa model) was endorsed for implementation by the Acute Federation Chief Executives in March 2019 and by the Accountable Officers of the CCGs in April 2019.

While we have **good commitment from the Trusts**, **implementation is being hindered by lack of resources**.

Yorkshire Cancer Research have expressed an interest in **funding the specialist stop smoking advisors** needed **within trusts** to implement the **QUIT programme in 2019/20 and 2020/21.**

Before taking a paper to their Strategy Impact Group in July and Board in September, the ICS needs to demonstrate that the ICS, Trusts, CCGs and Local Authorities will make an interim investment until the NHSE funding is available:

- To **cover the costs of other elements needed to implement QUIT** (eg coordination and management of the programme and specialist stop smoking advisors, release of staff for training, pharmacotherapy, specialist stop smoking support post discharge)

- To **cover costs of the specialist advisors from 21/22** if there is a delay to, or a shortfall in, the national NHSE funding that is due in 2021/22.

This paper builds a business case for the SYB ICS Health Executive Group for a partnership approach to add to the funding potentially available from Yorkshire Cancer Research to enable the implementation of the QUIT programme at pace and scale prior to the NHSE funding becoming available.

Outline and benefits of the programme

The QUIT programme is based on the Ottawa programme and entails a change of culture within secondary care, **considering tobacco dependency as a long term condition that can be treated**, rather than a lifestyle choice. The programme includes the **systematic identification**, **treatment** and **specialist support of smokers** in both **inpatient and outpatient settings** in **acute and mental health trusts**.

The Programme will increase the proportion of smokers who are:

- Identified during their non-elective or elective admission, outpatient appointment or preoperative assessment or mental health contact
- Given brief advice
- Given pharmacotherapy (eg nicotine replacement therapy (NRT), varenicline)
- Supported to use e-cigarettes in mental health settings
- Referred to specialist Stop Smoking Services for specialist advice while in hospital or before their elective admission
- Given on going specialist stop smoking support during their admission and post discharge.

Based on an estimated 37,853 spells[3] in **SYB acute hospitals** being for patients **who smoke** at time of admission (assuming a 20% smoking rate in patients), if we had the same baseline and outcomes as seen in Ottawa, implementing QUIT would lead to:

- **2,271 lives saved at one year**
- **2,347 readmissions to acute trusts within 30 days prevented**
- **4,429 readmissions to acute trusts within a year prevented**
- **5,678 6 month quits**
- **£7.1m saving from acute trust readmissions alone within a year**[4]
- **£273k savings from A&E attendances within 30 days.**

In addition, over time a **reduction in the incidence of cancer** will be seen.

Treating tobacco dependency in people with **severe mental illness will**:

- Increase life expectancy and help to decrease the gap in life expectancy between people with severe mental illness and the general population
- Improve physical and mental health eg reduction in depression, anxiety and stress.

There is evidence that for patients with severe mental illness, receiving care in a **smokefree setting** can **support mental health recovery.**

The program will fully integrate and ensure parity of esteem for the treatment of tobacco dependency in acute trusts and mental health trusts.

The **financial benefits** of the QUIT programme for the NHS will **start to be seen within a few weeks of patients starting to receive the intervention.**

Smoking in pregnancy is being covered within the SYB ICS's Better Births work programme and thus is not included within this business case

Key timeframe for implementation

We are still discussing with Trusts the exact timelines for implementation within each Trust, so the timelines may vary a little to those indicated below.

[3] Non elective admissions, transfers and elective admissions to Acute Trusts, LOS 0 and ≥1, (Day cases, Maternity and Sheffield Children's Hospital admissions excluded), aged > 15 years, Assumes 20% spells smokers, full year activity, SYB CCG patients only

[4] Based on estimated number of readmissions prevented, with mean admission cost £1,603 and A&E of £160. (2017/18 Department of Health Reference Costs average for non-elective hospital admission)

May/June 2019	ICS development and consideration of business case	Communication and Engagement Staff Training
Sept 2019	Yorkshire Cancer Research Board consideration of business case	
Sept- Nov 2019	Following posts commence: • SYB ICS Clinical lead • Healthy Hospital Programme Manager in each Acute and Mental Health Trust	
Dec 2019	Hospital based Specialist Stop Smoking Manager for each Trust and Trust based stop smoking specialist advisors commence in: • BHNFT, DBTH, STH, SCH & SH&SC With patients in these Trusts receiving QUIT interventions about a month later	
Jan/Feb 2020	Trust based stop smoking specialist advisors commence in: • TRFT • SWYFT, RDASH and Notts Health Care (TBC) With patients in these Trusts receiving QUIT interventions about a month later	
Throughout 2020	Ongoing monitoring, evaluation and refinement of the programme	

Investment required

A **short term investment** is **required until the NHSE LTP** funding becomes available which will be phased in from **2021/22.**

The table below suggests how the investment could be share across the partners. More detail is given in the main body of the paper.

Table 17 Costs by organisation (excluding contribution in kind)

	2019/20	**2020/21**	
Cancer Alliance	74,431	116,595	1 wte ICS Programme Lead from Aug 18, 0.3 wte Clinical Leads
Yorkshire Cancer Research			
Acute	293,884	918,756	SSSA inpt and output
Mental health	115,672	448,668	SSSA inpt and community
SYB comms & engagement	15,142	22,712	
Total	424,698	1,390,137	
ICS Transformation Funding	547,482	1,060,232	Healthy Hospital Programme Manager, Stop Smoking Manager and admin for Acute and Mental Health Trusts, development of shared material and on line training modules, 0.5 wte band 8a project manager for 15 months
Acute Trusts	Pharmacotherapy costs only estimated		Based on pro rata of GM CURE costs to estimated number of smokers and provision of 4 week TTA, of which CCG fund one week. 3/12 for 2019/20 Contributions in kind eg: Provision of very brief advice leadership, clinical champions,
BHNFT	£31,603	£126,411	
DBTH	£55,904	£223,615	
STH	£88,411	£353,643	
TRFT	£20,292	£121,750	
SCH			
Total	£196,209	£825,420	
Mental Health Trusts			

RDASH	Not yet estimated		staff training, IT, comms and engagement Asking smoking status, checking CO monitoring,
SH&SC			
SWYPFT			
Notts			
LAs	Community stop smoking advisors – to be locally determined		
CCGs			
Barnsley	43,635	£244,189	Based on pro-rata of current community SSS drug costs to QUIT related activity referred to Community SSS assuming 4 week TTA. Includes one week of 4 week TTA costs, Plus estimated dispensing fees. 2 months activity for 2019/20. 1 month activity for Rotherham.
Bassetlaw	8,575	£44,815	
Doncaster	40,013	£219,144	
Rotherham	17,074	£135,789	
Sheffield	71,647	£396,757	
Total	180,944	1,040,693	
Total	**£1,423,765**	**£4,433,077**	Not including contributions in kind, mental health drug costs or Community stop smoking advisors

Sustainability plan

The Yorkshire Cancer Research funding would enable the **pump priming** of the implementation of the QUIT programme for 2019/20 and 2020/21.

It is therefore suggested that **from 2021/22** (table 18):

- In light of the reductions in admissions expected due to people stopping smoking, CCGs **growth forecast for acute admissions for 21/22 onwards will reduce**, '**releasing' the funding** to commission the **Trust based specialist stop smoking service managers, advisors, admin support and inpatient and community pharmacotherapy costs**. This will be **part funded by the NHSE funding** as it is incrementally introduced.
    - **CCGs commitment to picking up these costs is dependent on Trusts having demonstrated good levels of implementation during 2020/21.**
    - If Trusts continue to have a CQUIN that covers NRT costs, this would need to be factored in.
- **Trusts** pick up the funding of the **Healthy Hospital Programme Managers**.
- **LAs** continue to **ensure and fund sufficient capacity within Community Stop Smoking Services** but with **their share of the NHSE funding** as this is incrementally increased.

Table 18 Summary of Sustainability Plan By Organisation

Staffing	2019/20	2020/21	21/22	22/23	23/24	
Cancer Alliance	74,431	116,595				Clinical leads and ICS Healthy Hospital Programme Lead
Yorkshire Cancer Research	424,698	1,390,137				SSSA for Acute and Mental Health Trusts, SYB comms
ICS Transformation Funding	527,482	1,060,232	116,595	77,005		19/20 & 20/21 ICS project management, HHPM, admin & SSS managers Acute & MH trusts, 21/22 QUIT clinical leads and Programme manager, 22/23 QUIT programme manager
CCGs	180,944	1,040,693	459,885	459,885		Community pharmacotherapy, assumes Trusts give 4 week TTA in 2019/20 and 20/21, of which CCGs fund one week. After that SSSA , SS manager and admin for mental health community and acute trust outpts.
CCGs/NHSE			3,341,880	3,341,880		Inpt, TTA & community pharmacotherapy and SSSA , SS manager and admin for inpts acute trust & MH.
Acute Trusts	196,209	825,420	304,715	304,715	304,715	19/20 & 20/21 inpt drug costs including 4 week TTA of which CCG funds one week , 21/22 onwards Healthy Hospital Programme Manager
Mental Health Trusts	Not yet calculated drug costs		163,029	163,029	163,029	19/20 & 20/21 inpt drug costs and TTA; 21/22 onwards Healthy Hospital Programme manager
LA	To be locally determined					Community SSSA
LA /NHSE			To be locally determined			
NHSE					3,801,766	All costs except healthy hospital programme managers. Plus also need to add in mental health drug costs and Community SSSAs
Total	**1,403,765** (plus £20k non recurrent ICS funded)	**4,433,077**	**4,386,104**	**4,346,514**	**4,269,509**	Not including mental health drug costs or community SSSA In yr one, also £20k for development of e-learning package and other materials funded by ICS

Recommendations

The Health Executive Group is asked:

1. To note the **huge potential health gain and reduction in health inequalities** possible through the systematic provision of stop smoking support within secondary care.

2. To note that supporting people to stop smoking is **cost saving** and implementation of QUIT at scale in the acute Trusts alone would lead to **savings of over £7 million pounds a year** in prevented non-elective admissions, while also **saving over 2,000 lives a year.**

3. To **support the application for funding from Yorkshire Cancer Research** to fund the hospital based stop smoking advisors in 2019/20 and 2020/21.

4. To note that **Yorkshire Cancer Research** would want **full recognition as a partner in the programme in all QUIT related publicity**, for the **staff they are funding to be recognisable** as their staff and for **their logo to be on QUIT related materials**.

5. To note that **YCR will require us to agree milestones and KPIs with them. We will thus develop an outline service specification for Trusts and agree evaluation and monitoring requirements.**

6. To note that subject to the business case being approved and all parties agreeing to contribute, this would enable the **first Trusts to be delivering QUIT at scale from January 2020.**

7. To **approve the QUIT business plan** and **agree Dr Richard Jenkins as the CE SRO for the programme**

8. To **approve the proposed contribution from the ICS** utilising transformation **funding this year and next year.**

9. To **approve the release of the ICS funding for the Healthy Hospital Programme Manager if the indication from the YCR Strategy Impact Group is positive.** This will enable the rapid recruitment of the posts by Trusts to a common SYB job description and the preparation for QUIT to progress at pace from September in all Trusts. We will also seek to **appoint the SYB QUIT clinical leads at that point**.

10. **To note that the:**

- **CCGs contribution to the business case and sustainability plan has been supported by the CCG CFOs.**
- **SYB DPHs have given a commitment to ensure that there is sufficient capacity within the Community Stop Smoking Services to meet demand for the follow up support.**

11. To note that in order to access the ICS Transformation Funding and Yorkshire Cancer Research funding (if their Board agrees the proposal), **Places will be expected to:**

- **Submit an implementation plan to the ICS demonstrating how the partners at Place will work together to implement the QUIT programme.**
- **Work collaboratively across SYB to co-design and implement the same core QUIT clinical pathway, clinical guidelines and supporting resources such as e-learning package**
- **To collect an agreed SYB data set and participate in the monitoring/evaluation of the programme**
- **Abide by the (to be agreed) YCR communications and marketing requirements To note that the Healthy Hospital Programme Managers will have a common job description and all take a lead for the system for a certain aspects of the programme**

13. **To note that smoking during pregnancy is being covered within the Better Births work stream.**

1. Introduction

Tobacco dependence is a **chronic, relapsing clinical condition** that prematurely **kills at least half** of people who smoke.

The Collaborative Partnership Board agreed last year that **embedding the treatment of tobacco dependency in secondary care (acute and mental health trusts)** is a **priority** for the South Yorkshire and Bassetlaw Integrated Care System (SYB ICS).

The **SYB QUIT programme** is an **evidence based programme,** which is based on the **Ottawa model.**

It was endorsed for implementation by the Acute Federation Chief Executives in March 2019 and by the Accountable Officers of the CCGs in April 2019.

It has subsequently been endorsed by the Cancer Alliance and a range of other SYB forums.

Implementation of the QUIT programme has been fully supported by the SYB:

- Cancer Alliance (4th May 2018)
- Acute Federation Chief Executives - March 2018
- CCG Accountable Officers - April 2018.
- Citizen's Panel (28th February 2019).
- Acute Trusts Medical Directors (Clinical Reference Group 8th March 2019)
- Directors of Public Heath
- SY&B ICS Workforce Health & Well Being meeting (13th November 2018)

Each of the Trusts has identified an executive sponsor for the programme (SWYFT pending).

The QUIT programme is in line with commitments given in the **NHS Long Term Plan** that:

- By 2023/24, **all people admitted to hospital who smoke will be offered Ottawa style NHS-funded tobacco treatment services** (ie the QUIT programme), with a modified programme for **expectant mothers**, and their partners.
- There will be a new universal smoking cessation offer as part of **specialist mental health services** for long-term users of specialist mental health, and in **learning disability services.** On the advice of PHE, this will include the option to switch to **e-cigarettes while in inpatient settings.**

Smoking in pregnancy is being covered within the Better Births work programme and thus is not covered in this business case.

While there is **excellent commitment from each Trust** to implement QUIT, **progress is being hindered by a lack of resources**. There is a danger that the current momentum will be lost if resource is not quickly identified; or that local approaches are designed that can be implemented within current resources that are not in line with the Ottawa model, are unlikely to be in line with the national service specification that NHSE is developing, will be small in scale and will not deliver the anticipated outcomes.

With QUIT implementation across **acute and mental health secondary care Trusts**, SYB ICS has an opportunity to lead the way in promoting truly integrated working and the promotion of **parity of esteem across physical and mental health**. In supporting the delivery of **bespoke smoking cessation interventions within mental health settings** the ICS is demonstrating **early translation of 'research in to practice'** regarding the new evidence as to what works for this client group[5].

The GM CURE programme has demonstrated that the Ottawa model does transfer to the acute setting in the NHS but has not included mental health Trusts. SYB has the opportunity to be the **forerunner in providing systematic treatment of tobacco dependency within mental health trusts** and to **share this learning widely across the country.**

[5] https://www.thelancet.com/journals/lanpsy/article/PIIS2215-0366(19)30047-1/fulltext

We understand from the central NHS England Team that **there will be dedicated NHSE funding for Ottawa style NHS-funded tobacco treatment services, but this will not begin to be phased in until 2021/22.**

Yorkshire Cancer Research has expressed an interest in **supporting the programme by funding, in 2019/20 and 20/21 the salary costs of the specialist stop smoking advisors** needed **within trusts** to implement the programme.

Before taking a paper to their Board, the ICS needs to demonstrate to Yorkshire Cancer Research that the ICS, Trusts, CCGs and Local Authorities will between them make an interim investment until the NHSE funding is available:

- To **cover the costs of the other elements needed to implement QUIT** (eg coordination and management of the programme, staff training, pharmacotherapy, specialist stop smoking support post discharge).

- To **cover costs of the specialist advisors from 2021/22** if there is a delay to, or a shortfall in, the national NHSE funding that is due from 2021/22.

This proposal builds a business case for a partnership approach to add to the funding potentially available from Yorkshire Cancer Research to enable the implementation of the QUIT programme at pace and scale prior to the NHSE funding becoming available.

2. Background and Evidence Base

Smoking is the single largest cause of ill health and preventable death in England. It kills about half of all lifetime users. It accounts for **half of the health gap** between the poorest and most affluent communities and is a major contributor to the 15 – 20 years gap in life expectancy between people with a severe mental health illness and the general population.

Smoking is the single **biggest avoidable risk factor for cancer**. Tobacco smoke is estimated to be responsible for 15% of cancers in the north of England and 27% of all cancer deaths. For South Yorkshire, Bassetlaw and North Derbyshire Cancer Alliance this is **1,670 cancers** and **1,432 cancer deaths attributed to smoking each year**.[6]

Continued smoking after a diagnosis of cancer can **limit the effectiveness of cancer treatments**; increase the risk of complications and of developing additional primary and secondary cancers; increase pain; and reduce quality of life and survival.[7]

An estimated **213,000 adults in SYB smoke** (appendix one). The adult prevalence of smoking across SYB varies between 16.2% and 19.7%. It is significantly higher in Barnsley and Doncaster than the national average.

Smoking prevalence is **markedly higher across all mental health populations** compared to the general population (figures one and two). Approximately **60 per cent of people admitted to acute mental health admission wards smoke** and approximately 40 per cent of people on the GP QOF severe mental illness registers are recorded as smoking.

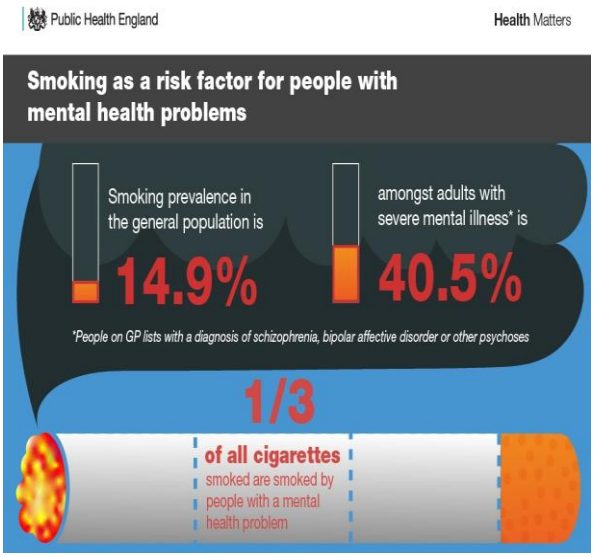
[6] Source – NCRAS. Figures for SYBND cancer alliance do not include data for Bassetlaw, North Derbyshire and Hardwick CCG areas as it has not been possible to disaggregate data to this population level.

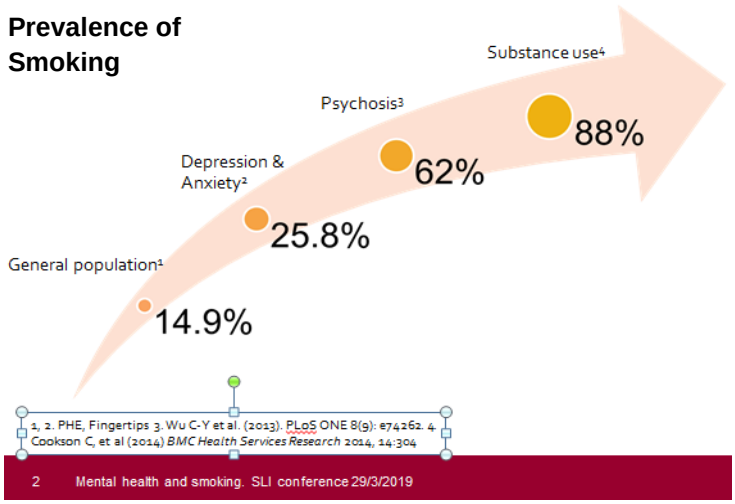
[7] ASH factsheet Smoking and cancer

While the **prevalence of smoking** has been falling in the general population, it has remained **stable in those with mental illness, further increasing the inequalities.**

People with a mental health condition also tend to smoke more heavily and intensively.

Figures one and two





People with a mental health condition who smoke:

- Experience more severe symptoms of psychosis, depression and anxiety
- Have an increased risk of the onset of panic attacks
- Have an increased risk of dementia
- Spend longer time in hospital and less time out of hospital
- Require higher doses of some psychotropic medicines

The **standardised mortality rate for deaths attributable to smoking** per 100,000 is **53% higher in South Yorkshire than the English average** (319 compared to 208).

Smoking **cost SYB CCGs £26.6 million in smoking attributable admissions** in 2016/17.

The estimated **cost to the NHSE** in England of **staff smoking breaks** and **excess absenteeism** attributable to smoking is £200 million a year[8].

Reducing the number of people smoking has an **immediate positive impact on both people's own health and on NHS and social care demand.**

Treating tobacco dependency is the quickest and most effective thing within the power of the NHS to do to support a reduction in health inequalities.

[8] RCP Hiding in plain sight Treating tobacco dependency in the NHS. A report by the Tobacco Advisory Group of the Royal College of Physicians. 2018

It is also one of the most effective demand management measures for the NHS – with risk of hospital admission falling as soon as people stop smoking.

There are highly clinically and cost effective treatments, that save lives.

The **Royal College of Physicians:**

- Sees **preventing smoking** as the **highest priority in medicine**[9]

and

- **The failure of clinicians and systems to offer the cost effective stop smoking treatments as unethical.**

RCP Hiding in plain sight Treating tobacco dependency in the NHS. A report by the Tobacco Advisory Group of the Royal College of Physicians. 2018

"Responsibility for **treating smokers lies with the clinician who sees them.** Clinicians working in almost all areas of medicine will see their patient's problems improved by quitting smoking.

Systematic intervention is a cost-effective means of both improving health and reducing demand on NHS services**.**

Smoking cessation is not just about prevention. For many diseases, smoking cessation represents effective treatment. As doctors we must therefore recognise that treating tobacco dependence, effectively and routinely, **is our business**.

Failing to provide help to quit smoking while delivering other similarly or less cost-effective interventions to smokers represents **distributive injustice which both perpetuates and exacerbates health inequalities.**

Heath service commissioners and practitioners have a **responsibility** to ensure that **cost-effective smoking interventions** are provided and properly implemented. **Failure to identify and treat smokers is no less negligent than failure to identify and treat patients with cancer. Systems failure is no less negligent** in this respect than individual failure.

Smoking cessation should be incorporated, as a priority, as a systematic and opt-out component of all NHS services, and delivered in smoke-free settings. It is unethical to do otherwise."

In recognition of the benefits of decreasing smoking prevalence, the **original 2016 SYB Sustainability and Transformation Plan** set an ambition to **decrease adult smoking prevalence in SYB to 10%.**

Treating tobacco dependency in people who have been admitted to hospital will be a key element in helping to meet this objective and the effectiveness of hospital based approaches has been recognised within the NHS Long Term Plan.

Up to 70% of smokers attending hospital for a variety of reasons say that they would like to stop.[10]

Research shows that health professionals can be very effective in triggering quit attempts and that patients expect them to raise the issue of tobacco dependence.[11]

[9] RCP Hiding in plain sight Treating tobacco dependency in the NHS. A report by the Tobacco Advisory Group of the Royal College of Physicians. 2018

[10] Lewis K, Rajanna H, Murphy J, et al. Where do smokers prefer their smoking cessation to be based? Thorax 2005;60:S37. Quoted in British Thoracic Society Recommendations for Hospital Smoking Cessation Services for Commissioners and Health Care Professionals 2012

[11] Rigotti N, Munafo' MR, Stead LF. Interventions for smoking cessation in hospitalised patients. Cochrane Database of Systematic Reviews 2007, Issue 3. Art. No.: CD001837. DOI: 10.1002/14651858.CD001837.pub2

The British Thoracic Society estimates that **25% of people admitted to acute Trust hospitals are current smokers.**

When patient contacts in A&E and outpatients, as well as the opportunity to support staff who smoke, are also taken into consideration, Acute and Mental Health Trusts have contact with a high proportion of the local population who smoke each year.

The Tobacco Plan for England (2017) set out the need for urgent action in inpatient and community mental health settings to reduce the stark difference in smoking rates, and ensure people with a mental health condition are not left behind in the move towards a smoke free generation.

An **encounter with secondary care** is a **unique opportunity for smoking cessation** due to the motivation provided by illness & health worries, feeling too unwell to smoke and being in a ward environment unable to smoke.

There is an **expectation within the Long Term Plan that all hospitals, mental health and learning disability services will implement an Ottawa like model of smoking cessation support for their patients.**

The **SYB QUIT programme** has been designed **based on** research and findings from the **Ottawa Model, London Senate Model, and on NICE Public Health Guidance 48 Smoking: Acute, Maternity and Mental Health Services.**

Evidence from the Ottawa model for smoking cessation (OMSC) showed that within acute trusts treating tobacco dependency leads to:

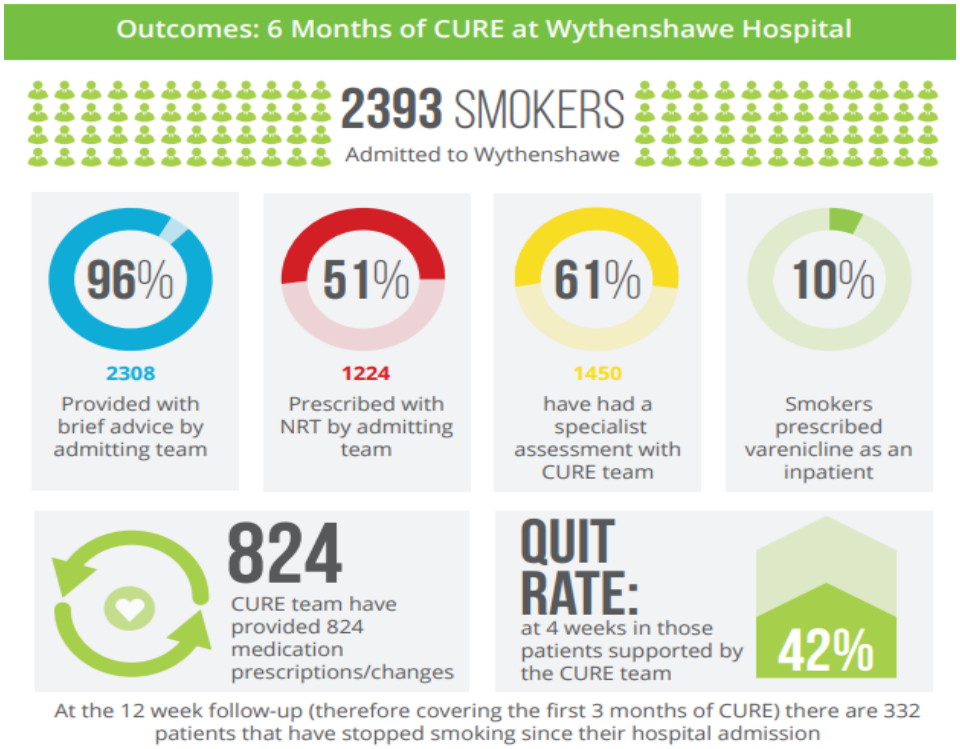
- An **11.1 percentage point increase** (from 18.3% to 29.4%) in **long-term quit rates** among general patient population.[12]
- **35%** of the patients who received the OMSC were **smoke-free at 6-months**, compared to only 20% of the usual care participants.[13]
- Patients who received the OMSC were **50% less likely to be re-admitted** to the hospital for any cause, and **30% less likely to visit an emergency department** within 30 days;
- Smokers who received the OMSC were **21% less likely to be re-hospitalized** and **9% less likely to visit an emergency department over 2 years;**
- Most importantly, smokers who received the OMSC had a **40% reduction in risk of death over 2 years.**

The first six months of data from **Wythenshawe Hospital** in Greater Manchester, which has recently implemented an Ottawa like model (branded the **CURE** programme) demonstrates that **the model can be embedded quickly within UK acute trust hospital setting** and with impressive results (figure three).

[12] Reid RD, Mullen KA, Slovinec D'Angelo ME, Aitken DA, Papadakis S, Haley PM, et al. Smoking cessation for hospitalized smokers: an evaluation of the "Ottawa Model". Nicotine Tob Res. 2010;12(1):11-8.

[13] Mullen KA, Manuel DG, Hawken SJ, et al. Tob Control Published Online First: 2016. doi:10.1136/tobaccocontrol- 2015-052728

Figure three



People with a **mental health condition** who smoke **want to quit as much as smokers in the general population,** but often lack confidence in their ability to do so. They may therefore be less likely to make a quit attempt compared to smokers in the general population.[14] People who use mental health services, who smoke, often historically have not been offered a way out of tobacco dependence that is genuinely helpful to them.

For people with **mental ill health**, research has demonstrated that health systems should provide smoking cessation services **tailored and responsive to the needs** of people who use these services.

The recent SCIMITAR trial found that when people in primary care and community mental health services with severe mental illness are provided with a **bespoke smoking cessation intervention (delivered by mental health staff),** smoking quit rates were doubled compared to those with usual care[15] - with a **15.2% quit rate at 12 months** (appendix two).

In addition to the well-established benefits of **increased life expectancy and improved physical health**, **stopping smoking in people with mental illness** is associated with:[14]

- Reduced depression, anxiety, and stress
- Improved positive mood and quality of life
- More disposable income

[14] Smoking cessation and smokefree policies: Good practice for mental health services, National Centre for Smoking Cessation and Training (NCSCT), March 2018

[15] https://www.thelancet.com/journals/lanpsy/article/PIIS2215-0366(19)30047-1/fulltext#

- Doses of some medicines such as clozapine and olanzapine can be reduced up to 25% in the first week after stopping smoking.

Receiving care in a **smokefree setting** can **support mental health recovery** (box one).

Box one Ways that smokefree settings support mental health recovery[14]

- Smokefree settings help to **protect** people who are non-smokers from **secondhand smoke** and from **initiation into smoking**; for ex-smokers, smokefree settings can help to protect them from **relapse.**
- The provision of tobacco dependence treatment, during an admission to a smokefree hospital, **increases the chances of quitting**. The longer the admission in smokefree settings, the higher the quit rate.
- The service user is **less likely to be readmitted** if provided with tobacco dependence treatment and follow-up support.
- If the service user does not quit during the current admission, there is an **increased chance they will make a subsequent quit attempt** following discharge.
- Smokefree inpatient settings, if implemented properly, increase the likelihood that the ward environment will be less disruptive and, when accompanied by staff training, is associated with a significant **decrease in physical violence.**
- Smokefree settings also mean that clinical time, previously spent on facilitating smoking, can be used to focus on **promoting health and wellbeing.**

3. Overview and benefits of the SYB QUIT Programme

The QUIT programme will be implemented as an integrated programme in **all acute and mental health trusts in South Yorkshire and Bassetlaw** (table one). This covers a population of approximately **1.5 million** people in Barnsley, Bassetlaw, Doncaster, Rotherham and Sheffield.

The QUIT programme will **build on existing work and services** occurring in Place[16] to support a reduction in smoking prevalence. All five places have a **community stop smoking service** commissioned by the local authority. They also prioritise **wider tobacco control initiatives**, coordinated through **local tobacco alliances.**

Details of the **local Community Stop Smoking Services** providers and commissioners are given in table two. Further information about the Stop Smoking Services is given in appendix one.

Table one Trusts in South Yorkshire and Bassetlaw			
Acute Trusts	Barnsley Hospital NHS Foundation Trust	BHNFT	
	Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust	DBTH	
	Sheffield Teaching Hospitals NHS Foundation Trust	STH	Also provide community health services
	The Rotherham NHS Foundation Trust	TRFT	
	Sheffield Children's NHS Foundation Trust	SCH	
Mental Health Trust	Sheffield Health and Social Care	SH&SC	
	Rotherham, Doncaster and South Humber NHS Foundation Trust	RDaSH (Rotherham and Doncaster Services)	Also provide community health services
	South West Yorkshire Partnership NHS Foundation Trust	SWYPFT (Barnsley services)	
	Nottinghamshire Healthcare NHS Foundation Trust	Bassetlaw	

Table two Providers and commissioners of SYB Community Stop Smoking Services		
	Provider	**Commissioner**
Barnsley	Smoke Free Yorkshire, SWYFT	Barnsley Council
Doncaster		Doncaster Council
Sheffield		Sheffield City Council
Rotherham	Parkwood Health Care, part of wider wellbeing service - Get Healthy Rotherham programme	Rotherham Council
Bassetlaw	Solutions 4 Health	Nottinghamshire County Council

QUIT is a **comprehensive secondary care treatment programme**, where active **smokers will be:**

- **Systematically identified on admission** to hospital
- Provided with tobacco dependency **pharmacotherapy** eg nicotine replacement therapy

[16] Within SYB we refer to 'Places' as being the local health and care economy and communities in each of our five areas of Barnsley, Bassetlaw, Doncaster, Sheffield and Rotherham.

- **Advised to stop smoking**
- Seen while in hospital by **specialist stop smoking advisors**
- And referred to Community Stop Smoking Services for **ongoing stop smoking support.**

Patients will also be identified in outpatients and **A&E** and given **brief advice** and mostly be **signposted to Community Stop Smoking Services**. **Hospital based stop smoking advisors** will **support priority outpatient pathways,** especially those that may lead to surgery, cardiology, respiratory and cancer services.

QUIT **within mental health services** for people with severe mental ill health, will be modified and incorporate the evidence base for stop smoking support in mental health services. Assessment and bespoke smoking cessation interventions will be provided by **secondary care specialist smoking advisors within the mental health service** (see appendix two) with ongoing follow up post discharge also being provided by the mental health advisors.

Trust staff who smoke will also be encouraged to quit and offered support.

The aims of the QUIT programme are given in box two.

Box two The Aims of the SY&B QUIT Programme are:

- Every health care professional is aware of the **smoking status of every patient** they care for
- Every health care professional has the **competence and confidence to offer help** to stop smoking through direct action and referral
- Every patient has access to the **best available treatments and expert support** to treat this disease
- There is recognition that **tobacco addiction is a chronic and relapsing disease**, not a lifestyle choice
- Staff policies **support all hospital staff to quit** or remain tobacco-free during working hours, including the offer of smoking cessation support and appropriate short-term medication
- All the hospitals in SY&B become institutions of health promotion and truly **smoke free zones**

The QUIT programme is based on **4 comprehensive steps**:

Box three

- **Q** – Ask the **question**: *all* hospital patients should be asked if they are a current smoker.
- **U** – **Understand** their addiction: all hospital patients should be asked to exhale into a **CO monitor** and their result noted in patient records. This provides not only evidence of the conversation taking place, but provides a strong indicator of level of addiction which will support and indicate further treatment, but also contributes to triggering quit attempts.
- **I** – **Inform** patients about **smokefree sites**: all patients should be informed that the hospital site is smokefree and that patients and visitors are not permitted to smoke anywhere on site, but that they can access support for nicotine replacement.
- **T** – Initiate **treatment**: refer patients to smoking cessation support including **advice and treatment (NRT, varenicline and other options)** as soon as possible, enabling them to quit during their inpatient stay where possible and ensuring appropriate ongoing support after discharge. The gold standard is that patients should be offered nicotine replacement support within 30 minutes of arrival on the ward.

The approach recognises that **smoking is an addiction**; **reframing the way we treat smoking to medicalise it rather than considering it to be a lifestyle choice. Ie the treatment of tobacco dependency as a chronic, relapsing clinical condition.**

As noted previously QUIT is based on the **Ottawa model** and is **very similar to the CURE programme** being implemented in Greater Manchester, but with the **addition of CO monitoring in the acute Trusts**. By adding in CO monitoring we hope to **identify a greater proportion of smokers** – current CQUIN data based on self-reported smoking status is showing a smoking rate in the acute Trusts of about 14% which is significantly lower than the background population smoking rates and half the British Thoracic Society estimate for admitted patients of 25%. Undertaking CO monitoring is in itself is also a **powerful intervention**.

The **benefits of implementing** the evidence-based SY&B QUIT programme will be:

- Significant reductions in the numbers of people who smoke in SY&B
- Improved health outcomes for our residents and staff
- Saved lives
- Significant reductions in smoking related hospital admissions and readmissions
- Reduction in health inequalities
- Reduction in the premature mortality and morbidity gap, attributable to smoking, for people with mental ill health and the population overall
- Reduction in incidence of cancer
- Improvements in mental health
- Contributing to significant savings to health and wider social economy
- And opportunities for positive news stories about local coordinated action together for the benefit of the health of our communities.

These benefits will be realised over a relatively short time period. **Hospital re-admission rates** to acute trusts have been seen to **fall within as little as 30 days** and **reductions in mortality observed within a year**.

Based on an estimated 37,853 spells[17] in **SYB acute hospitals** (excluding SCH) being for patients **who smoke** at time of admission, if we had the same baseline and outcomes as seen in Ottawa, we would see (table three A):

- **2,271 lives saved at one year**
- **2,347 readmissions within 30 days prevented**
- **4,429 readmissions within a year prevented**
- **5,678 6 month quits**
- **£7.1m saving from acute Trust readmissions within a year**
- **£272k savings on A&E attendances within 30 days.**

Table three B breaks this down by CCG.

[17] Non elective admissions, transfers and elective admissions to Acute Trusts, LOS 0 and ≥1, (Day cases and Maternity excluded), aged > 15 years, Assumes 20% spells smokers, full year activity, SYB CCG patients only

Table three A Anticipated outcomes in SYB if the Ottawa outcomes are replicated in SYB for patients who have an admission in an Acute Trust.					
	Ottawa (%)		SYB		
	Before	After	Before	After	Reduction
Estimated number SYB spells who are smokers (1)			37,853		
Mortality at 1 year	11.4	5.4	4,315	2,044	2,271
Mortality at 2 years	15.1	7.9	5,716	2,990	2,725
Readmission at 30 days	13.3	7.1	5,034	2,688	2,347
Readmission at 1 year	38.4	26.7	14,536	10,107	4,429
Quit rates at 6 months	20	35	7,571	13,249	5,678
ED attendances	20.9	16.4	7,911	6,208	1,703
Saving on readmission costs at one year (2)					£7,099,406
Saving on ED costs at 30 days (2)					£272,543
Total					£7,371,949
(1) Non elective admissions, transfers and elective admissions, LOS 0 and ≥1, (Day cases and Maternity excluded), aged > 15 years, Assumes 20% spells smokers, full year activity, SYB CCG patients only					
(2) The 2017/18 Department of Health Reference Costs state that an average non-elective hospital admission costs £1,603 and A&E attendance £160.					

Table three B Anticipated outcomes in SYB if the Ottawa outcomes are replicated in SYB for patients who have an admission in an Acute Trust by CCG.						
	Reduction by CCG					
	Barnsley	Bassetlaw	Doncaster	Rotherham	Sheffield	Total
Estimated number SYB spells who are smokers (1)	7,081	2,666	8,412	6,385	13,310	37,853
Mortality at 1 year	425	160	505	383	799	2,271
Mortality at 2 years	510	192	606	460	958	2,725
Readmission at 30 days	439	165	522	396	825	2,347
Readmission at 1 year	828	312	984	747	1,557	4,429
Quit rates at 6 months	1,062	400	1,262	958	1,996	5,678
ED attendances	319	120	379	287	599	1,703
Saving on readmission costs at one year (2)	£1,327k	£500k	£1,578k	£1,198k	£2,496k	£7.1m
Saving on ED costs at 30 days	£51k	£19k	£61k	£46k	£956k	£273k
Total Savings from admissions within a year and ED within 30 days (gross)	£1.4m	£519k	£1.6m	£1.2m	£2.6m	£7.4m

Quantifying **the impact of the mental health** strand of the programme is more difficult as we do not have any equivalent study to model the impacts from.

However, we have seen in the previous section the wide range of benefits that treating tobacco dependency and smoke free sites have for people with mental illness.

We also know that as people with a mental health condition tend to smoke heavily and intensely, their health is disproportionally affected compared to smokers without a mental health condition, due to the greater exposure to carbon monoxide and other toxins present in tobacco smoke.[14] Thus **people with mental health conditions have the most to gain from stopping smoking** or if they are not ready to quit to decrease their cigarette consumption or switch to e-cigarettes.

Benefits for Yorkshire Cancer Research

- Opportunity to sponsor the **systematic treatment of the largest risk factor for cancer** in residents in South Yorkshire and Bassetlaw.
- To be part of a programme that will be a **forerunner for the treatment of tobacco dependency in mental health settings** and look at ways of **increasing access to e-cigarettes** for mental health patients. Recognition as a partner in the **learning from this work that we would want to share across the country.**
- Full recognition of being a **partner in all the QUIT related publicity and materials**, helping increase **YCR brand recognition** in a health care economy that has:
    - A population of 1.5 million
    - 5 Acute Trusts and 4 Mental Health Trusts, 5 Clinical Commissioning Groups and 5 Local Authorities
    - Has 72,000 staff across health and social care
    - Just from the Acute Trust inpatient perspective we are anticipating asking just under 200,000 inpatients a year about their smoking status, with nearly 38,000 being smokers and being referred to the specialist stop smoking advisors.
    - The four adult Acute Trusts combined have 3 million outpatient appointments per year.
    - Thousands of people in contact with secondary care mental health services per year. 36,000 per year for Sheffield Health and Social Care NHS Foundation Trust alone.
- Recognition on the QUIT website, which will have both patient and professional pages and be accessed via the SYB ICS website. Links from the QUIT pages to YCR website can be included.
    - Opportunity to build relationships with all the SYB ICS organisations.

4. Implementing the SYB programme

We are in **close contact with the CURE team** in Greater Manchester and also **Northumbria Healthcare NHS Foundation Trust** who have also implemented an Ottawa like model. Both are being very supportive in sharing their learning and the CURE programme is making available copies of their resources. SH&SC are also working collaboratively with the team at the **University of York** who led the Smoking Cessation Intervention for People with Severe Mental Ill Health Trial (see appendix two), Kings College Hospital and the Yorkshire and Humber CLAHRC.

A number of factors have been identified as **key elements for successful implementation** (box four).

Box four Key elements for successful implementation

- Strong organisational commitment from Board downwards
- Strong clinical leadership and role models
- Good project management
- Good communication and engagement of staff
- Ongoing training of staff and a **change of culture:**
  - **Away from seeing smoking as a lifestyle choice to an approach that recognises it as a chronic condition that requires treatment.**
  - So that all staff see this as an **integral part of their role and routine clinical care.**
- Having specialist stop smoking advisors working within the Trusts and good interfaces with Community Stop Smoking Services.
- Having ready access to NRT on the acute wards and NRT and e-cigs on mental health wards.
- Tailoring the approach in mental health Trusts to the specific needs of people with mental ill health
- Having good IT systems to enable electronic recording of patient smoking status, the advice and management they have received and to generate referrals to the specialist stop smoking advisors.
- Measurement of process indicators and feeding back levels of success

4.1. Programme and clinical leadership

Each Trust has identified an **Executive Sponsor** and a **QUIT lead**.

A **SYB QUIT steering group**[18] has been established and is supporting shared learning across the Trusts.

The terms of reference and membership of the group will be reviewed and more detailed planning will be undertaken in short term task and finish groups, reporting to the steering group.

A new **SYB QUIT Oversight Group** will be established, chaired by the **QUIT programme Senior Responsible Officer** (Dr Richard Jenkins, Chief Executive of BHNFT and SYB ICS SRO for Provider development) – further details are given in the governance section.

Each Trust will have a **local steering group**, many of these are already established.

Two **SYB QUIT clinical leads** will be appointed (0.3 wte combined split across Acute Trusts and Mental Health Trusts).

Senior public health and programme management support for the programme will continue to be provided by the **SYB ICS QUIT Programme Manager (box five), who will be supported by additional central ICS project management (0.5 wte for 15 months) and administrative support .**

[18] Members include the Trust QUIT leads, LA PH tobacco control leads, managers of local stop smoking services, PHE regional lead for tobacco control, ICS PHS/QUIT programme manager

The ICS Consultant in PH will provide senior public health leadership, and will commit the majority of her time over the next 4 months to supporting the collaborative work, and then reduce commitment down to approximately 1 day per week.

Box Five Role of the SYB ICS QUIT Programme Manager

- Continue to support the ICS QUIT steering group and the QUIT Executive Sponsors peer group.
- Support the SYB ICS QUIT clinical leads, provide professional support to the Healthy Hospital Programme Leads and ensure programme integrity
- Lead the co-production, with the Trust QUIT leads, LA tobacco control leads and Stop Smoking Services, of:
  - QUIT related SYB policies, protocols and pathways (eg for e-cigarettes, provision of NRT and varenicline).
  - Training programme for the executive sponsors, QUIT leads and clinical and managerial champions
  - E-learning modules
  - Metrics and evaluation framework
  - Patient materials
- Coordinate 6 monthly SYB QUIT events. The next one is focusing on learning from the Greater Manchester CURE programme
- Together with the ICS communications team, implement a SYB QUIT external communications plan and develop materials and messages that can be used at a local level by place based comms teams
- Liaise with NHSE, Royal College of Physicians and other areas implementing QUIT like programmes, Right Care Respiratory Programme, and the Smoking and Mental Health Partnership
- Evaluate the programme

Each Acute and Mental Health Trust will appoint a **Healthy Hospital Programme Manager**[19] to drive forward implementation. The co-ordinator will be **employed by the Trust.** While their initial focus will be on implementing the QUIT programme, it is envisaged that over time they will also take on additional areas within a **'healthy hospital' programme implementing the Long Term Plan prevention priorities** eg supporting implementation of alcohol care teams, the healthy foods standards, encouraging active transport, staff health and wellbeing. The Healthy Hospital Programme Managers will have **a common job description** and all **lead on a different area for the System** (eg one may lead on the Trust input to the development of staff training materials for QUIT, another on supporting the evaluation).

Box six Role of the Trust Healthy Hospital Programme Manager

- Be a member of the **SYB QUIT Steering Group** and contribute to the coproduction of SYB QUIT related policies, protocols, patient materials and training programmes
- **Lead on certain areas of the Healthy Hospital Programme for the System**
- **Develop strong links and collaborative working** between the Trust and the local Public Health department, Stop Smoking Service, Primary Care Networks and the CCGs to develop **integrated stop smoking pathways**
- **Lead the development and implementation** of the Trust's **QUIT action plan**
- **Support the Trust's QUIT executive sponsor, managerial and clinical leads**
- Support the **identification of the Trust's QUIT clinical champions** and managerial capacity within **each**

[19] Costed as 1 wte band 8a for BHNFT, TRFT, DBTH, SHSC,RDASH; 1 wte band 8a and 1 wte band 7 for STH; 0.4 wte for SCH and SWYFT. In DBTH the band 8a post will be supported by a band 7 post in Bassetlaw hospital, funded by Notts County Council PH team.

directorate and specialty and provide ongoing support to them

- **Promote the QUIT programme across the Trust, promoting a change in culture** to recognise smoking as a chronic addiction that needs treating**, and** working with the **Trust's communications team implement an internal communications plan** and contribute to the SYB external communications plan
- Working with the Trust's engagement officers, **seek patient and publics views on** how best to implement the QUIT programme and seek their feedback as it is implemented.
- **Lead the development and coordination of the training programme** for clinical and other staff, in association with the Trusts education and training department and the hospital based stop smoking manager and with advice/support from their local community stop smoking service and PH tobacco lead
- Support Trust's occupational health services to develop and implement a **plan for enhanced stop smoking support for staff**
- **Lead the monitoring and evaluation of the programme** within the Trust
- **Once the QUIT programme is establish, support the implementation of the other LTP prevention priorities within the Trust.**

Within each directorate additional **programme management support** and **clinical champions** will be identified by the Trust (from within current resources) to **support the roll out of QUIT within that directorate**. They will be supported by the Trust's Healthy Hospital Programme Manager.

Within each Trust there will be a number of **hospital based specialist stop smoking advisors**[20] and a **stop smoking manager**[21]. Depending on **local preference** these posts could **either be employed by the Trust or provided as an in-reach service from the existing Local Authority commissioned local Community Stop Smoking Services.** Whichever approach is taken, continuity of care and ensuring a smooth interface between stop smoking support provided while in hospital/outpatients and ongoing support in the community is going to be essential.

Specialist Stop Smoking Advisors will be available **7 days a week** in **Acute Trusts** to undertake face to face interventions with smokers. The number of hours available per day will vary depending on the size of the hospital and day of week (eg less on a Sunday as fewer admissions/discharges than on other days). A 5 day a week service will be provided in mental health trusts.

Administrative support will service both the Healthy Hospital Programme Manager and the hospital based stop smoking service.

Box seven Role of the Trust Based Stop Smoking Manager

- Be on the Trust's QUIT task group
- Contribute to the development and delivery of the Trust's QUIT action plan
- Contribute to the coproduction of SYB and Trust QUIT related policies and protocols
- Support the culture change and promotion of smoke free environment
- Provide training for the Trust's clinical and non-clinical staff
- Provide expert advice to the Trust's QUIT executive sponsor, clinical lead and champions
- Manage the hospital based specialist stop smoking advisors
- Manage the interface between the hospital service and the community stop smoking service
- Liaise with pharmacy to ensure that appropriate pharmacotherapy is available within the Trust
- Provide specialist stop smoking support to patients (30% of role direct patient contact)
- Contribute to the evaluation and ensure continuous quality development of the programme

[20] Costed as AfC band 3. These post should be a minimum of a band 3.

[21] Costed as AfC band 6.

4.2. Communications and engagement

Communications and engagement with both **staff and patients** will be key.

Patient and public engagement:

The ICS Programme lead for QUIT has already sought the advice of the **ICS Citizen's Panel** who gave their full support to the quit programme. The Panel will be regularly updated and asked for advice at relevant stages of the roll out of the quit programme.

As part of the engagement on the NHS Long Term Plan a number of **public focus groups** are planned, the quit programme will be included within the discussions around the prevention the elements of the Long Term Plan.

Some Trusts have already undertaken some **social media surveys** with their patients and public, and received strong support for smoke free sites and providing support to help patients stop smoking.

Patients' views and feedback, via **Trust's existing engagement channels**, will be sought throughout implementation and contribute to the evaluation.

Focus groups with **staff** are in the process of being undertaken in some of the mental health trusts.

Communications:

The **SYB ICS Programme Lead for QUIT and the SYB ICS Communications Team** will lead the:

- Development of an **external communications plan** and branding
- Co-development with Yorkshire Cancer Research, Trusts, CCGs and LAs **consistent messages and materials** that can support Trusts with their internal and external communications. Including copies of clinical pathways, clinical guidelines, public and staff posters, patient leaflets.
- Development of publically accessible **SYB QUIT programme website** that contains all of the QUIT related resources. This will be similar to the GM CURE programme website (thecureproject.co.uk) but will also include pathways and resources for **mental health trusts**. This resource will be a key way of **sharing the mental health learning** wider than just within SYB. The website will also have public facing pages.
- Co-development of **on line training modules** for staff.
- Undertake **wider promotion of the healthy living resources** available from PHE eg the One You and Fit 4 Life resources.

Trusts will be responsible for the **delivery of their internal communications and communications with patients and visitors.**

The ICS will **agree with Yorkshire Cancer Research a set of marketing and communications requirements***,* that all partners will work to.

The ICS recognises that a **condition of the funding from Yorkshire Cancer Research** would be that their **logo is included in all QUIT related materials and their contribution is acknowledged in all publicity**.

Trusts are aware of YCR request that the **staff they fund will be easily recognisable** eg by wearing lanyards, badges. YCR will cover any costs associated with distinctive uniforms for staff they are funding.

4.3. Training for clinical and non-clinical staff

A comprehensive on-going, training programme will be required for both clinical and non-clinical staff. A **key element of the training will be the reframing of smoking away from a lifestyle choice to a chronic illness that requires treatment.**

A variety of training will be required depending on the role of the individual.

The Healthy Hospital Programme Manager, hospital based Stop Smoking Manager and local Stop Smoking Services will contribute to the training.

The ICS will support the co-production of **SYB online training modules**.

It is anticipated that the **Trusts' education and training departments** will help to develop, coordinate and monitor the training programme.

4.4. Clinical pathway – Acute Trusts

The **outline pathway for admitted patients in acute trusts** is summarised in figure four. This will be further developed with Trusts and LA tobacco leads.

The pathway will apply to **all non-elective and elective patients admitted with any length of stay**, including 0 Length of stay (LOS). It excludes maternity patients who will have a different pathway and day cases.

A phased approach to roll out among different cohort of patients within a Trust is **not recommended** as:

- This would complicate the communication and training programme
- Will be confusing to staff if some patients are / are not included
- A critical mass of patients is needed in order to warrant a seven day rota of specialist advisors.

Discussion is ongoing with Trusts regarding the timelines and roll out approach for each Trust.

The QUIT pathway assumes that the hospital stop smoking service will do **one follow up phone call** post discharge, with community stop smoking team following up thereafter. **The Community Stop Smoking Services are concerned** that just giving a **two week TTA will potentially leave patients with a gap before they receive their first community review and vouchers**. Hence a **four week TTA is suggested.**

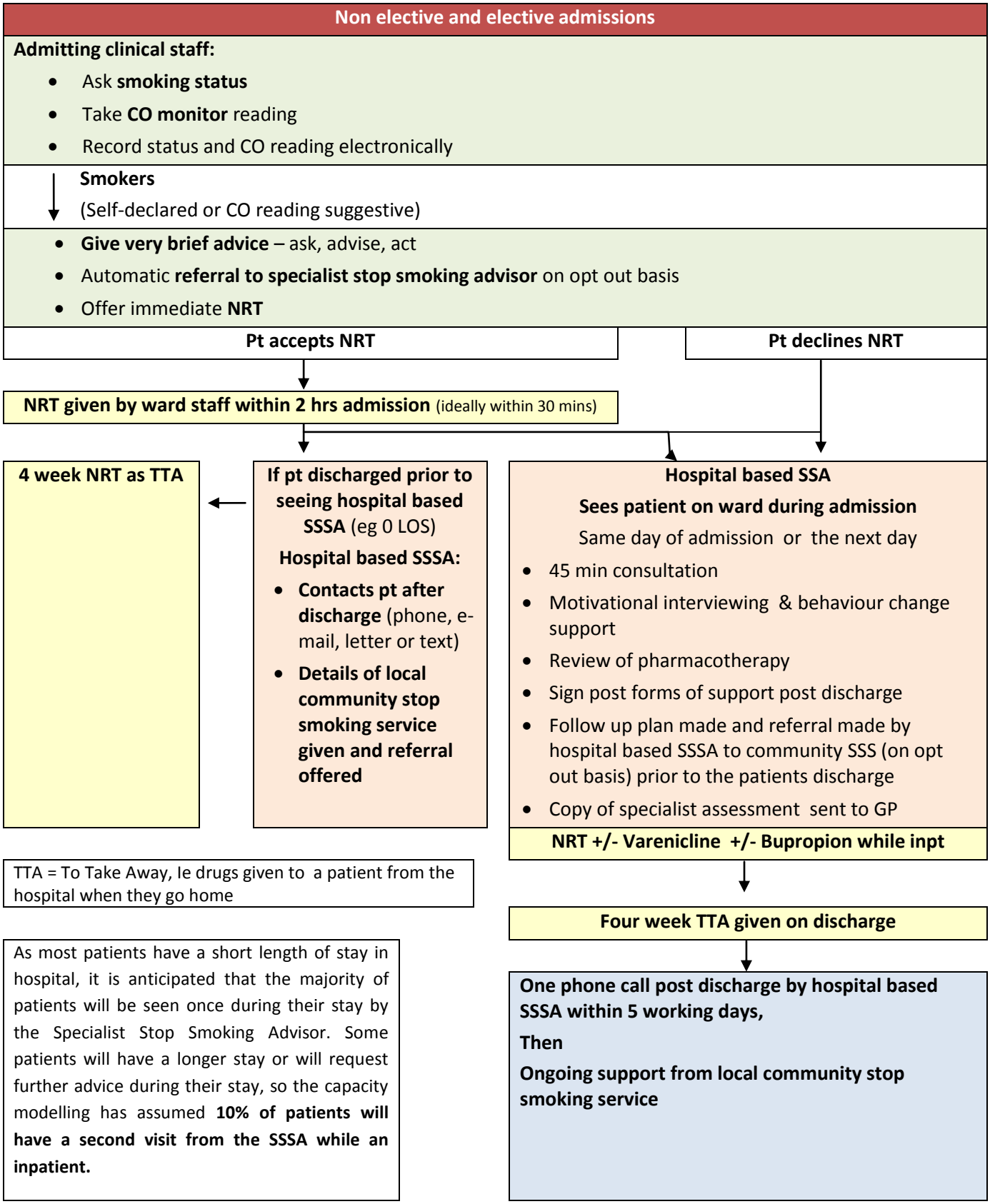
Additional pathways will be co-designed for:

a. **Paediatric wards at the DGHs and for Sheffield Children's Hospital**

- These will need a greater focus on smokefree environments
- Support for parents who smoke**. Hospital based stop smoking advisors** will be able to **support parents** of children who have been admitted to quit smoking and to provide them with onward referral to Community Stop Smoking Services.

Figure four Draft Outline QUIT Pathway for admitted patients to Acute Trusts

SSSA = Specialist stop smoking advisor



TTA = To Take Away, Ie drugs given to a patient from the hospital when they go home

As most patients have a short length of stay in hospital, it is anticipated that the majority of patients will be seen once during their stay by the Specialist Stop Smoking Advisor. Some patients will have a longer stay or will request further advice during their stay, so the capacity modelling has assumed **10% of patients will have a second visit from the SSSA while an inpatient.**

b. Specialist stop smoking support for family members of patients

- The chance of a successful quit is likely to be higher if family members who also smoke are offered support to quit at the same time.
- Hospital Stop Smoking Services should be flexible and also offer support to family members of inpatients. If the patient is likely to be an inpatient for some time, this may include an initial assessment of the family member by the SSSA and provision of NRT. In the majority of cases it will be signposting to local Community Stop Smoking Services.

c. **Outpatients and pre-assessment clinics**

- The hospital stop smoking service will have an advisor(s) available to support priority outpatient pathways, in particular cardiology, respiratory, cancer and surgical pathways. It will be for local determination how best to use this capacity.
- Surgical pathways:
    - Ideally GPs will refer patients to their local community stop smoking service at the time of referral to the hospital if they think the patient may require surgery.
    - Patients will also be asked their smoking status in outpatients and pre-assessment clinics and signposted to the outpatient hospital stop smoking advisor and / or local community services.

d. **Day cases**

- The majority of patients attending as day cases are only at the hospital for a few hours for an investigation, treatment or minor surgery (eg endoscopy, cataract surgery).
- Those undergoing surgery should have either been referred in advance by their primary care practitioners to the local community stop smoking service or to the outpatient stop smoking advisor from outpatients or pre-assessment clinics.
- On the day of their investigation/minor surgery patients should be asked if they smoke, given very brief advice and sign posted to their Community Stop Smoking Services.
- **Day case patients have not been included in the modelling of the activity levels** for the hospital stop smoking team or the post discharge onward referrals to the Community Stop Smoking Services.

4.4.1. Ongoing community stop smoking support for patients who have been admitted to acute Trusts

- As indicated above the acute trust's hospital stop smoking advisor will refer on patients wishing to quit to the local community stop smoking service. The referral 'paperwork' will be completed prior to the patients discharge. This will be an 'opt out 'offer.
- The **hospital stop smoking service advisor** will contact patients by phone **within five working days** of discharge to give support and ensure the patients has the community stop smoking referral appointment.

- Smokers who have been **discharged from hospital before being seen** by the hospital stop smoking advisor will also **receive a call** from the hospital based team and be offered advice and a referral to their local community stop smoking service.

- The patient's **subsequent stop smoking support** will be provided by the **local community stop smoking service advisors** and the patient will be offered a range of different methods of support – in line with the community service's current offer – eg face to face, group, on line, text and phone support

- Varenicline is usually continued for a total 12 weeks and NRT for a variable length of time depending on patient need and local SSS policy (appendix three).

- NICE recommends that for patients in hospital dual NRT products are used ie a patch plus an alternative preparation such as inhalators, lozenges or gum.

- All of the Stop Smoking Services support patients who wish to purchase **e-cigarettes** and some are considering providing free e-cigs as an alternative to NRT.

- The use of e-cigarettes is supported by PHE and they are cheaper than NRT. NICE currently recommends NRT, varenicline or bupropion and provides the advice given in box eight regarding e-cigarettes.

Box eight NICE Advice on e‑cigarettes

Stop smoking interventions and services NICE guideline [NG92] March 2018

For people who smoke and who are using, or are interested in using, a nicotine-containing e‑cigarette on general sale to quit smoking, explain that:

- Although these products are not licensed medicines, they are regulated by the Tobacco and Related Products Regulations 2016
- Many people have found them helpful to quit smoking cigarettes
- People using e‑cigarettes should stop smoking tobacco completely, because any smoking is harmful
- The evidence suggests that e‑cigarettes are substantially less harmful to health than smoking but are not risk free
- The evidence in this area is still developing, including evidence on the long-term health impact.

NB: - There are logistically difficulties in the use of e-cigs within the acute hospitals but as noted above patients wishing to use e-cigs post discharge will be supported by the Community Stop Smoking Services. See mental health section for use and evaluation of e-cigs in mental health pathways.

4.5. **Clinical Pathways for Mental Health Inpatient and Community Services**

There are distinctive features pertaining to QUIT implementation within secondary care mental health settings. To be successful, QUIT implementation has to be undertaken in combination with the implementation of **smoke free environments** and the achievement of a **new cultural norm** in relation to tobacco and mental health.

The QUIT pathway development for mental health secondary care services is informed by a thorough understanding of the extent of the problem and the complexity and nature of the challenge, including the following:

- As noted previously, smoking prevalence is markedly higher across all mental health populations compared within prevalence within acute hospitals.

- People with a mental health condition tend to smoke more heavily and intensively.
- Historically, smoking has been deeply entrenched in the culture of mental health services across the UK.
- Whilst the number of mental health inpatient beds is smaller compared with acute trusts, intensive clinical services are provided by staff within **crisis teams, community home treatment and rehabilitation teams, as well as community mental health and other community teams**.
- Learning from staff surveys undertaken via CLAHRC YH investigating staff views, attitudes, experiences and ideas regarding smoke free implementation within mental health Trusts (including SHSC, SWFT and RDASH) and the CLAHRC YH 'Pausing for Breath' event
- Good practice guidance for mental health services for smoking cessation and smoke free policies https://www.ncsct.co.uk/shopdisp_mental_health_guidance.php and the wider specialist mental health stop smoking support evidence base

For QUIT within mental health secondary care, the pathways will comprise:

- All the elements of QUIT, but adjusted to the needs of mental health patients
- Support to **reduce harm from tobacco** and assist patients with being smoke free during an inpatient admission (**temporary abstinence**) and if they wish **support to quit**
- The option to enable patients to switch to an **e-cigarette** whilst in mental health inpatient settings, in line with the NHS Long term Plan
- Facilitation of **smoke free environments** within mental health settings, including attention to wider elements of physical health promotion, and activities to help to take the place of smoking
- For people with severe mental ill health the **stop smoking specialist support** (assessment and intervention), both while an **inpatient and in community settings** will be delivered by **Trust specialist mental health smoking cessation advisors.**
    - This is based on the evidence that tailored smoking cessation interventions delivered by staff with mental health training results in better engagement and is more clinically and cost effective. SHSC, RDASH and SWYFT were all contributing sites to the recent University of York trial.[22]
    - Community patients with low level mental health problems will access the generic community stop smoking service.

The role of **specialist advisors within mental health will differ from those in acute care,** in that as well as providing smoking cessation assessment and interventions **within inpatient and community based mental health teams,** they will also:

- **Provide advice and support to ward staff** – many patients with SMI will be too unwell to interact with the community stop smoking advisors for much of their inpatient stay. The SSSA will advise ward staff on appropriate pharmacotherapy and the patients tobacco dependency treatment plan. This may focus on **temporary abstinence** during an admission (for people who do not or may not want to quit at that stage.
- Reinforce the training provided to inpatient teams by the Healthy Hospital Programme Manager and Stop Smoking Manager to reduce harm from tobacco and the **promotion smoke free settings**.
- Ensure **robust discharge planning** for the patients ongoing specialist stop smoking support for patients wishing to quit or have an ongoing harm reduction programme.

[22] See appendix two

A draft inpatient pathway is given in figure five. This will be further developed with the mental health trusts.

Figure five Draft QUIT Inpatient Pathways for Mental Health Trusts

Admission

Admitting clinical staff:

- **Ask smoking status**
- (Feasibility of undertaking CO monitoring will be piloted)

↓ **Smokers**

- Offer immediate **NRT or free e-cigs**
- Inform service user and carer of **Smoke Free Policy** and support available
- Inform service user that fire hazard items are prohibited
- Ask if service user has smoking materials, including lighters/matches; if th
-
- ey do, ask them to give to a carer/relative to return home OR to hand them to staff for safe storage until first leave home or discharge. Record outcome. If service user does not respond to request, **assess all risks**, including fire risk, and refer to local Standard Operating Procedures
- Automatic **referral to specialist stop smoking advisor** on opt out basis
- Record smoking status and advice given electronically

↓

NRT or e-cigs given by ward staff within 2 hrs admission (ideally within 30 mins)

↓ ↓

Ward staff throughout admission:

- **All patients given individual support from ward staff including on use of NRT and/or e-cigs** (within agreed parameters)
- Support activity based alternatives to smoking
- **Support compliance**. Be alert for surreptitious smoking and follow procedures
- Remind service users going, and returning from leave, that smoking materials (including lighters and matches, which are prohibited) are not be brought back on to the ward, and that support is available to manage abstinence when on leave.

Hospital based SSA

Liaises regularly with ward staff to:

- Determine when patient well enough to be seen by SSA
- Give advice to ward staff on the patient's tobacco dependency management in the mean time

↓ **When pt well enough**

Hospital based SSA

- Pt assessment on ward
- Supports patients to choose **one of three pathways**

PATHWAY 1 **Temporary abstinence *with* NRT or e-cigs**	**PATHWAY 2** **Sustained quit attempt**	**PATHWAY 3** **Temporary abstinence *without* NRT or e-cigs**

NB:- patients may change between pathways during admission

- **Reviews pharmacotherapy** – including consideration of eg addition of varenicline if sustain quit to be attempted
- Provides **motivational and behavioural support**, for the **duration of the admission** (repeat visits – frequency led by patient's needs)
- **Ensures follow up plan agreed and arranged prior to discharge**
- Ensure that service users know how to **access future supplies** of NRT/medication either through local specialist stop smoking service, or know where to get an e-cigarette/ e-liquid.
- Copy of specialist assessment sent to GP

Pharmacotherapy / e-cigs as inpatient and as TTA

↓

Ongoing support after discharge from mental health stop smoking advisors

Patients wishing to quit	**Harm reduction by use of e-cigs or ↓ number of cigs smoked**
• First contact with in a week of discharge • Home visits as needed • Appts up to 40 mins each • Weekly for four weeks, then frequency and duration titrated to patient's needs – but aim for at least 3 months support, with additional FU at 6, 9 and 12 months • Check pts are using sufficient NRT/ other stop smoking medication/e-cigarettes and in the correct way. • Ensure plasma levels of medication affected by smoking/ stopping smoking are checked soon after discharge	• Less intensive modified programme of support depending on patients needs

As the knowledge base is less developed for the treatment of tobacco dependency at scale in mental health settings, the inpatient pathway will be continually reviewed and modified as needed.

Due to the longer length of admissions, the SSSAs will offer ongoing support to patients while they are an inpatient – the frequency of this will be titrated to the patients need.

We will explore the pros and cons of different models of **improving access and use of e-cigarettes on mental health inpatient wards**, including provision of free vaping products, and the provision of e-cigs post discharge for patients having ongoing support from the mental health stop smoking advisors. SH&SC are undertaking a 'test for change' project to enable electronic-cigarettes to be made available, free of charge, to eligible services users during an inpatient admission. The use of e-cigarettes will be a specific focus within the **evaluation.**

Following discharge patients may require longer appointments than patients in the acute pathways, more frequent follow ups and longer duration of support. This should be tailored to the individual patient's needs. The University of York trial offered up to 12 appointments (mean number 6.4) with mean duration of 40 mins.

Home visits will also be available.

Similar offers of support by the mental health specialists stop smoking advisors for patients with severe mental illness will be provided for patients under the care of crisis teams, community home treatment and rehabilitation teams, community mental health and other community teams. Patients under community mental health teams who have low level mental health problems will access the generic Community Stop Smoking Services.

4.6. Trust staff who smoke

- Will be encouraged and **supported to QUIT, with the Trust based stop smoking advisors providing initial interventions and ongoing support to staff.**

4.7. Smoking during pregnancy

- **Smoking during pregnancy** is being covered within the ICS's **Better Births work stream and thus not included in this business case.**

4.8. Smoke free grounds

As noted previously, supporting smoke free sites is one element of the QUIT programme. Trusts will follow the advice in the NICE guidance on the best approach to achieving a smoke free site.

4.9. IT

Electronic smoking status and CO results recording systems will be needed and an **automated referral system** to the hospital based stop smoking service.

It is suggested that patient electronic records are set up in a way that makes recording of the smoking status a mandatory field.

Electronic referral systems and data sharing agreements will need to be in place between the hospital and Community Stop Smoking Services.

4.10. Monitoring and evaluation

A 'framework' service specification will be agreed with Trusts, that will include the quality standards that will be co-designed with Trusts and stop smoking services.

A **SYB standard data set** and **evaluation framework** will be agreed and collected by all Trusts and stop smoking services (see section 5).

KPIs, monitoring and evaluation requirements will be agreed with Yorkshire Cancer Research.

4.11. NHSE service specification

NHSE have indicated that they may produce a **national service specification** for stop smoking support to hospital patients. The **above pathways and monitoring requirements may need to be modified** depending on the NHSE service specification.

4.12. Implementation timelines

Over the last year Trusts have been doing preparatory work including:

- Baseline reviews against national best practice frameworks
- Forming local QUIT steering groups and developing local action plans
- Gaining organisational 'buy in'
- Awareness raising eg bulletins, at staff educational sessions
- Work to support smoke free sites eg improvements in signage, changes in security contracts to support security staff to speak to people who are smoking, removal of smoking shelters, changes to patient appointment letters
- Identification of some clinical champions
- Liaison with Community Stop Smoking Services

The **Trusts are at varying levels of readiness** for full roll out and as noted above progress is now being hindered by lack of resource for programme coordination and funding for recruitment of the Trust based specialist stop smoking posts.

It is proposed that the **recruitment process of the Healthy Hospital Programme Managers and SYB clinical Lead** should **commence in all Trusts in June/July 2019/20, with a view to commence from September onwards.**

We are having ongoing discussions with the Trusts regarding **timelines for implementation for each Trust**. The costing in the business case assumes:

Of the Acute Trusts:

- **Barnsley Hospital**
- **Doncaster and Bassetlaw Hospitals**
- **Sheffield Teaching Hospitals**
- **and Sheffield Children Hospitals**

Are in a position to **move quickly once funding is identified** and would be able to aim for the **commencement of patient delivery of QUIT** from **Jan 2020.**

Rotherham Hospital will need a little longer to prepare and will aim for **commencement of patient delivery** of QUIT from **Feb 2020.**

From the Mental Health Trust perspectives,

- **Sheffield Health and Social Care Trust aims to commence patient delivery of QUIT from January 2019.**
- **Discussion is ongoing with SWYFT, RDASH** and **Notts Health Care** as to when they would aim for commencement.

Table four sets out key implementation points.

Table four Implementation time lines	**2019**								**2020**				
Key events	**May**	**Jun**	**July**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**April**	**May**
1 B'ness case considered by **ICS System Health Board**													
2 B'ness case considered **Yorkshire Cancer Strategy Group and then their Board**													
3 Recruitment of: • SYB ICS Clinical leads & SYB Comms and Engagement post • Healthy Hospitals Programme Manager by each Trust & admin support													
4 Commencement of above posts													
5 Co-design of **QUIT communications plan**													
6 Implementation of communications plan													
7 Co-design of: • Patient pathways & clinical guidelines • Information leaflets and posters • Policies for e-cigs, provision of NRT and varenicline • Training programmes and e-learning modules • Metrics data set, data collection and evaluation methodology													
8 Clinical guidelines approved by Trust Governance structures													
9 Identification of programme management support within Trusts in each directorate													
10 Identification of Trust clinical and managerial champions													
11 Training of Trust champions													
12 LA planning with Community Stop Smoking Services to **ensure adequate capacity in Community Stop Smoking Services**													
13 Acute Trusts:													
• **Recruitment of hospital based specialist stop smoking advisors (SSSAs) and Hospital Based Specialist Stop Smoking Managers** **1 = BHNFT, DBTH, STH & SCH**						**1**	**TRFT**						
• **Commencement of hospital based SSSA and stop smoking manager** **1 = BHNFT, DBTH, STH , SCH**								**1**	**TRFT**				
• **Awareness raising and training for wider staff**					**BHNFT , DBTH, STH & SCH**								
							TRFT						
• **Patients and staff start receiving QUIT intervention** **Site smoke free**									**BHNFT, DBTH, STH & SCH**				
										TRFT			
14 Mental Health Trusts													
• **Recruitment of SSSAs and Stop Smoking Manager** **2 – SH&SC 3 – other mental health trusts (TBC)**						**2**	**3**						
• **Commencement of hospital based SSSA and Stop Smoking Manager**								**2**	**3**				
• **Awareness raising and training for wider staff**					**SH&SC**								
							SWYFT, RDASH. Notts Healthcare						
• **Patients and staff start receiving QUIT intervention**									**SH&SC**				
										SWYFT, RDASH. Notts Healthcare			
15 Collection of metrics for evaluation													

5. Measuring the success of the programme

A standard set of **process metrics** will be co-designed with Trusts, LA Tobacco Leads and stop smoking services, Yorkshire Cancer Research and collected by Trusts and stop smoking services (box nine).

This will be supported by qualitative stakeholder feedback (including staff, patients and family members) and monitoring of some outcome measures such as:

- Increase in number overall recorded quits in SYB
- Increase in the number of staff members who quit
- Decrease in prevalence of overall adult smoking and in routine and manual workers
- Reduction in smoking attributable hospital admissions and mortality

Box nine Some areas that the QUIT process metrics will cover
Data will be collected for each Trust/Place and also given as a SYB total

- The number (%) of staff who have received training in giving very brief advice and the ethos of the QUIT programme
- Numbers and proportion of inpatients who have recorded their:
    - Smoking status
    - CO levels
- Numbers and proportion of inpatients who have been identified as a smoker
    - Self-reported
    - By their CO levels
- Numbers and proportion of patients who are smokers, who:
    - Are given very brief advice on admission
    - Are seen by hospital based SSSA while an inpatient
    - Receive NRT and / or varenicline as an inpatient
    - Receive e-cigarettes as an mental heath inpatient
    - Are contacted by hospital stop smoking service post discharge if they were unable to see them before discharge (eg 0 LOS)
    - Are referred on to and accept Community Stop Smoking Services post acute admission
    - Receive ongoing support from the mental health SSSAs post discharge from a mental health trust admission
    - Are non-admitted mental health patients who receive support from the mental health SSSAs
- The number of people receiving community stop smoking support who have been referred from secondary care has increased
- QUIT rates for patients who support to stop smoking commenced via secondary care – 4 and 12 week quits – broken down by age, sex and area of residence to help with monitoring of health inequalities, whether the patient had been seen by SSSA while and inpatient or phoned post discharge
- Number of staff members seeking stop smoking support and quit rates
- Plus feedback from staff on culture shift, what they are doing differently, barriers and opportunities
- Pharmacotherapy costs – Hospital and community/primary care
- E-cigs costs – Hospital and community
- Programme costs

Consideration needs to be given to the best way of assessing progress for smoke free sites.

As noted previously we would need to agree KPIs with Yorkshire Cancer Research.

Also the provision of e-cigs within the mental health trusts will be a particular focus of the evaluation.

6. Modelling of patient numbers, pharmacotherapy uptake and quit rates

6.1. QUIT support for inpatients in Acute Trusts

Detailed modelling has been undertaken to estimate the number of patients who are **admitted to the acute Trusts** who would be smokers and who would receive the different elements within the QUIT pathway (table five).

The modelling has been **informed by data** from both **Ottawa and CURE programmes**.

The modelling is based on the **patient cohort**:

- Spells between Dec 2017 and Nov 2018
- **All non-elective admissions, transfers and elective admissions to BHNFT, DBTH, STH and TRFT aged > 15 years**
- **Excludes day cases and maternity admissions**
- Length of stay (LOS) 0 and ≥1
- Spells relating to SYB CCG patients only.

The modelling **assumes that 20% of spells** are in patients who **smoke.** This is above our population prevalence rates but 5% below the estimates from the British Thoracic Society. We have opted for the slightly more conservative rate, partly as smoking prevalence rates in our general population have been falling recently and also we have not taken in to account patients who have had multiple spells. The CURE programme also used 20%, and has found their number of smokers to be similar to predicted levels.

Patients who are **readmitted will follow the same pathway** and be reoffered support. But some patients (eg some of those having ambulatory care) may be having numerous visits within a short time and would not be referred to specialist stop smoking advice each time and would still be on the same course of NRT / varenicline. Some may already have successfully quit.

Over time as more patients quit, the prevalence of smoking in the hospital population should decrease.

The model assumes that patients who have a LOS ≥1 would be seen while an inpatient by a specialist stop smoking service advisor but recognises that it is **very unlikely that patients with a 0 LOS would be seen as an inpatient**. 0 LOS patients will be contacted by the hospital based stop smoking advisor post discharge and referred on to Community Stop Smoking Services. Likewise if the SSSA missed any patients with a longer length of stay (eg those with LOS 1) they will be phoned by the hospital team post discharge.

Table Five Modelling of QUIT Pathway for Acute Trusts Inpatient Adult Activity: Number of Smokers, Uptake of QUIT Pathway and Number of Quits

All non-elective admissions, transfers and elective admissions, LOS 0 and ≥1, (Day cases and Maternity excluded), aged > 15 years, Assumes 20% spells smokers, full year activity, HES data from Dr Foster

A	Number of patients and number of contacts with hospital based stop smoking advisor								Notes
1	**Number of spells**	Non elective, transfers, elective with LOS 0 and ≥1, excluding day case and mat, > 15 yrs age, Dec 17 - Nov 18, HES, Dr Foster		BHNFT	DBTH	STH	TRFT	Total	
			Total	**29,910**	**52,348**	**78,918**	**28,090**	**189,266**	
			0 LOS	7,679	17,380	18,602	4,238	47,899	
			%	26	33	24	15	25	
			≥ 1 LOS	22,231	34,968	60,316	23,852	141,367	
			%	74	67	76	85	75	
2	**Number Smokers**	Assumes 20% spells smokers	**Total**	**5,982**	**10,470**	**15,784**	**5,618**	**37,853**	BTS estimates 25% of spells are smokers. SYB CQUIN finding about 14% self-reported smokers - lower than our population prevalence. We will be doing CO monitoring that will identify more than the self reported numbers. 20% is a conservative estimate but some spells will be readmissions of pts who are already taking NRT products and having SSS support etc.
			0 LOS	1,536	3,476	3,720	848	9,580	
			≥ 1 LOS	4,446	6,994	12,063	4,770	28,273	
3	**Seen by stop smoking advisor as inpt**	Assumes 75% of all smokers with LOS ≥1	≥ 1 LOS	3,335	5,245	9,047	3,578	21,205	Pts will be referred automatically but some patients will be discharged before being seen, others will be too unwell (eg end of life care, ITU, severe dementia)
11	**Number of smokers taking up NRT**	54% of all smokers admitted (all LOS)	Total	4,038	7,067	10,654	3,792	25,551	Based on GM CURE three months figures, breakdown by 0 and ≥1 not available

				BHNFT	DBTH	STH	TRFT	Total	
15	**Numbers of smokers having varenicline**	10% of all smokers admitted	Total	598	1,047	1,578	562	3,785	From GM CURE data, breakdown by LOS not available
4	**Receives one post discharge phone call from hospital based team**	Assumes 65% of smokers with LOS ≥ 1	≥ 1 LOS	2,890	4,546	7,841	3,101	18,378	

5	**0 LOSs Contacted post discharge by hospital based SSSA as not seen while inpt**	Assumes 60% of smokers with LOS 0	0 LOS	921	2,086	2,232	509	5,748	

20	**Number of inpt smokers referred on to Community Stop Smoking Services**	Assumes:	Total	2,377	3,844	6,404	2,470	15,095	
		10%	0 LOS	154	348	372	85	958	
		50%	LOS ≥ 1	2,223	3,497	6,032	2,385	14,137	
21	Number of referrals per week			46	74	123	47	290	

28	**Number of 4 week quits** (for pts who had had an inpt admission)	47%	**Total**	**1,567**	**2,465**	**4,252**	**1,682**	**9,966**	From GM CURE 5 month data - 47% of those who see specialist stop smoking advisor in hospital

This shows that in a year, **for SYB CCG patients admitted to BHNFT, DBTH, STH and TRFT** there are (table five):

- **37,853 spells** for patients **who smoke**
- **21,205** of which will be **seen by a specialist stop smoking advisor as an inpatient** (75% of those with LOS ≥1)
- **25,551** will receive **NRT** while an inpatient and as a TTA (54%)
- **3,785** will receive **varenicline** while an inpatient and as a TTA (10%)
- **18,378** will receive a **post discharge FU call** from the hospital stop smoking advisor (65% smokers with LOS ≥ 1)
- **5,748 patients who had a 0 LOS** (who are unlikely to get to see stop smoking advisor while in) **will receive a post discharge call** from the hospital stop smoking advisor (60% of smokers with 0 LOS)
- **15,095** will accept onward **referral to their local community stop smoking service** (10% of smokers with 0 LOS and 50% of those with LOS ≥1)
- **9,966** will have **quit at 4 weeks**. (47% of those who see a specialist stop smoking advisor while they were an inpatient at an Acute Trust)

6.2. Modelling for other Acute Trust Pathways

We do not have available similar data to help inform uptake of stop smoking support for:

- Children and young people and their parents
- Acute Trust outpatients
- Trust staff who smoke

Further development of these pathways is needed.

Local trusts will have flexibility as to how they use the acute Trust outpatient stop smoking service advisor capacity. Trusts may wish to prioritise key clinics eg respiratory, CVD, diabetes, cancer and / or pre-operative assessment and surgical clinics.

6.3. Modelling of mental health pathways

As noted previously we do not have any comparator studies to help inform the inpatient mental health pathways. Mental health commissioning data is also not as reliable as that for acute trusts and is not always available in the formats required.

Table six gives an indication of the **number of people with mental illness in SYB**:

- 13,647 people are on GP QOF severe mental illness(SMI) registers
- **27,285** SYB CCG patients were **in contact with adult secondary care mental health services at the end of quarter 3 2018/19** (excludes learning disability services) – this is just a snap shot of case load at a particular point in time. Many other patients will have been seen over the year. Sheffield CCG had a snapshot figure of 9,970. Data from the Trust that serves Sheffield patients (**SH&SC**) indicates that over the last 12 months **36,060** patients had **one or more contacts with the Trusts** secondary care mental health services.

- **2,775 SYB CCG patients** had an **admission to a mental health trust in the last 12 months (all ages, includes learning disability services).**
- Assuming 60% of people admitted to mental health trusts are smokers, this gives **1,665 smokers who were admitted.**

Based on clinical judgement the QUIT lead for SH&SC has estimated the number of SSSAs that would provide a good level of capacity to support **SH&SC patients** who smoke on inpatient wards and in community and home-based support services, community mental health and learning disability teams as **6 wtes.**

We have **pro-rataed** this for the other areas in SYB **based on CCG population sizes**.

We will need initially to be **flexible** as to what **proportion of this capacity** will be needed for **inpatients** and what proportion for patients **post discharge/community based mental health referrals**, until the pathways bed in and it becomes clearer the relative demands of the different elements of the pathway.

To give an indication table seven assumes that **30% of the SSSAs time** will support **inpatients** and **70% patients in the community.**

This would allow:

- **An average of 4 hours of support from a mental health SSSA per patient admitted who smokes.**
- A total of **2,146 people in SYB** with mental illness to be **treated for tobacco dependency with mental health SSSA support per year outside of hospital.**
- Assuming that all of the patients who quit, go on to receive support post discharge, the **estimated number of mental health patients per year across SYB who will QUIT at 12 months is 326.**

NB: - The SCIMITAR trial recruited patients with mental health conditions who were in the community who were interested in stopping smoking. Hence, their results may not be directly transferable to the QUIT programme.

Table six Numbers of people in contact with or admitted to secondary care mental health services and estimated number of smokers							
Source: NHS Digital via PHE Severe Mental Illness dashboard. NB: NHS Digital gives a warning about the data quality of these data sets							
		CCG					
	Time period	**All SYB CCGs**	**Barnsley**	**Bassetlaw**	**Doncaster**	**Rotherham**	**Sheffield**
Number of people on GP QOF Severe Mental Illness Registers (schizophrenia, bipolar affective disorder and other psychoses, all ages)	2017/18	13,647	2,056	840	2,581	2,433	5,737
Number of people in contact with adult secondary care mental health services (18 yrs +, excludes learning disability services)	End quarter 3 2018/19 snap shot	27,285	5,350	1,285	4,590	6,090	9,970
Number of Adult Inpt Admissions to Secondary Mental Health Services (all ages, includes learning disability services)	Quarter 4 2017/18 to Quarter 3 2018/19	2,775	310	230	635	700	900
Estimated number of people admitted who are smokers	Assumes 60% are smokers	**1,665**	**186**	**138**	**381**	**420**	**540**

Main Mental Health Trust Pts referred to			SWYFT	Notts HealthCare	RDASH	SHSC
Note: RDASH, SWYFT and Notts Health Care also cover non SYB patients so data given by CCG rather than by Trust						

Table seven Estimating the Mental Health Specialist Stop Smoking Advisor Time per Patient and Number of Patients Supported

A. SSSA appointment schedule per patient attempting to quit and number of pts that can be supported per WTE SSSA - post discharge and community based mental health services			
1. Number of mental health SSSA appts		**Num appts / pt**	
One appt each week weeks 1 - 4, then 2 weekly to 12 weeks, 6, 9 and 12 months FU		Total 11 appts	Similar schedule to the SCIMITAR trial that offered up to 12 appts
If average of 60% take up of the 11 appts		6.6 appts/pt	Some pt will not require such intensive FU & some will default. Similar mean num/pt as in the SCIMITAR trial
2. **Hours mental health SSSA time per pt**		**Average num hrs/pt**	
Direct pt contact	40 mins per appt, Average 6.6 appts per pt	4.4	
Travel time	If 40% home visits, with 40 mins travel time added per appt	1.76	
Case notes etc	10 mins per appt	1.1	
Total SSSA hours per pt		**7.3**	
3. **Caseload per wte SSSA**			
Number of direct patient contact hours per wte SSSA per year		1,391	Excludes following days per year: annual leave (33 days), bank holidays (8 days), Sick leave (5 days), CPD/man training (5 days). Plus 2 hours per week for general admin/team meetings and 1hr 30 mins for travel between sites per week
Number of pts that can be supported per wte SSSA		**192**	

B. Number of wte mental health SSSA and number of pts that can be supported as inpatients and in the community plus estimated quit rates

	SH&SC	**SWYFT**	**RDASH**	**Notts**	**Total**	
1. Total WTE SSSAs	6	2.5	6	1.5	16	
2. Capacity for support in the community						
If 70% of total capacity for community based support, WTE SSSA	4.2	1.8	4.2	1.1	11.2	
Num pts supported (assuming average of 7.3 hrs each)	805	335	805	201	2,146	
3. **Capacity for support for mental health and LD inpatients**						
If 30% of total capacity for inpts, WTE SSSA	1.8	0.8	1.8	0.5	4.8	
Number of working hours for direct pt contact					6,676	
Total number smokers admitted					1,665	
Number of hours per pt					4.0	
4. Number quits at 12 months assuming 15.2% quit rate	122	51	122	31	326	Quit rate as per in the SCIMITAR trial, assumes all patients who quit who were an inpt were referred on to community mental health SSSAs and no other quits.

7. Number of specialist stop smoking advisors needed

Appendix four sets out the **number of stop smoking advisors** needed **in the Acute and Mental Health Trusts by Trust**.

In summary, it is estimated that in addition to the Hospital Based Stop Smoking Manager we would need across SYB:

- **Acute Trusts**
    - 19.5 wte for inpatient assessments, post discharge FU calls and 0 LOS contact post discharge
    - 8.4 wte for outpatient priority pathways
    - 0.5 wte for Sheffield Children Hospital
    - Total of 28.4 wte
    - Staff support to quit– from the 30% clinical time for the stop smoking manager
- **Mental Health Trusts**
    - 16 wte to cover inpatient wards, community and home-based support services, community mental health and learning disability teams. This capacity will need to be used flexibly across both the inpatient and community settings.

8. Community Stop Smoking Services

8.1. Number of referrals from QUIT to Community Stop Smoking Services

The suggested **Acute Trust QUIT inpatient pathway** includes one post discharge call from the hospital based stop smoking service and then **ongoing follow up by the local Community Stop Smoking Services**. Table eight gives the anticipated number of onward referrals to the Community Stop Smoking Services, following on from the modelling given in table five, for patients who receive QUIT support in acute trusts as an inpatient (excludes day cases and maternity).

This estimates that there will be **15,095 referrals per year** from **acute trusts to SYB Community Stop Smoking Services** for patients who have had an **inpatient stay.**

This is a **several fold increase in activity** for the stop smoking services compared to in 2017/18 (table nine).

It is estimated that this will require the equivalent of **12.4 wte stop smoking advisors across SYB community services.**

Some of this activity will be able to be accommodated **within existing capacity:**

- A number of services are currently **functioning below full capacity.**
- A number of services have noted that they currently are utilising significant staff time to ‘generate referrals’ that **will be able to be redirected to direct client contact.**
- There is scope to look at the way support is provided, with potential to move to some **less labour intensive methods** eg use of more phone and text support rather than face to face.

Some of the QUIT referrals may be in patients that would have already been referred from the hospital to stop smoking service or would have self-referred themselves at some point ie bring forward their time of contact with SSS.

Table eight Number of referrals received by the Community Stop Smoking Services from secondary care acute Trusts after an inpatient admission							
	Barnsley	**Bassetlaw**	**Doncaster**	**Rotherham**	**Sheffield**	**Total**	
Number of referrals per year	2,824	1,063	3,354	2,546	5,307	15,095	Based on the % spells in each Trust by CCG. LA co-terminus with CCGs
Number of referrals per week	54	20	65	49	102	290	
Number of 4 week quits	1,864	702	2,215	1,681	3,504	9,966	Assumes quit rate of 47% of all those that see a stop smoking advisor (in and / or out of hospital)
Number WTE SSSA needed	2.32	0.87	2.75	2.09	4.35	12.39	Assumes 1 hr of support plus 20 mins admin per referral
Cost SSSA	£59,059	£22,237	£70,164	£53,259	£111,015	£315,734	Based on top of band 3, with no OOH supplements. NB:- Some SSS are working under capacity at the moment; some will have some current staff that can be realigned rather than needing to recruit all new staff. There is also possible scope to move to less intensive methods of follow up.

Table nine Quits in Community Stop Smoking Services in 2017/18, PHE Fingertips data

Local Authority	**Barnsley**	**Doncaster**	**Rotherham**	**Sheffield**	**Total**	No data for Bassetlaw as part of Nottinghamshire
Number pt setting QUIT date	1,502	2,595	1,689*	2,036	7,822	
Number pts quit at 4 weeks	1,018	1,526	1,062	1,062	5,132	
% quit of those setting quit date	68	59	63	52	66	
Number pts CO validated 4 week quit	653	1,151	768	754	3,326	

*There has been a recent drop in referrals in Rotherham since the commencement of a new Well Being service. 733 people set a quit date between April and Dec 2018, with 4 week quit rate of 55%.

There will also be some **referrals from acute trust outpatients** – but the numbers for these are **difficult to predict,** partly as Trusts will be given flexibility on how best to use the outpatient SSSA capacity.

As the evidence base shows that stop smoking support for people with **mental illness is best delivered within mental health services** rather than generic stop smoking services, the plan is that the mental health tobacco dependency pathways will be 'self-containing' and **not generate extra referrals to the Community Stop Smoking Services.**

8.2. Implications for Community Stop Smoking Services

a) Community Stop Smoking Services contracts

As seen above, there will be a major demand on Community Stop Smoking Services to support:

- Provision the ongoing stop smoking support for inpatients post discharge.

Plus also some referrals from:

- Outpatients who have been sign posted to Community Stop Smoking Services
- Parents of children who have been admitted

There may also be an increase in **self-referrals** of family members of patients trying to quit and general public following the publicity about QUIT.

We need to **ensure consistency of pathways within hospitals and at which point patients are handed over from hospital to community services**, otherwise **patients who receive their hospital care in one Place but live in an area covered by a different community stop smoking service will 'fall through the net'.**

Local Authorities will ensure that:

- Their community stop smoking contracts:
    - Enable referrals from secondary care for both patients and family members of patients.
    - Enable self-referrals from any member of the public. The publicity around the QUIT programme may prompt members of the general public to seek support from their local stop smoking service.
- There is sufficient capacity within the community stop smoking service to meet the increased demand
- Community Stop Smoking Services will mentor / share CPD resources with Trusts who wish to directly employ the stop smoking advisors.

Places will also ensure that they **alert neighbouring area's** CCGs, LAs and stop smoking services that the QUIT programme is being initiated and that any of their patients admitted to SYB Trusts will be offered stop smoking support and directed to local Community Stop Smoking Services post discharge/as outpatients.

Current community stop smoking service specifications and contracts will need to be amended to take account of the additional follow up activity and also if they are the hosts of the Trust based SSSAs.

b) Impact on primary care

Some patients may accept NRT/other pharmacotherapies while an inpatient and want to continue the NRT post discharge but decline ongoing specialist stop smoking support.

Each Place will need to consider how patients can access **further pharmacotherapy post discharge through either their general practice or community pharmacy** (without having stop smoking service support). This will require a **change in policy for some CCGs.**

9. Pharmacotherapy costs

There will be increased pharmacotherapy costs for Trusts, Community Stop Smoking Services and primary care prescribing.

9.1. Acute Trusts

Estimating the likely drug costs is complex. Three different approaches were looked at:

a. **Bottom up costing** based on advice from PHE's regional lead for tobacco.

b. **Pro-rata costs** based on applying the **actual drug costs incurred in the GM CURE** programme to the estimated activity levels for SYB to estimate Trust costs

c. **Pro-rata current community stop smoking drug costs** to estimated activity level and splitting between Trusts and Community Stop Smoking Service

The calculations have been complicated by:

- **Marked differences between prescribing practices** between the stop smoking services with regard to duration of therapy offered, whether single or dual therapy provided, whether patients are asked to pay a prescription fee (appendix one and three).
- **Multiple different preparations of NRT and difficulty predicting how much a patient would use**

The **bottom up costing** significantly overestimated costs compared to current spend by Community Stop Smoking Services and thus has been **discounted.** This was also the experience of the CURE programme, who over predicted the drug costs for the Trust four fold.

As the estimates based **on CURE data** are based on 'real life' experience of an Acute Trust it is **these estimates that have been used to estimate acute Trust costs.**

In order that we take account of the differences in practices of the Community Stop Smoking Services, we have **used the estimated cost per day of the current community stop smoking service drug spend to estimate the additional future costs,** taking account that the first few weeks of therapy will be provided by the Trust.

These estimates do not take account of current Trust prescribing costs for smoking cessation pharmacotherapy nor activity already generated by secondary care referrals or any underspend on current community stop smoking drug budgets. They may thus be an **overestimate of additional cost**.

The QUIT pathway assumes that the hospital stop smoking service will do one follow up phone call post discharge, with community stop smoking team following up thereafter. **The Community Stop Smoking Services are concerned** that just giving a **two week TTA will potentially leave patients with a gap before they receive their first community review and vouchers**. Hence a **four week TTA is suggested.**

Drug costs for Trusts supporting their own staff to quit have not been estimated.

9.2. Mental Health Drug Costs

Drug costs for the **mental health element** have not yet been estimated.

SH&SC are planning a 'Test for change' project **on the provision of free E-cig to inpatients. This will help to inform the future costs.**

RDASH has also been doing some recent estimates that will be able to inform the drug cost estimates.

9.3. Sharing the Drug Costs

It is suggested that for **2019/20 and 2020/21** the **pharmacotherapy drug costs are split**:

- **Acute Trusts** fund the **drug costs while the person is an inpatient** and **fund 3 weeks of the 4 week of drugs the patient takes home from hospital (TTA)** (table 10B).
    - Most of the early savings from implementation of the QUIT programme will come to the Acute Trusts through a reduction in readmissions and decrease in length of stay. Due to blended contracts, this will not be immediately recoverable by CCGs, thus it seems appropriate that Trusts fund part of the extended TTA. By splitting the cost of the extra two week TTA we also get almost equal sharing of the total drug budget between the Trusts and CCGs.
    - Giving a four week TTA also maximises the savings for the system from the discount that Pfizer offer on varenicline (90% discount for first two weeks initiation pack, then 45% discount on four week follow on pack).
- **CCGs** fund one week of the four week TTA given post discharge by Acute Trusts (table 10C) and the **additional costs incurred by Community Stop Smoking Services due to an increase in referrals from secondary care** from acute Trusts (table 11 and 12). CCGs will also fund the associated dispensing costs.

    As:

    - There is some secondary care activity currently occurring (to varying degrees between Trusts/Community Stop Smoking Services)[23]
    - Some Stop Smoking Services have an underspend on existing pharmacotherapy budgets

    it is suggested that **CCGs who no longer hold the tobacco prescribing budget agree with their local stop smoking services and Local Authority tobacco leads a baseline sum, above which the CCGs would fund the additional drug and dispensing costs** incurred.

- **Acute and Mental Health Trusts** fund the pharmacotherapy costs incurred from **supporting their own staff to quit.**
- **Mental Health Trusts** fund the costs of pharmacotherapy +/- free e-cigs for their **inpatients and the discharge TTA** (estimates outstanding).
- **CCGs** fund the pharmacotherapy costs of **mental health patients receiving support from the mental health SSSAs post discharge** and for those having stop smoking support **within the community mental health and learning disability services** (estimates outstanding).

Note:

- **If the use of e-cigs increases** (either provided by the SSS or patient funded) **then the estimated increase in drug costs to CCGs will be less.**

[23] Approximate number of referrals in last 12 months from Acute Trust to community stop smoking service: Barnsley 700, Doncaster 120, Rotherham ?, STH 300, Bassetlaw <50

- Some of the pharmacotherapy costs will be offset by a reduction in drug use by former smokers (eg less inhaler use if someone with COPD stops smoking).
- **Trusts** will wish to ensure that they have **contracts with Pfizer** to receive the **varenicline discount.**
- **Trusts** may also wish to **negotiate discounts for NRT products.**
- **From 2021/22, some NHSE funding** will come on line that will contribute to the pharmacotherapy costs. See Sustainability Plan section.
- We will only have **part year costs in 2019/20.** These have been estimated as **3 months for BHNFT, DBTH & STH and 2 months for TRFT. And a month less for CCGs.**
- There will also be a **small pharmacy dispensing fee for community pharmacotherapy provision.** It is suggested that this would be covered by the **CCGs** (table 10).
- Mental health patients' pharmacotherapy costs have not yet been estimated.
    - As the service will be Trust delivered, the discount for varenicline may be available for the whole pathway, if the Trust dispenses the drugs.
    - The Long Term Plan also recommends the use of e-cigs in mental health setting. Some SYB Mental Health Trusts have already installed e-cog vending machines.

Acute Trust Drug Costs

Table 10A Drug costs incurred by the first six months of the CURE programme

	Total drug costs for 6 months	Number smokers six months	Duration of supply	Cost per smoker per day
Wythenshawe	£27,974	2,393	14 days	£0.83

Table 10B Acute Trust QUIT Drug Costs - Pro-rata of CURE drug costs – full year costs

	BHNFT	DBTH	STH	TRFT	Total SYB
Number of smokers per year	5,982	10,470	15,784	5,618	37,853
Mean length of stay	4.3	4.6	5.8	5.0	
Inpt stay plus 14 day TTA Cost / yr	£91,446	£162,421	£261,389	£88,913	£604,169
Inpt stay plus 4 week TTA Cost/yr	£161,376	£284,809	£445,898	£154,587	£1,046,670
Difference between two and four week TTA	£69,929	£122,389	£184,509	£65,674	£442,501
50% of difference between two and four week TTA – revised figures	£34,965	£61,194	£92,255	£32,837	£221,251
Inpt stay plus 4 week TTA with sharing 50:50 difference in cost between 2 and 4 week TTA with CCGs	**£126,411**	**£223,615**	**£353,643**	**£121,750**	**£825,420**
Part year cost 2019/20 - 3 months for BHNFT, DBTH and STH, 2 months for TRFT					
Inpt stay plus 14 day TTA cost/yr	£22,862	£40,605	£65,347	£14,819	£143,633
Inpt stay plus 4 week TTA cost/yr	**£40,344**	**£71,202**	**£111,474**	**£121**	**£223,141**
Difference between two and four week TTA	£17,482	£30,597	£46,127	£10,946	£105,152
50% difference between two and four week TTA	£8,741	£15,299	£23,064	£5,473	£52,576
Inpt stay plus 4 week TTA with 50:50 share of the extra two week TTA	£31,603	£55,904	£88,411	£20,292	£196,209

Table 10C Cost for CCGs of funding 50% of the difference between Trusts giving a 2 week and 4 week TTA

	Barnsley	Bassetlaw	Doncaster	Rotherham	Sheffield	Total
% of all smokers by CCG	18.71%	7.04%	22.22%	16.87%	35.16%	
£ per CCG if fund 50% of the difference between 2 and 4 week TTA - full year	**£41,386**	**£15,583**	**£49,168**	**£37,321**	**£77,794**	**£221,251**
Part year cost 2019/20 - 3 months for BHNFT, DBTH and STH, 2 months for TRFT	£9,835	£3,703	£11,684	£8,869	£18,486	£52,576

Table 11 CCG Drug Costs from Funding Community Stop Smoking Service Costs from Additional Secondary Care Referrals from Acute Trusts

NB:- Note caveats in main text re these not taking into account current secondary care related activity or current underspends on community SSS drug budgets

Full year	Barnsley	Bassetlaw	Doncaster	Rotherham	Sheffield	Total
Number referrals to community stop smoking service from QUIT	2,824	1,063	3,354	2,546	5,307	15,095
Current Com Stop Smoking Service:						
a) Drug cost per person setting quit date	£102.70	£49.73	£77.91	£70.00	£86.18	
b) Duration of supply currently from Com SSS	12 weeks	6 weeks NRT (68% pts), 12 weeks varenicline (28.8% pts). Model on 7.5 weeks	8 weeks. Assume 12 weeks for varenicline (44%). Model on 10.5 weeks	8 - 10 weeks NRT, Varenicline 12 Weeks, Model on 9 weeks	12 weeks	
c) Mean £ per pt per day	£1.22	£0.95	£1.06	£1.00	£1.03	
Duration of community supply for quit referrals post TTA – assuming a 4 week TTA	52	20	40	30	50	
Community SSS drug cost - Assuming pt has had a 4 week TTA	**£178,446**	**£20,061**	**£141,039**	**£76,503**	**£273,178**	**£548,187**

NB: - All the drug costs should be taken as a guide of the likely order of cost and not as exact figures.

Table 12 Estimated CCG / Community Stop Smoking Service Dispensing Costs

NB: - Dispensing cost data was not available from all Community Stop Smoking Services, so the mean rate for Barnsley for 2018 has been used as a proxy for all services

Full year	**Mean per person**	**Barnsley**	**Bassetlaw**	**Doncaster**	**Rotherham**	**Sheffield**	**Total**	**Assumes**
Number referrals to community stop smoking service		2,824	1,063	3,354	2,546	5,307	15,095	
Mean per pt setting quit Barnsley 2018	£12.94							
If Trusts issue 4 week TTA	£8.63	£24,357	£9,171	£28,938	£21,965	£45,785	£130,217	2 of 6 scripts given already

Table 13 Summary CCG drug and dispensing costs

	Barnsley	**Bassetlaw**	**Doncaster**	**Rotherham**	**Sheffield**	**Total**
Full year						
50% contribution to difference between 2 and 4 week TTA	£41,386	£15,583	£49,168	£37,321	£77,794	£221,251
Community stop smoking service additional drug costs	£178,446	£20,061	£141,039	£76,503	£273,178	£689,226
Dispensing fees	£24,357	£9,171	£28,938	£21,965	£45,785	£130,217
Total	**£244,189**	**£44,815**	**£219,144**	**£135,789**	**£396,757**	**£1,040,693**
Part year 2019/20						
50% contribution to difference between 2 and 4 week TTA	£9,835	£3,703	£11,684	£8,869	£18,486	£52,576
Community stop smoking service additional drug costs	£29,741	£3,343	£23,506	£6,375.24	£45,530	£108,496
Dispensing fees	£4,060	£1,529	£4,823	£1,830	£7,631	£19,872
Total	**£43,635**	**£8,575**	**£40,013**	**£17,074**	**£71,647**	**£180,944**
Assumes 2 months costs for all CCGs except Rotherham one month						

10. Return on investment

In 2016/17 **smoking attributable admissions cost SYB CCGs £26.6 million**.[24]

Smoking is the biggest single cause of health inequalities and smoking related illness are a major contributor to **multi-morbidity** – which leads to escalation of health and care costs.

Stopping smoking is the single most effective thing that an individual can do to improve their health and will lead to **savings in health and social care costs throughout their lives.**

For SYBND Cancer Alliance smoking causes an estimated **1,670 cancers** and **1,432 cancer deaths each year**.[25]

We have strong evidence from Ottawa and London that smokers offered stop smoking support following a hospital admission have **high long term quit rates.**

Based on an estimated 37,853 spells[26] in **SYB acute hospitals** (excluding SCH) being for patients **who smoke** at time of admission and a smoking prevalence rate in those patients of 20%, if we had the same baseline and outcomes as seen in Ottawa, implementing QUIT would lead to:

- **2,271 lives saved at one year**
- **2,347 readmissions to acute trusts within 30 days prevented**
- **4,429 readmissions to acute trusts within a year prevented**
- **5,678 6 month quits**
- **£7.1m saving from acute trust readmissions alone within a year[27] (table three)**
- **£273k savings from A&E attendances within 30 days**

Table 14 below breaks these outcomes and savings down by CCG.

People's risk of A&E attendance and admission decreases immediately after stopping smoking – as indicated by the Ottawa model that found that patients were **50% less likely to be re-admitted to the hospital for any cause, and 30% less likely to visit an emergency department within 30 days.**

The **financial benefits** of the QUIT programme for the NHS will **start to be seen within weeks of patients starting to receive the intervention.**

Section two outlines some of the benefits of treating tobacco dependency in patients with mental health conditions. As mental health patients tend to smoke more intensively than others, smoking disproportionately affects their health and hence they have the most to gain from stopping smoking.

The savings will initially be mainly seen by the Trusts due to block/blended contracts being in place.

[24] PHE Local Tobacco Profile

[25] Source – NCRAS. Figures for SYBND cancer alliance do not include data for Bassetlaw, North Derbyshire and Hardwick CCG areas as it has not been possible to disaggregate data to this population level.

[26] Non elective admissions, transfers and elective admissions to Acute Trusts, LOS 0 and ≥1, (Day cases and Maternity excluded), aged > 15 years, Assumes 20% spells smokers, full year activity, SYB CCG patients only

[27] Based on estimated number of readmissions prevented, with mean admission cost £1,603 and A&E of £160. (2017/18 Department of Health Reference Costs average for non-elective hospital admission)

However, if implemented at scale during end of 2019/20 and during 2020/21, the QUIT programme will lead to a significant reduction in non-elective admissions and enable **CCGs to negotiate acute activity levels at a lower level than otherwise would have been possible from 2021/22.**

It will also **reduce pressures on primary care.**

Table 14 Estimated outcomes and savings by CCG if we achieve the same outcomes as Ottawa						
	CCG					**Total**
	Barnsley	**Bassetlaw**	**Doncaster**	**Rotherham**	**Sheffield**	
Estimated number SYB spells who are smokers (1)	7,081	2,666	8,412	6,385	13,310	37,853
6 month quits	1,062	400	1,262	958	1,996	5,678
Number of deaths saved at:						
1 year	425	160	505	383	799	2,271
2 years	510	192	606	460	958	2,725
Readmissions prevented at: 30 days	439	165	522	396	825	2,347
1 year	828	312	984	747	1,557	4,429
ED attendances	319	120	379	287	599	1,703
Saving on readmission costs at one year (£)	1,327,966	500,010	1,577,671	1,197,538	2,496,220	7,099,406
Saving on ED costs at 30 days (£)	50,980	19,195	60,566	45,973	95,829	272,543
Total Gross saving (£)	**1,378,946**	**519,205**	**1,638,237**	**1,243,511**	**2,592,049**	**7,371,949**
Non elective admissions, transfers and elective admissions to Acute Trusts, LOS 0 and ≥1, (Day cases and Maternity excluded), aged > 15 years, Assumes 20% spells smokers, full year activity, SYB CCG patients only						
Savings based on estimated number of readmissions prevented, with mean admission cost £1,603 and A&E of £160. (2017/18 Department of Health Reference Costs average for non-elective hospital admission)						

Greater savings will accrue across the person's whole life span with reduction in demand for primary, secondary care, community and social care; reduction in drug costs; reduction in staff absenteeism; healthier more productive workforce for the NHS and the local economy as a whole.

11. Funding

11.1. NHSE LTP funding

We understand from the national NHS England lead for the prevention section of the LTP, that **there will be NHSE funding for Ottawa style NHS-funded tobacco treatment services which will be phased in from 2021/22.**

- For inpatients that will cover the **costs of the in-hospital support** and **also for the patients' on going QUIT attempt post discharge.** It will include funding for specialist stop smoking advisors, pharmacotherapy (such as NRT and varenicline), plus some clinical leadership and project support. Identification of smokers and brief advice is considered to constitute routine care.
- For some high-risk outpatient pathways (eg preoperative pathways)
- Mental health
- For smoking in pregnancy

- Supporting NHS staff to quit

However, there will be a delay before the NHSE funding is available, with none in 2019/20 and only a small amount in 2020/21 for a few early adopter sites. Increasing amounts of funding will be available from **2021/22 to 2023/24.**

11.2. CQUIN funding

The Tobacco and Alcohol CQUIN for 2019/20 covers the provision of non-specialist advice including:

- **Asking patients about their smoking status**
- **Provision of brief advice**
- **Offering NRT.**

The CQUIN is available to Acute and Mental Health Trusts. Table 15 details the funding by Trust assuming full achievement.

Table 15 CQUIN Funding for Tobacco and Alcohol 2019/20						
Trust						
Acute Trust:	**BHNFT**	**DBTH**	**STH**	**TRFT**	**SCH**	**Total**
Tobacco and alcohol screening	£126,991	£168,666	£393,185	£115,920	-	
Tobacco brief advice including offer of NRT	£126,991	£168,666	£393,185	£115,920	-	
Alcohol brief advice	£126,991	£168,666	£393,185	£115,920	-	
Total CCG funded	£380,973	£505,998	£1,179,556	£347,760	-	
Total CCG funded excluding alcohol brief advice	**£253,982**	**£337,332**	**£786,371**	**£231,840**	-	
NHSE PH funding (total)	£10,637	**£11,463**	**£66,001**	Elected for Y&H local CQUIN	-	
Mental Health Trust:	**SH&SH**	**SWYFT**	**RDASH**		**Notts**	**Total**
			RCCG	DCCG		
Tobacco and alcohol screening	£102,503	£34,755	£25,208	£56,469		
Tobacco brief advice incl offer of NRT	£102,503	£34,755	£25,208	£56,469		
Alcohol brief advice	£102,503	£34,755	£25,208	£56,469		
Total	£307,509	£104,265	£75,624	£169,406		
Total excluding alcohol brief advice	**£205,006**	**£69,519**	**£50,416**	**£112,938**		

11.3. Partnership approach to interim funding

At the time of agreement of implementation last year, no ICS Transformation Funding was identified to support the programme and only £60k funding was available from slippage in 2018/19.

It is proposed that a **partnership approach** is taken to **covering the costs to enable the implementation at scale and pace of the QUIT programme** until the LTP funding from NHSE becomes available.

Yorkshire Cancer Research has expressed an interest in **supporting the programme by funding, in 2019/20 and 2020/21, the salary costs (including on costs) of the specialist stop smoking advisors** needed **within health trusts** to implement the programme.

Before taking a paper to their Board, the ICS needs to demonstrate that the ICS, Trusts, CCGs and Local Authorities will between them cover the other costs until the NHSE funding is available.

Table 16 sets out the estimated costs for **2019/20 and 2020/21** and suggests **which partner may provide the funding for the different elements.** The investment required is a mix of **cash and contribution in kind**. In summary it suggests that:

- **Cancer Alliance** pays for:
    - The SYB QUIT Programme Manager
    - The SYB QUIT clinical leads

- **ICS Transformation Funding** covers the cost of:
    - Healthy Hospital Programme Manager for each Acute and Mental HealthTrust
    - Hospital based Stop Smoking Manager for each Trust
    - Admin support for the Healthy Hospital Programme Manager and Hospital Stop Smoking
    - A part time project manager for 15 months
    - Set up costs for development of the online training modules
    - And provides contribution in kind for senior communications and engagement advice/supervision, admin support, input from the Consultant in Public Health Medicine and analytical support via the Hosted Clinical Networks.

- **Yorkshire Cancer Research** fund:
    - Hospital based specialist stop smoking advisors:
        - Acute Trusts (including Sheffield Children Hospital)
            - Covering inpatient and outpatients
        - Mental Health Trusts
            - Covering inpatients, community and home-based support services, community mental health and learning disability teams
    - SYB Comms and engagement part time band 5 post

- **Acute and Mental Health Trusts** cover the costs of:
    - Pharmacotherapy while the patient is an inpatient and for 3 weeks of a 4 week TTAs and for their own staff trying to stop smoking
    - Direct costs – eg printing of leaflets, CO monitors, signage
    - Contributions in kind areas such as:
        - Clinical and managerial leadership
        - Comms and engagement expertise
        - Staff training
        - Pharmacy staff time

        - IT support
        - Staff asking smoking status, recording CO levels, provision of very brief advice, offering and providing NRT, referral and liaison with specialist stop smoking advisors

    Based on the CQUIN values in table 15, the value of the two tobacco elements of the CQUN would more than cover the Trusts pharmacotherapy costs.

- **Local Authorities** cover the costs of:
    - Any additional community based stop smoking advisors required

- **CCGs fund:**
    - Pharmacotherapy:
        - One week of the Trust's 4 week TTA
        - Post discharge for acute and mental health patients – the additional costs above the current LA community SSS pharmacotherapy budget.
        - For mental health community patients receiving SSSA support.

Table 16 Suggested contributions from partners to the costs of the QUIT implementation prior to NHSE funding being available – 2019/20 and 2020/21

	Area of expenditure	Funded by	Costs £ or Contribution in kind		Notes
			2019/20	2020/21	
1	**System Leadership and Coordination**				
1.1	SYB ICS QUIT Programme Manager	NHSE & ICS	CiK		NHSE and ICS CiK - 0.6 wte June to Aug 2019, 1 wte band 8b funded by Cancer Alliance 8 months 2019/20, and all 2020/21
		Cancer Alliance	51,337	77,005	
1.2	SYB Clinical Leads for QUIT	Cancer Alliance	23,094	39,590	0.3 wte combined for acute and MH Trusts to work at SYB level, costed as top of band 9, 7 months 2019/20
1.3	Project manager	ICS	14,556	24,260	0.5 wte band 8a for 15 months, June 2019 to Aug 2020, 10/12 for 2019/20 (NB:- this will be delivered by half of the time of a current post holder whose contract would have expired Dec 19. Their current role can be extended over longer time period, so they do half quit and half current role for next 15 months.
1.4	Consultant in PHM	ICS	CiK		0.7 wte Medical Consultant June - Sept 2019, decreasing to 0.4 wte until Dec 2019, then 0.2 wte
1.5	Admin support for system leadership		CiK		
	Subtotal		88,987	140,855	Overheads covered as CiK
2	**Hospital Trust Leadership and Coordination**				
2.1	Executive Sponsor	Trusts	CiK		
2.2	Trust QUIT senior manager/nursing lead				
2.3	Trust Clinical Lead				
2.4	Clinical and managerial champions in each directorate / service				
2.5	Healthy Hospital Programme Managers (Acute and mental health)	ICS transformation funding	272,850	467,743	Costed as mid point 1 wte band 8a for BHNFT, TRFT, DBTH, SH&SC, RDASH; 1 wte band 8a and 1 wte band 7 for STH; 0.4 wte for SCH, SWYFT and Notts health care. Total wte 7.2 band 8a and 1 wte band 7. In DBTH the band 8a post will be supported by a band 7 post in Bassetlaw Hospital, funded by Notts County Council PH team. 7/12 for 2019/20

2.6	Admin support for HH programme manager and hospital based stop smoking service (Acute and mental health)		118,222	202,666	Costed at top band 3, 1 wte for BHNFT & TRFT, 1.75 wte for DBTH, 2.6 Wte for STH, 0.5 wte for RDASH and SH&SC, 0.2 for SWYFT, SCH and Notts healthcare, Total wte 7.95, 7/12 for 19/20
	Sub total		391,072	670,409	Overheads covered by Trusts as CiK
3	**Hospital based specialist stop smoking expertise**				
3.1	Stop smoking managers - Acute Trusts	ICS transformation funding	80,246	240,737	5.4 wte Costed at mid point band 6, 1 wte BHNFT, TRFT, DBTH, 2 for STH. 0.4 for SCH, 4/12 for 2019/20. Plus 10% for direct costs and overheads
3.2	Specialist stop smoking advisors - Acute Trusts - inpatients	Yorkshire Cancer Research	218,172	683,205	20 wte Costed at top band 3, (£25,493, with 10% time with 70% supplement (Sunday) and 15% of time with 35% supplement (Saturday)). 2019/20 BHNFT, DBTH, STH, SCH - 4/12 activity, TRFT 3/12 activity Plus 10% for direct costs and overheads
3.3	Specialist stop smoking advisors - Acute Trusts - outpatients		75,713	235,551	8.4 wte Costed at top of band 3, with no OHH supplement, 1.2 wte BHNFT and TRFT, 2.4 wte DBTH, 3.6 wte STH, 2019/20 3/12 activity at TRFT, 4/12 at others. Plus 10% direct costs and overheads
3.4	Stop smoking manager - mental health trusts	ICS transformation funding	41,609	124,826	Costed at mid point band 6, 1 wte SH&SC and RDASH, 0.4 wte SWYFT and Notts County, 4/12 for 2019/20. Plus 10% direct costs & overheads
3.5	Specialist stop smoking advisors - mental health trusts	Yorkshire Cancer Research	115,672	448,668	Costed at top band 3, 6 wte SH&SC and RDASH, 2.5 SWYFT and 1.5 for Notts Health Care (pro-rated on population size). 2019/20 4/12 for SH&SC, 3 months for SWYFT, RDASH and Notts. Plus 10% direct costs and overheads
	Sub total		531,411	1,732,987	
4	**Hospital Based Pharmacotherapy**				
4.1	Inpatients and TTAs	Trusts	196,209	825,420	Based on pro-rata of GM CURE costs to estimated number of smokers, assumes 3 months pharmacotherapy costs in 19/20 except for TRFT which is 2/12, 4 week TTA of which one week funded by CCG
4.2	Outpatients TTA	Trusts	Not estimated		

4.3	Pharmacy dispensing staff time	Trusts	To be locally determined and funded		
5	**Community Stop Smoking Services**				
5.1	Stop smoking specialist advisor support post discharge and for outpatients referred from Hospital	LA	To be locally determined		Some stop smoking services have spare capacity and / or will be able to switch methods of support to increase capacity within current resource.
5.2	Pharmacotherapy post discharge (continuation after TTAs) plus dispensing costs plus one week of TTA costs	CCGs	180,944	1,040,693	Based on pro-rata of current community SSS drug costs to QUIT related activity. Assumes Trusts give 4 week TTA, of which CCGs fund one week. Likely to be slight overestimate as not taken into account existing expenditure from current referrals from secondary care to SSS. Some SSS also have under spends on existing budgets so may be able to accommodate some increase in activity within current budgets. Estimated dispensing fees included. Assume 2 months activity for 2019/20 except for Rotherham which would be 1 month.
6	**Comms, engagement and staff training**				
6.1	ICS Comms and engagement expertise	YCR	15,142	22,712	Funding for 0.7 wte of ICS band 5 post, 8 months for 2019/20
6.2	Place based comms and engagement expertise	Trusts, CCGs, LAs	CiK		
6.3	Design costs of shared communications materials	ICS	20,000		
6.4	Design costs of e-learning materials	ICS			
6.5	Printing costs - All Trusts combined	Trusts	To be locally determined		
6.6	SYB training for clinical/managerial leads and champions	Trusts	To be locally determined		

6.7	Trust staff training programme coordination	Trusts	CiK		
6.8	Trust staff time to attend training and backfill				
6.9	Staff training of specialist stop smoking advisors	Stop smoking services	CiK		
	Sub total				
7	**Other**				
7.1	IT	Trusts	CiK		
7.2	Co monitors and mouth pieces	Trusts	To be locally determined		
7.3	Signage and other smoke free site related expenditure	Trusts	To be locally determined		
	Sub total				
8	**Total costs (excluding contribution in kind)**		**1,423,765**	**4,433,077**	Not including contributions in kind, mental health drug costs or Community stop smoking advisors

Table 17 Costs by organisation (excluding contribution in kind)

	2019/20	2020/21	
Cancer Alliance	74,431	116,595	1 wte ICS Programme Lead from Aug 18, 0.3 wte Clinical Leads
Yorkshire Cancer Research			
Acute	293,884	918,756	SSSA inpt and outpt
Mental health	115,672	448,668	SSSA inpt and community
SYB comms & engagement	15,142	22,712	
Total	424,698	1,390,137	
ICS Transformation Funding	547,482	1,060,232	Healthy Hospital Programme Manager, Stop Smoking Manager and admin for Acute and Mental Health Trusts, development of shared material and on line training modules, 0.5 wte band 8a project manager for 15 months
Acute Trusts	Pharmacotherapy costs only estimated		
BHNFT	£31,603	£126,411	Based on prorata of GM CURE costs to estimated number of smokers and provision of 4 week TTA, of which CCG fund one week. 3/12 for 2019/20 Contributions in kind eg : Provision of very brief advice leadership, clinical champions, staff training, IT, comms and engagement Asking smoking status, checking CO monitoring,
DBTH	£55,904	£223,615	
STH	£88,411	£353,643	
TRFT	£20,292	£121,750	
SCH			
Total	£196,209	£825,420	
Mental Health Trusts			
RDASH	Not yet estimated		
SH&SC			
SWYPFT			
Notts			

LAs	Community stop smoking advisors – to be locally determined		
CCGs			
Barnsley	43,635	£244,189	Based on pro-rata of current community SSS drug costs to QUIT related activity referred to Community SSS assuming 4 week TTA. Includes one week of 4 week TTA costs, Plus estimated dispensing fees. 2 months activity for 2019/20. 1 month activity for Rotherham.
Bassetlaw	8,575	£44,815	
Doncaster	40,013	£219,144	
Rotherham	17,074	£135,789	
Sheffield	71,647	£396,757	
Total	180,944	1,040,693	
Total	**£1,423,765**	**£4,433,077**	Not including contributions in kind, mental health drug costs or Community stop smoking advisors

12. Sustainability Plan

The Yorkshire Cancer Research funding would enable the pump priming of the implementation of the QUIT programme.

NHSE funding will be available in future years in line with the timetable that will be published in the Long Term Plan Implementation Framework. Our understanding is that the funding will go to commissioners, probably as part of the CCGs baseline.

The national NHSE programme manager has given an indicative timeline for when it is anticipated that the NHSE funding will be available (figure six). Within the roll out periods the amount of funding will increase for that programme area in an incremental manner. The amount of funding that will be available in each of the years has not yet been confirmed.

Figure Six Indicative Timeline for NHSE Funding.

	2019/20	2020/21	2021/22	2022/23	2023/24
Programme initiation	Initiation				
Inpatient smoking cessation		Early Implementers		Roll out	
Smokefree pregnancy		Early Implementers		Roll out	
Outpatient smoking cessation				Early Implementers	Roll out
NHS Staff support		Early Implementers		Roll out	

Implementation of the QUIT programme will give a very good return on investment financially as well as with regard to health outcomes and reduction in health inequalities.

The programme will more than recover its costs in reduction in acute admissions alone.

The number of hospital admissions in smokers will start to decrease as soon as the programme is implemented.

Some of the pharmacotherapy costs will be offset by a reduction in drug use by former smokers (eg less inhaler use if someone with COPD stops smoking).

The funding from YCR gives Places time to plan for the picking up of the costs of the stop smoking advisor posts that will be funded by YCR until the end March 21.

It is suggested that **from 2021/22** as the **NHSE funding starts becoming available to CCGs** that:

- In light of the reductions in admissions expected due to people stopping smoking, CCGs **growth forecast for acute admissions for 21/22 onwards will reduce**, '**releasing' the funding** to commission the **Trust based specialist stop smoking service managers, advisors, admin support and inpatient and community pharmacotherapy costs**. This will be **part funded by the NHSE funding** as it is incrementally introduced.
    - **CCGs picking up these costs are dependent on Trusts having demonstrated good levels of implementation during 2020/21.**
    - If Trusts continue to have a CQUIN that covers NRT costs, this would need to be factored in.
- **Trusts** pick up the funding of the **Healthy Hospital Programme Managers**.
- **LAs** continue to **ensure and fund sufficient capacity within Community Stop Smoking Services** but with **their share of the NHSE funding** as this is incrementally increased.

There is a **risk** that the **NHSE funding may be inadequate to cover all of the costs of the programme** and this will **need to be kept under assessment as further information is obtained from NHSE**.

However, as supporting people to quit is cost savings, the CCGs should still have a net financial gain from implementing the QUIT programme.

See appendix six for detailed sustainability planning information. This is summarised in the table 18 below.

Table 18 Summary of Sustainability Plan By Organisation

Staffing	2019/20	2020/21	21/22	22/23	23/24	
Cancer Alliance	74,431	116,595				Clinical leads and ICS Healthy Hospital Programme Lead
Yorkshire Cancer Research	424,698	1,390,137				SSSA for Acute and Mental Health Trusts, SYB comms
ICS Transformation Funding	527,482	1,060,232	116,595	77,005		19/20 & 20/21 ICS project management, HHPM, admin & SSS managers Acute & MH trusts, 21/22 QUIT clinical leads and Programme manager, 22/23 QUIT programme manager
CCGs	180,944	1,040,693	459,885	459,885		Community pharmacotherapy, assumes Trusts give 4 week TTA in 2019/20 and 20/21, of which CCGs fund one week. After that SSSA , SS manager and admin for mental health community and acute trust outpts.
CCGs/NHSE			3,341,880	3,341,880		Inpt, TTA & community pharmacotherapy and SSSA , SS manager and admin for inpts acute trust & MH.
Acute Trusts	196,209	825,420	304,715	304,715	304,715	19/20 & 20/21 inpt drug costs including 4 week TTA of which CCG funds one week , 21/22 onwards Healthy Hospital Programme Manager
Mental Health Trusts	Not yet calculated drug costs		163,029	163,029	163,029	19/20 & 20/21 inpt drug costs and TTA; 21/22 onwards Healthy Hospital Programme manager
LA	To be locally determined					Community SSSA
LA /NHSE			To be locally determined			
NHSE					3,801,766	All costs except healthy hospital programme managers. Plus also need to add in mental health drug costs and Community SSSAs
Total	**1,403,765** (plus £20k non recurrent ICS funded)	**4,433,077**	**4,386,104**	**4,346,514**	**4,269,509**	Not including mental health drug costs or community SSSA In yr one, also £20k for development of e-learning package and other materials funded by ICS

13. Risks

The greatest risk comes from failing to implement the QUIT programme at pace and at scale, resulting in huge opportunity costs of not realising the potential to decrease tobacco related harm and admissions.

Table 17 Risks Associated with the Implementation of QUIT

	Description	Mitigation
1.	Failure of agreement of sharing of costs (until NHSE funding available) between partners and thus failure to: - Progress application with Yorkshire Cancer Research - Progress with implementation of QUIT Leading to continued high smoking rates and smoking related morbidly, mortality and inequalities. And thus, demand for primary, secondary, community and social care services.	• Organisations to show strong leadership and partnership working • Prior discussion of business case with stakeholders
2.	Failure of NHSE funding to come on line when expected and / or to not fully cover costs	• Keep in close contact with NHSE colleagues to identify any gaps early • Appoint SSSA on the grade that we know NHSE are modelling on (band 3) • Financial planning by CCGs to be mindful of this risk
3.	Patient numbers and uptake rates varying from the modelling - Modelling has either under or over estimated the number of patients who will be referred on to Community Stop Smoking Services – if overestimated this will lead to increased drugs costs that will not materialise and lower quit rates, if under estimated this will lead to increased costs but more successful quits - Modelling has under estimated the proportion of patients having pharmacotherapy and thus the drug and dispensing costs. It is however, more likely that we have overstated the proportion of people that take up community stops smoking support and thus drug costs.	• Have modelled hospital costs based on experience in GM with the first six months of the CURE programme • Collect data for ongoing monitoring and adjust staffing levels and or pathways accordingly • If we have overestimated the number of SSSA needed for inpt work, they could be utilised to ether support care post discharge or to expand the outpatient offer
4.	We have not yet estimated the drug costs for mental health patients and it is difficult to predict what impact increasing Very Brief Advice provision in outpatients will have.	• Work with MH Trusts to estimate likely patient numbers and drug costs for mental health pathways
5.	Failure of implementation by Trusts ▪ Eg lack of prioritisation of the training of staff and to support the culture change required, leading to low rates of asking about smoking status, CO monitoring and provision of VBA ▪ Failure to provide NRT quickly on wards	• Strong executive leadership • Strong clinical leadership with a Trust clinical lead and clinical champions in all directorates / specialities • Identification of programme management and clinical champions in all relevant directorates/specialities • Integration of staff training into induction and mandatory training • Effective implementation of staff communication plan • Good programme management and coordination

		lead by dedicated HHPM • Adjust electronic records to ensure that smoking status and CO levels have to be entered • Wards to maintain stock of variety of NRT products • Implement protocols to allow NRT to be provided without need for prescription
6.	Lack of access to specialist stop smoking advisors on ward leading to patients unable to access specialist support or delays in access that may lead to delays in discharge for patients with short stays.	• Implement electronic referral system to specialist stop smoking advisors from wards, that includes predicted date of discharge to allow prioritisation of pts with short LOSs • Ensure stop smoking advisors are available 7 days per week, with greater capacity in mornings to prevent delays in discharge for patients with short LOSs • Model predicted demand and ensure flexible contract with ability to adjust capacity in relation to demand
7.	Lack of consistency in clinical pathways and guidelines across SYB resulting in: - Staff confusion/frustration if working across sites - Patients falling through the net if they receive hospital care in different Place to their local community stop smoking service - Inequities in provision across SYB	• Co-design and implement: • Consistent clinical pathways and guidelines • Consistent staff training • Ensure hand overs between hospital and Community Stop Smoking Services occur at a consistent place in the pathway across SYB
8.	Insufficient capacity within community stop smoking contracts to meet demand for ongoing support	• Good communication between Trusts, LA and Stop smoking services • Predict likely impact and plan accordingly an increase in capacity – negotiate flexible contract with provider that enables increases in capacity in line with generated demand • Reorientation of existing specialist stop smoking resources away from 'demand generation' and streamline way support provided
9.	Barnsley stop smoking service is currently out for re-procurement.	• Procurement tender documentation includes provision of support to QUIT programme and need to be flexible re activity volume.
10.	If both acute and mental health trusts want community stop smoking services to provide an in reach service, then the expansion may be above that which could be done as a contract variation with the stop smoking service	• Early discussion at a Place level regarding the employer of the trust based SSSAs • Early discussion with procurement colleagues to explore all possible options and their procurement implications

14. Governance

The **ICS Senior Responsible Officer** for the delivery of the QUIT programme will be a **Dr Richard Jenkins, Chief Executive of Barnsley Hospital NHSF Trust** and the ICS's Lead CE for Provider Development.

The **SYB QUIT Steering Group** will be responsible for **the delivery of the programme** and will report to the SYB ICS QUIT Oversight Group. This will be an executive level group that will oversee the delivery of the project and support the 'unblocking' of any barriers that occur during implementation. See box ten for membership of the two groups.

The QUIT programme will form part of the Hospital Services Portfolio, and through that's Programme Board report to the **ICS Health Executive Group and ICS Collaborative Partnership Board.**

We see YCR as a key member of the Oversight Group. The **Cancer Alliance** will have a representative on the SYB QUIT Steering Group and **NHS Sheffield CCG's Director of Finance** will be on the group and also liaise with the other CCG's Directors of Finance/Chief Finance Officers on a regular basis.

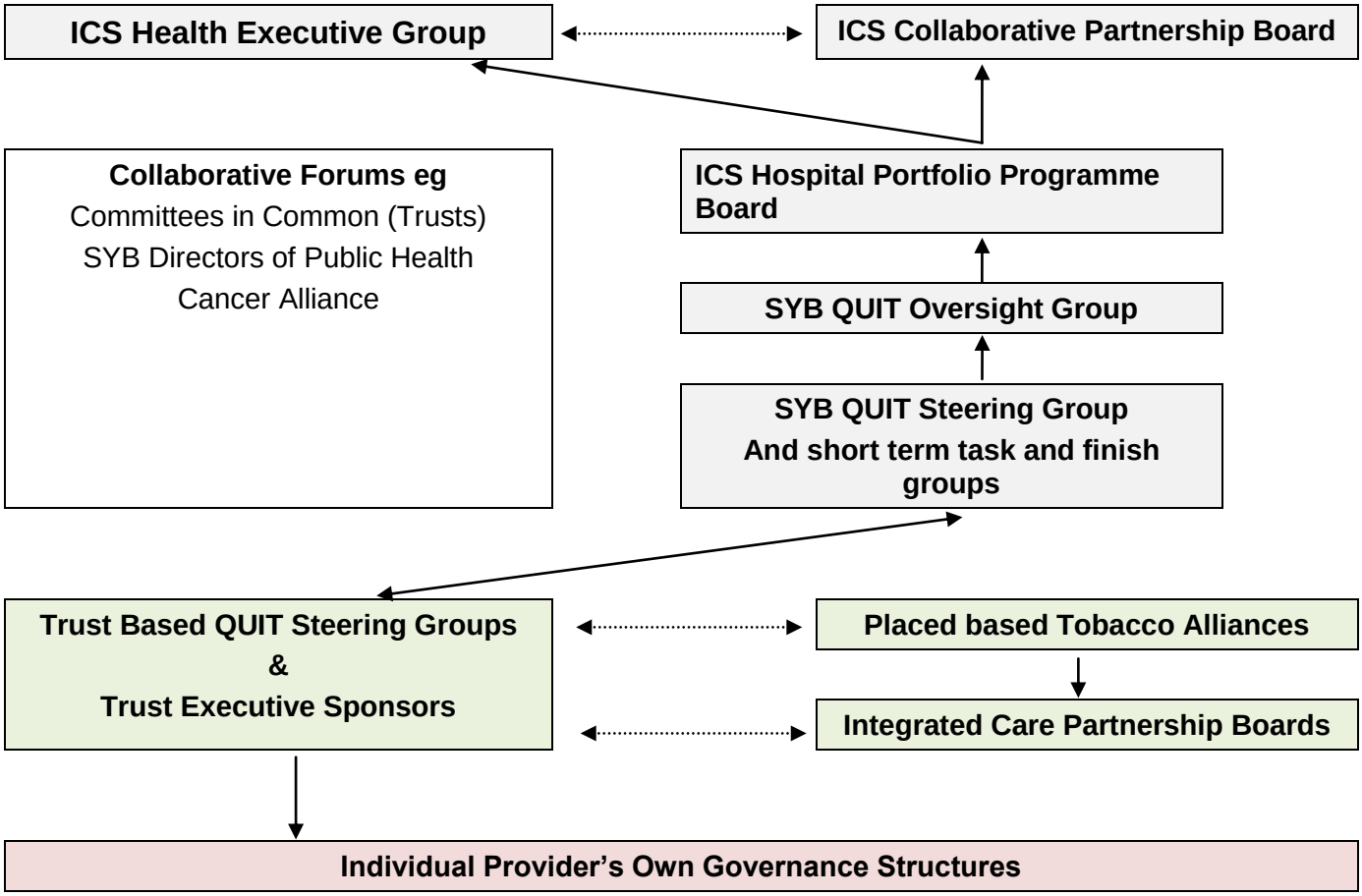
Each Trust has an identified **Executive Sponsor**, who will be responsible for the delivery of the programme within their Trust, and has a **QUIT steering group** to drive delivery within the Trust.

Julia Burrows, Director of Public Health for Barnsley Council, is the **lead Director of Public Health** for the programme.

The **Local Authority Tobacco Lead** in each Place will **ensure coordination at a Place level** between the various Trusts and the local Community Stop Smoking Services and update the local **Tobacco Alliance** and the **Integrated Care Partnership** in each Place.

Each Trust / service provider retains **responsibility for the governance of their own service**.

Figure seven QUIT Programme Governance



Box ten Membership of the QUIT Oversight and Steering Groups	
QUIT Oversight Group SRO - Dr Richard Jenkins (chair), CE Barnsley Hospital NHSF Trust QUIT Exec Sponsors from each Trust SYB QUIT Clinical Leads Sheffield CCG Director of Finance – Jackie Mills Lead Director of Public Health – Julia Burrows Cancer Alliance Programme Director – Julia Jessop Yorkshire Cancer Research Rep PHE Programme Manager for Tobacco – Scott Crosby SYB ICS QUIT Programme Manager – Caroline Burrows SYB ICS Consultant in PHM – Dr Lisa Wilkins SYB QUIT Project Manager – Karen Smith SYB AD Comms & Engagement – Helen Stevens	**QUIT Steering group** Trust QUIT lead/Health Hospital Programme Manager LA Tobacco Leads Stop Smoking Service rep SYB QUIT Clinical Leads PHE Programme Manager for Tobacco – Scott Crosby SYB ICS QUIT Programme Manager – Caroline Burrows SYB ICS Consultant in PHM – Dr Lisa Wilkins SYB QUIT Project Manager – Karen Smith SYB Comms & Engagement post ? CCG rep

Finance and contracting

The **funding** from Yorkshire Cancer Research will be **hosted by Sheffield CCG** and distributed to CCGs and LAs as appropriate for onward funding of the specialist stop smoking advisors subject to the ICS QUIT team confirming that the Trusts/SSS have been meeting their milestones.

A **service specification** for Acute Trusts and a separate one for Mental Health Trusts will be developed by the ICS with Trusts that:

- Outlines the key elements of the quit model and the concept of the wider Healthy Hospital Programme
- Notes the areas that require consistency across Trusts and areas where there is local flexibility
- Details KPIs and anticipated activity levels
- Details monitoring and evaluation requirements
- Includes the communications and marketing requirements of Yorkshire Cancer Research

The specifications will need to vary depending on whether the Trust will employ the stop smoking manager and SSSAs or whether these are employed by the community stop smoking service.

CCGs will include the service specification as a **contract amendment in Trusts contracts**.

Local Authorities, as commissioners of the local Community Stop Smoking Services will **amend the community stop smoking service specifications and contracts** to take account of the additional follow up activity and if they are the employer of the Trust based posts.

In order to access the ICS Transformation Funding and Yorkshire Cancer Research, **Places will be expected to submit an implementation plan to the ICS demonstrating how the partners at Place will work together to implement the QUIT programme.**

15. Summary and recommendations

Smoking is the biggest cause of preventable ill health and health inequalities and the biggest risk factor for cancer. But there are highly effective treatments for smoking. If we have the same outcomes as seen in Ottawa, we could save over 2,000 lives and £7.4 million of admissions and A&E attendances in the first year of implementation.

South Yorkshire and Bassetlaw CEs and AOs agreed to implement an Ottawa like tobacco dependency treatment programme in secondary care across SYB a year ago – the QUIT programme. While there is excellent commitment from Trusts to implement the programme, progress is being hindered by lack of resources.

This paper has set out the key steps for implementation, modelled the anticipated number of smokers who are admitted, the likely uptake rates and the number of specialist stop smoking advisors required to provide the specialist support.

It is predicted that just from supporting patients in the acute inpatient pathway that **9,966** 4 week quits will be achieved in a year.

As well as needing to invest in specialist stop smoking support and pharmacotherapy within Trusts, a big increase in demand for Community Stop Smoking Services compared to currently is likely.

Yorkshire Cancer Research has expressed an interest in **supporting the programme by funding, in 2019/20 and 2020/21, the salary costs of the specialist stop smoking advisors** needed **within trusts** to implement the programme.

Before taking a paper to their Strategy Impact Group in July and Board in September, the ICS needs to demonstrate that the ICS, Trusts, CCGs and Local Authorities will between them make an interim investment until the NHSE funding is available:

- To **cover the costs of the other elements needed to implement QUIT** (eg coordination and management of the programme, staff training, pharmacotherapy, specialist stop smoking support post discharge)

- To **cover costs of the specialist advisors from 2021/22** if there is a delay to, or a shortfall in, the national NHSE funding that is due in 2021/22.

This proposal has suggested a partnership approach to add to the funding potentially available from Yorkshire Cancer Research to enable the implementation of the QUIT programme at pace and scale prior to the NHSE funding becoming available. A sustainability plan for after the end of the YCR and ICS funding is also set out.

Recommendations: The Health Executive Group is asked:

1. To note the **huge potential health gain and reduction in health inequalities** possible through the systematic provision of stop smoking support within secondary care.

2. To note that supporting people to stop smoking is **cost saving** and implementation of QUIT at scale in the acute Trusts alone would lead to **savings of over £7 million pounds a year** in prevented non-elective admissions, while also **saving over 2,000 lives a year.**

3. To **support the application for funding from Yorkshire Cancer Research** to fund the hospital based stop smoking advisors in 2019/20 and 2020/21.

4. To note that **Yorkshire Cancer Research** would want **full recognition as a partner in the programme in all QUIT related publicity**, for the **staff they are funding to be recognisable** as their staff and for **their logo to be on QUIT related materials**.

5. To note that **YCR will require us to agree milestones and KPIs with them. We will thus develop an outline service specification for Trusts and agree evaluation and monitoring requirements.**

6. To **approve the QUIT business plan** and **agree a Trust CE SRO for the programme**

7. To note that subject to the business case being approved and all parties agreeing to contribute, this would enable the **first Trusts to be delivering QUIT at scale from January 2020.**

8. To **approve the proposed contribution from the ICS** utilising transformation **funding this year and next year.**

9. To **approve the release of the ICS funding for the Healthy Hospital Programme Manager if the indication from the YCR Strategy Impact Group is positive.** This will enable the rapid recruitment of the posts by Trusts to a common SYB job description and the preparation for QUIT to progress at pace from September in all Trusts. We will also seek to **appoint the SYB QUIT clinical leads at that point**.

10. To note that the:

- **CCGs contribution to the business case and sustainability plan has been supported by the CCG CFOs.**
- **SYB DPHs have given a commitment to ensure that there is sufficient capacity within the Community Stop Smoking Services to meet demand for the follow up support.**

11. To note that in order to access the ICS Transformation Funding and Yorkshire Cancer Research funding (if their Board agrees the proposal), **Places will:**

- **Be expected to submit an implementation plan to the ICS demonstrating how the partners at Place will work together to implement the QUIT programme.**
- **Be expected to work collaboratively across SYB to co-design and implement the same core QUIT clinical pathway, clinical guidelines and supporting resources such as e-learning package**
- **To collect an agreed SYB data set and participate in the monitoring/evaluation of the programme**
- **Abide by the (to be agreed) YCR communications and marketing requirements**

12. To note that the Healthy Hospital Programme Managers will have a common job description and all take a lead for the system for a certain aspects of the programme

13. To note that smoking during pregnancy is being covered within the Better Births work stream.

Appendix one Smoking Rates in SYB, SYB Community Stop Smoking Services and Local Tobacco Control Initiatives

Smoking Prevalence Rates

Smoking Prevalence in adults (18+) - current smokers (APS) 2017

Proportion - %

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Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	–	6,496,890	14.9	14.6	15.1
SYB	–	-	-	-	-
Barnsley	–	35,069	18.2	15.3	21.1
Doncaster	–	47,956	19.7	17.1	22.4
Rotherham	–	33,542	16.2	13.8	18.7
Sheffield	–	78,285	17.0	14.3	19.7

Source: Annual Population Survey (APS)

Smoking Prevalence in adults in routine and manual occupations (18-64) - current smokers (APS) 2017

Proportion - %

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Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	–	-	25.7	25.1	26.4
SYB	–	-	-	-	-
Barnsley	–	-	27.5	20.5	34.5
Doncaster	–	-	31.6	25.8	37.3
Rotherham	–	-	22.8	17.6	28.1
Sheffield	–	-	27.3	20.4	34.1

Source: Annual Population Survey (APS)

Local Stop Smoking Services Data, 2017/18 from PHE Local Tobacco Control Profile

Smokers setting a quit date 2017/18

Crude rate - per 100,000 smokers aged 16+

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Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	–	274,021	4,097	4,047	4,148
SYB	–	-	-	-	-
Barnsley	–	1,502	4,173	3,659	4,771
Doncaster	–	2,595	5,267	4,673	5,949
Rotherham	–	1,689	4,893	4,256	5,621
Sheffield	–	2,036	2,534	2,199	2,932

Source: NHS Digital Stop Smoking Services data, Annual Population Survey, and PHE Risk Factors Intelligence Team

Smokers that have successfully quit at 4 weeks 2017/18

Crude rate - per 100,000 smokers aged 16+

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Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	–	138,426	2,070	2,043	2,096
SYB	–	-	-	-	-
Barnsley	–	1,018	2,828	2,458	3,249
Doncaster	–	1,526	3,097	2,735	3,502
Rotherham	–	1,062	3,076	2,663	3,557
Sheffield	–	1,122	1,397	1,205	1,626

Source: Risk Factors Intelligence Team, Public Health England

Smokers that have successfully quit at 4 weeks (CO validated) 2017/18

Crude rate - per 100,000 smokers aged 16+

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Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	–	98,802	1,477	1,457	1,497
SYB	–	-	-	-	-
Barnsley	–	653	1,814	1,565	2,100
Doncaster	–	1,151	2,336	2,059	2,661
Rotherham	–	768	2,225	1,913	2,587
Sheffield	–	754	939	808	1,100

Source: Risk Factor Intelligence, Public Health England

Cost per quitter 2017/18

Crude rate - £

Export table as image Export table as CSV file

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	–	-	519*	-	-
SYB	–	1,268,222	581*	-	-
Barnsley	–	-	*	-	-
Doncaster	–	-	*	-	-
Rotherham	➡	669,654	631	-	-
Sheffield	➡	598,568	533	-	-

Source: Health & Social Care Information Centre - Statistics on NHS Stop Smoking Services, England

Appendix Two Evidence Base for Support for Patients with Mental Illness

Smoking Cessation Intervention for People with Severe Mental Ill Health: SCIMITAR+ Trial

The SCIMITAR+ trial, led by the University of York, has demonstrated that when people with severe mental ill health (SMI) are provided with a bespoke smoking cessation intervention, smoking quit rates were doubled compared to those who received usual care. The result was attenuated at 12 months indicating that more effort is needed to sustain the effects of the intervention in the longer term.

Background to SCIMITAR+

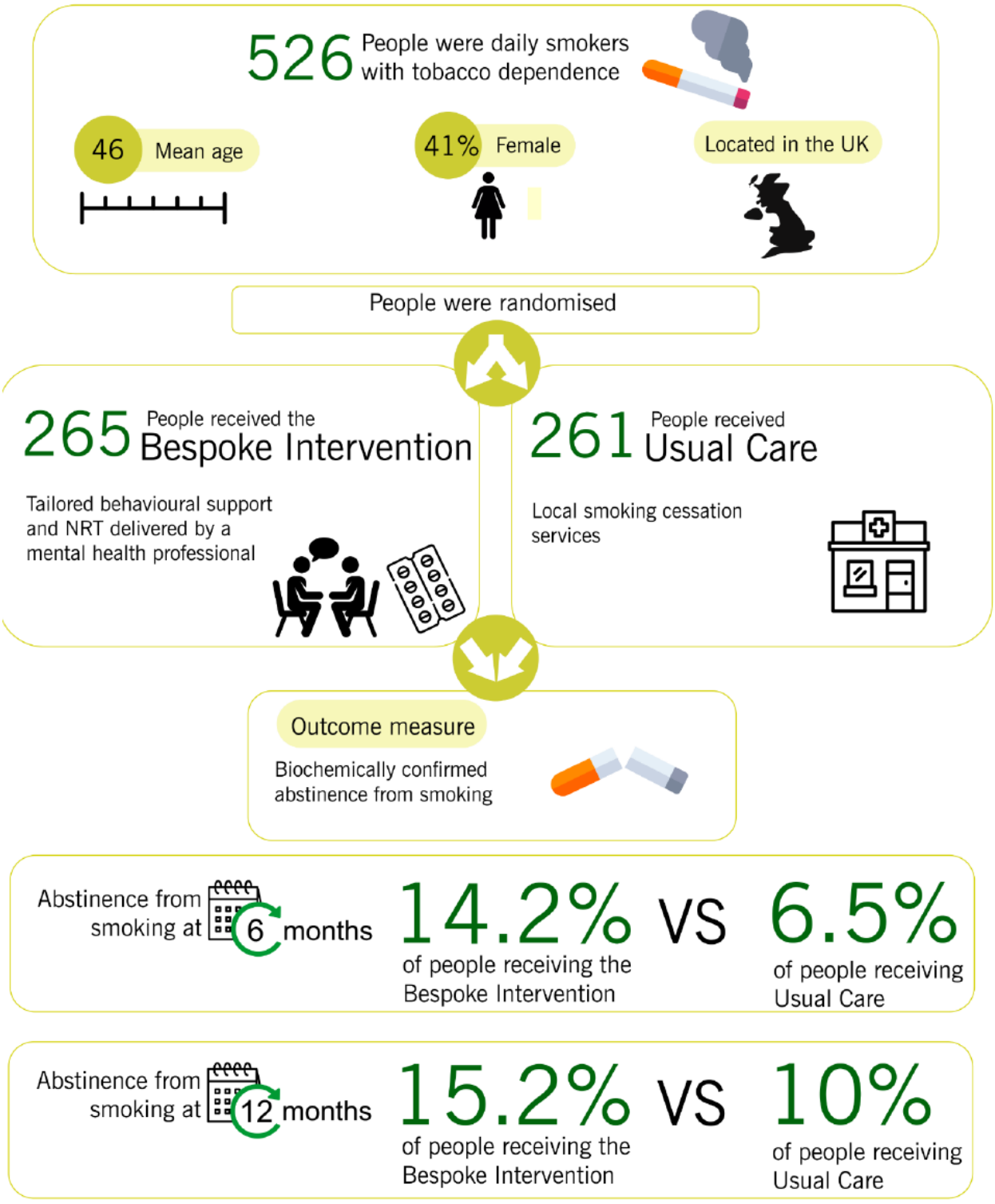
Smoking is a known health hazard and people who have experienced (SMI) are three times more likely to smoke than the wider population and are therefore more at risk to health inequalities. People with SMI tend to smoke more heavily and have not historically engaged with NHS smoking cessation services, yet, when asked, over half of people with SMI who smoke express a desire to cut down or quit smoking. The provision of services that are specifically designed for people with SMI could therefore address this health inequality and unmet need. Such innovative services need to be underpinned by rigorous research evidence, but there have been few trials to date in this area.

The SCIMITAR+ trial

The SCIMITAR+ trial which was designed to test a bespoke smoking cessation intervention for patients with SMI compared to standard NHS care. SCIMITAR+ is the largest trial of its kind ever undertaken. Participants were heavy smokers that said they would like to cut down or quit smoking. Those allocated to the bespoke smoking cessation intervention received support to help them quit from a mental health professional who had undergone brief but rigorous training. This support was based on National Centre for Smoking cessation and Training level 2 training with enhanced levels of contact and support. People in usual care were signposted to local smoking services. People were followed up six and 12 months later where they completed questionnaires that asked about their smoking status as well as giving a carbon monoxide breath measure to verify this.

Conclusions from SCIMITAR+

The SCIMITAR+ Trial demonstrates that bespoke smoking cessation interventions encourage engagement with services and help people with SMI to quit. Therefore, health systems should provide smoking cessation interventions that are tailored and responsive to the needs of people who use mental health services.


526 People were daily smokers with tobacco dependence
46 Mean age
41% Female
Located in the UK
People were randomised
265 People received the Bespoke Intervention
Tailored behavioural support and NRT delivered by a mental health professional
261 People received Usual Care
Local smoking cessation services
Outcome measure
Biochemically confirmed abstinence from smoking
Abstinence from smoking at 6 months
14.2% of people receiving the Bespoke Intervention
vs
6.5% of people receiving Usual Care
Abstinence from smoking at 12 months
15.2% of people receiving the Bespoke Intervention
vs
10% of people receiving Usual Care

Appendix Three – Pharmacotherapy

NICE Recommendations

Stop smoking interventions and services NICE guideline [NG92] March 2018

1.3 Evidence-based stop smoking interventions

These recommendations are for commissioners and providers of stop smoking support.

1.3.1 Ensure the following evidence-based interventions are available for adults who smoke:

- behavioural support (individual and group)
- bupropion
- nicotine replacement therapy (NRT) – short and long acting
- varenicline
- very brief advice.

1.3.2 Consider text messaging as an adjunct to behavioural support.

1.3.3 Offer **varenicline as an option for adults who want to stop smoking, normally only as part of a programme of behavioural support**, in line with NICE's technology appraisal guidance on varenicline.

1.3.4 For adults, prescribe or provide varenicline, bupropion or NRT before they stop smoking.

1.3.5 Agree a quit date set within the first 2 weeks of bupropion treatment and within the first 1 to 2 weeks of varenicline treatment. Reassess the person shortly before the prescription ends.

1.3.6 Agree a quit date if NRT is prescribed. Ensure that the person has NRT ready to start the day before the quit date.

1.3.7 Consider NRT for young people over 12 who are smoking and dependent on nicotine. If this is prescribed, offer it with behavioural support.

1.3.8 Ensure behavioural support is provided by trained stop smoking staff (see the National Centre for Smoking Cessation and Training [NCSCT] training standard).

1.3.9 Ensure very brief advice is delivered according to the NCSCT training module on very brief advice.

1.6.4 Explain that a **combination of varenicline and behavioural support or a combination of short-acting and long-acting NRT are likely to be most effective.**

1.6.5 If people opt out of a referral to local stop smoking support, refer them to a professional who can offer pharmacotherapy and very brief advice.

1.5 **Advice on e-cigarettes**

1.5.1 For people who smoke and who are using, or are interested in using, a nicotine-containing e-cigarette on general sale to quit smoking, explain that:

- although these products are not licensed medicines, they are regulated by the Tobacco and Related Products Regulations 2016
- many people have found them helpful to quit smoking cigarettes
- people using e-cigarettes should stop smoking tobacco completely, because any smoking is harmful
- the evidence suggests that e-cigarettes are substantially less harmful to health than smoking but are not risk free
- the evidence in this area is still developing, including evidence on the long-term health impact.

Smoking: acute, maternity and mental health services Public health guideline [PH48] 2013

Recommend and offer:

- **Licensed nicotine-containing products** (usually a **combination of transdermal patches with a fast-acting product** such as an inhalator, gum, lozenges or spray) to all people who smoke or
- **varenicline or bupropion** as sole therapy as appropriate. Do not offer varenicline or bupropion to pregnant or breastfeeding women or people under the age of 18. Varenicline and bupropion can be used with caution in people with mental health problems.
- Encourage people who do not want (or do not feel able) to stop smoking completely (including pregnant or breastfeeding women) to use licensed nicotine-containing products to help reduce cravings to smoke during their stay or visit.
- If stop smoking pharmacotherapy is accepted, ensure that it is provided immediately.
- The person should remove nicotine replacement therapy (NRT) patches 24 hours before microvascular reconstructive surgery and surgery using vasopressin injections.
- When people are discharged from hospital ensure they have sufficient stop smoking pharmacotherapy to last at least 1 week or until their next contact with a stop smoking service.
- Encourage people who are already using an unlicensed nicotine-containing product (such as unlicensed electronic cigarettes) to switch to a licensed product. Advise the person of local policies on indoor and outdoor use of unlicensed nicotine-containing products.
- Ensure hospital pharmacies stock varenicline, bupropion and a range of licensed nicotine containing products (including transdermal patches and a range of fast-acting products) for patients and staff .
- Ensure people using secondary care have access to stop smoking pharmacotherapies at all times.
- Ensure a range of licensed nicotine-containing products are available for sale in hospital to visitors and staff.

Smoking: supporting people to stop Quality standard [QS43] Published date: August 2013

- It is important that people who smoke who receive pharmacotherapy receive a full course, which will vary depending on the individual smoker. A full course for NRT is at least 8 weeks, for varenicline it is at least 12 weeks and for bupropion it is at least 8 weeks

BNF

Recommends:

- Varenicline for 12 weeks
- NRT for 12 weeks extending to 24 weeks in certain circumstances

Percentage of people accessing Community Stop Smoking Services who use pharmacotherapy, April to Dec 2018, NHSE Digital, Statistics on Stop Smoking Services

		% Of Those Setting a Quit Date											
	Number people setting quit date	Single NCP only	Combination of licensed NCPs concurrently	Bupropion only	Varenicline only	Licensed NCP and/ or Bupropion and/ or Varenicline consecutively	Combination of a licensed medication and an unlicensed NCP concurrently	Licensed medication and an unlicensed NCP consecutively	Unlicensed NCP	Did not use any licensed medication or unlicensed NCP	Not Known	Sum of all options including licensed NCP	Sum of all options including Varenicline (assumes that all licensed medication if not specified is varenicline)
England	166,880	21.7%	31.8%	0.3%	28.7%	2.0%	2.5%	0.9%	1.2%	7.2%	3.7%	55.5%	34.2%
Barnsley	1,231	12.0%	51.7%	0.0%	23.3%	3.7%	3.2%	0.0%	0.6%	5.6%	0.0%	67.3%	30.1%
Doncaster	1,904	45.4%	4.7%	0.0%	39.3%	3.7%	1.2%	0.3%	0.4%	4.8%	0.2%	53.9%	44.5%
Rotherham	733	31.4%	23.2%	0.0%	36.2%	1.0%	0.4%	0.0%	2.2%	3.4%	2.3%	55.5%	37.5%
Sheffield	1,581	47.5%	2.1%	0.1%	36.9%	4.9%	0.4%	0.2%	0.1%	2.9%	4.9%	54.5%	42.5%
Total SY	5,449												
Mean SY		36.6%	17.0%	0.0%	34.6%	3.7%	1.3%	0.2%	0.6%	4.2%	1.8%	57.3%	39.7%
Nottinghamshire	2,879	27.8%	38.5%	0.0%	19.9%	1.7%	6.8%	0.4%	0.7%	3.3%	0.9%	68.0%	28.8%

Feedback from SY&B Stop Smoking Services re Pharmacotherapy Policies / Practice (May 2019)						
	Questions	**Sheffield**	**Doncaster**	**Barnsley**	**Rotherham**	**Bassetlaw**
1	What is your current offer of community support? How much SSSA time per person do you currently work out staffing levels at?	Following referral from the hospital to the stop smoking service the patient will be referred to an appropriate venue (GP's, Market or Pharmacy) or telephone support service if can't travel to an advisor or if preferred. They would be offered a 12-week programme* of support with medication (NRT, Champix, zyban or advice on e-cigs). SSSS would endeavour to keep patient on whatever the hospital had initiated. *weekly f2f appts for 4 weeks, 2 weekly appts to 12 weeks. 1st appt 40 mins; subsequent appts 20 mins.	Weekly up to 4 weeks post quit date. Fortnightly after that up to 12 weeks in total. Where: variety of community of community venues 20% over phone (no difference in quit rate – popular/ liked by clients)	Same (as Doncaster)	F2f or telephone support for 8-12 weeks Pharmacotherapy: 8-10 weeks direct supply (phone clients have it posted to them) NRT or Champix. Support e-cigs but don't provide. Dual therapy available if requested or at advisor's discretion. Champix via PDG (pharma outcomes – requested to clients chosen pharmacy for collection by client)	In community – clinics in Bassetlaw plus also offer telephone support. Couple of advisors currently based in hospital and couple in GP Practices. Each patient – entered onto 6-week programme of behavioural support (f2f or phone). 1st appt 30 min Weeks 2-6 (5 contacts) 15 mins After 6 weeks – hoped they quit on week4. If still using pharmacotherapy advised to buy their own. 6 month follow up – offered help and support if smoking again.
2	Do you currently offer dual product NRT funded by the stop smoking service or just fund single product NRT?	Single product NRT. However, offer dual if we think they need it (via voucher). Most people are happy to buy the 2nd product.	Only 1 product free no prescription charge – client advised to buy 2nd product.	Can have combination therapy – free no prescription charge	Dual (as above)	1st 2 weeks offer dual if they want it by week 3 would only offer single NRT. NRT, E-Cigs, Champix available

	Questions	Sheffield	Doncaster	Barnsley	Rotherham	Bassetlaw
3	How many weeks of NRT do you offer free of charge? 4, 8 or 12 weeks.	None FOC. PGD for Champix every 2 weeks by voucher. Zyban get 2 vouchers 4 weeks on each – given separately and seen every 2 weeks (8 weeks medication in total). Prescriptions need to be paid for (if not exempt). NRT given for 12 weeks, every week for 1st 4 weeks, 2 weekly prescriptions after that.	8 weeks provided foc; then recommended to purchase to cont to 12 weeks	Given free for 12 weeks	Full course (8-12 weeks, patient choice) Foc – direct supply Champix – up to 12 weeks – issued fortnightly – **no** prescription cost for client Pharmacist gets dispensing fee £25 initially plus £5 each additional dispensing cost Reimburse tariff price (currently £27.30 for 2 weeks). Total cost if client on for 12 weeks is £213.80 (all inc). Champix is cheaper than dual therapy NRT over a 12-week period (£230-£240) depending on products used Often dual only used for 1st half of their quit attempt but can have for full duration	6 weeks NRT FoC If seen adviser give product there and then (direct supply). If phone support send product to them. Champix – 12-week course – given voucher collect from Pharmacist –pay prescription cost.
4	If numbers increase following implementation of QUIT how will you cope?	Could cope initially, 15 LES providers in GP Prac, Pharmacists and Dentists advisers insitu plus 23 local clinics in GP Practices plus Market stall (6 days a week). Will build up a waiting list, currently none. Could recruit more GP Practices – paid per QUIT date (£5) plus £42 if quit at	Probably be OK Some free capacity Could do things differently – phone support, groups	Ditto BUT currently out to tender – think budget will be reduced. Will need to change offer.	Capacity avail currently – additional 47 referrals per week (some drop out expected) Would need to review service plan and pharmacotherapy costs if increased radically	Could cope with a large increase in referrals. 25-30 referrals every week could be absorbed by current service.

		12 weeks. Sub contracted. Current contract payment by results at 12 week QUIT. Would need a change in contract. CO verified Will manage by booking into their own clinics – not LES providers. May rely on telephone appts with f2f at 12 weeks for CO monitoring.				

Appendix Four Number of Specialist Stop Smoking Advisors Needed in the Trusts

Number of WTE Specialist Stop Smoking Advisors Needed in Trusts									
				BHNFT	**DBTH**	**STH**	**TRFT**	**Total**	All figures (includes 20% added to cover annual leave, CPD etc)
7	**Acute Trusts - In pts**	Inpat assessments		2.29	3.60	6.22	2.46	14.57	45 mins initial assessment, 20 mins admin/liaison time per pt, 20 min second review for 10% pts, Total 67 mins per pt
		Post discharge FU call		0.59	0.93	1.61	0.64	3.77	20 mins per pt
		0 LOS contact post discharge		0.19	0.43	0.46	0.10	1.18	20 mins per pt
		Total		3.07	4.96	8.28	3.20	19.52	
33	**Acute Trusts - Outpts**			1.2	2.4	3.6	1.2	8.4	For input into priority pathways
30	**Sheffield Children's Hospital**							0.5	
	Sub Total			**4.27**	**7.36**	**11.68**	**4.2**	**28.4**	
				SH&SC	**SWYFT**	**RDASH**	**Notts**	**Total**	
34	**Mental Health Trusts**			6	2.5	6	1.5	16	Costed at top band 3. Based on SH&SC estiamtes of need for 6 wte. Wte for other Trusts pro-rated according to SYB CCG population covered by those Trusts
		BHNFT	**DBTH**	**STH**	**Sheffield Children's**	**TRFT**	**Total**		
31	**Support to Acute Staff to quit**	0.3	0.3	0.6	0.12	0.3	1.62		Within the Hospital Based Stop Smoking Manager posts we have allocated 30% of their time for direct pt care. As we have not deleted this from the WTE calculations for the hospital SSSA, suggest that this would cover support to staff to quit.
		SH&SC	**SWYFT**	**RDASH**	**Notts**		**Total**		
32	**Support to QUIT for Mental health Trust Staff**	0.3	0.12	0.3	0.12		0.72		

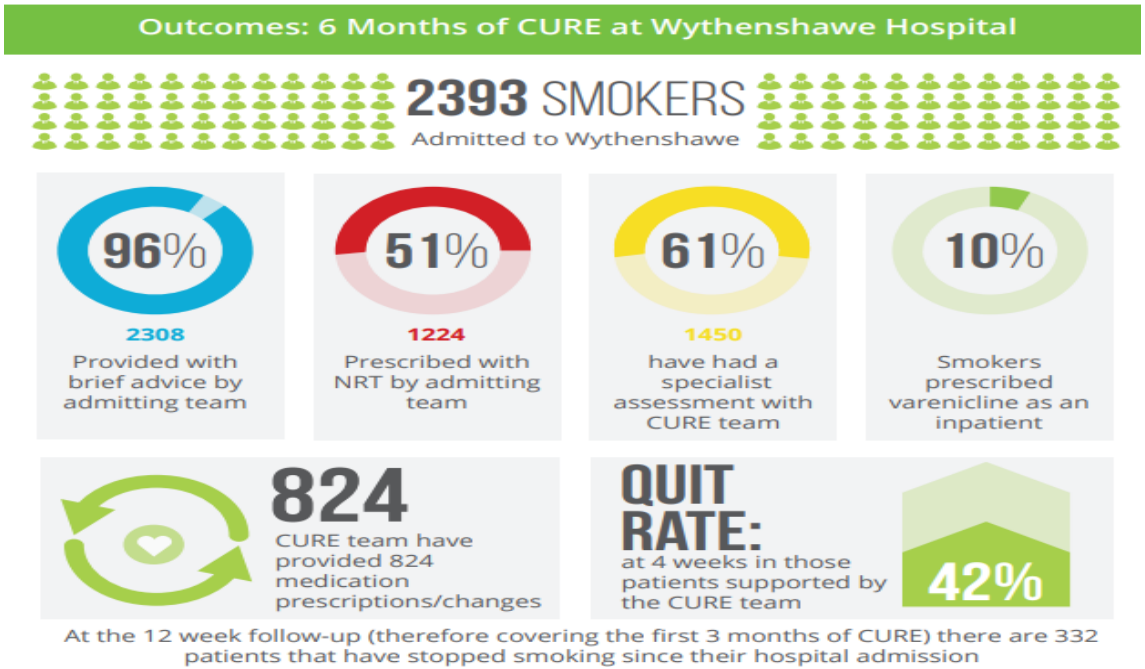
Appendix Five Learning from the CURE programme in Greater Manchester - Prescribing

The first six month data from Wythenshawe Hospital shows that 51% of patients were prescribed NRT by the admitting team and the CURE team made a further 824 drug changes.

Three month data from CURE was presented slightly differently and gave the total number of people who had had NRT, including after review by specialist stop smoking advisors, as 54%.

The infographic says that 10% of smokers had varenicline – 5% prescribed by the admitting team and an additional 5% prescribed once reviewed by the CURE team.

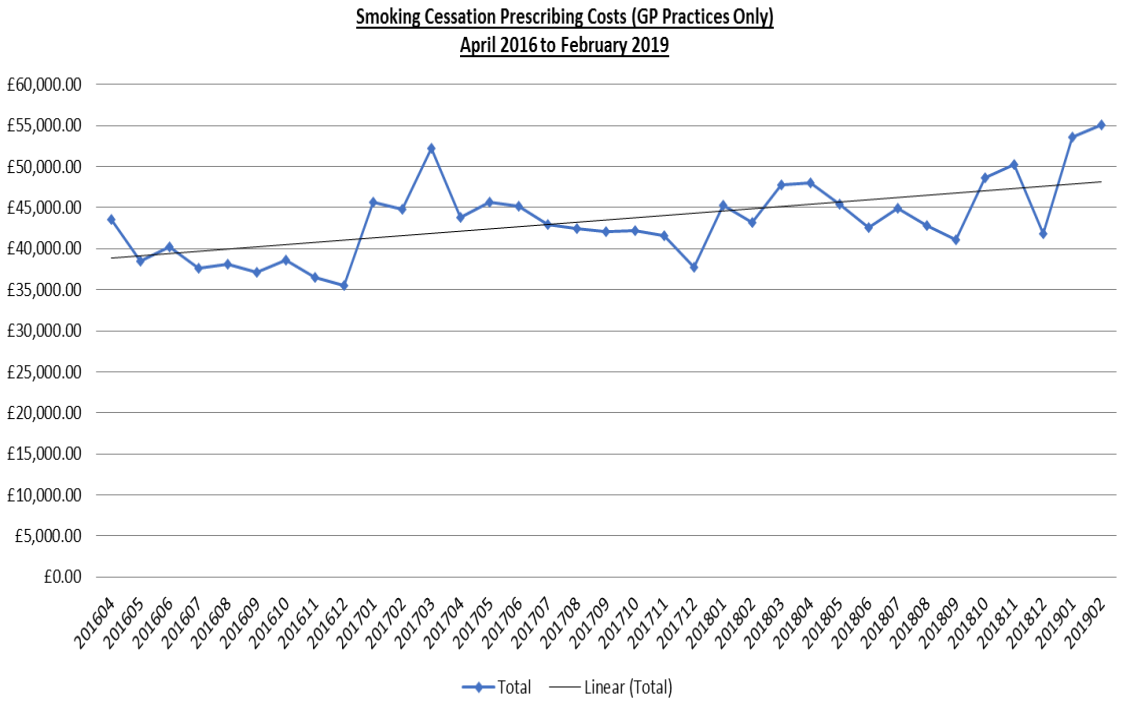
Short acting preparations of NRT were more commonly prescribed that patches, 38% and 25% of smokers respectively It is not clear how many had both short and long acting preparations.



The CURE team note that their **pharmacotherapy costs for inpatients were much less than they had modelled**, and for the first 6 months **for a total of 2,393 smokers the cost was £28k.** This is a mean of just **£11.69 per smoker**. We are checking with the CURE programme but think this covers **drug costs while an inpatient and for a two week TTA.**

Wythenshaw does not have a community stop smoking service, so patients **stop smoking support and prescribing is continued by primary care.** They estimate that their **primary care smoking cessation prescribing costs have increased by £5-10k per month**.

CURE – First 6 month data			
	Numbers	**% all smokers**	**% smokers seen by CURE team**
Smokers	2,393		
Smokers seen by CURE team	1,450	61%	
Level of addiction			
Low		27%	
Medium		42%	
High		31%	
Pharmacotherapy preparations received			
Short acting NRT (lozenges 172, gum 39, inhalator 491, microtabs 192)	909	38%	
Patches	602	25%	
Varenicline NB:- infographic says 10%	125	5%	8.6%
Bupropion	0		
CURE costs pharmacotherapy – total of 14 days including Inpt stay and 1 week TTA			
Total - six months, 2393 smokers	£27,974		
Mean per smoker admitted	£11.69		



Appendix Six Sustainability Plan

			2019/20	2020/21	21/22	22/23	23/24	Notes
NHSE funding	**Inpatients smoking cessation**			**Early implementers**	**Roll out**			
	Outpatient smoking cessation					**Early implementers**	**Roll out**	
	NHS Staff support			**Early implementers**	**Roll out**			
	Smoke Free Pregnancy			**Early implementers**	**Roll out**			Better births rather than QUIT

	Staffing and drug costs		**2019/20**		**2020/21**		**21/22**		**22/23**		**23/24**		
		WTE/ banding	**Funded by**	**£**	**Funded by**	**£**	**Funded by**	**£**	**Funded by**	**£**	**Funded by**	**£**	
1	**System Leadership and Coordination**												
1.1	SYB ICS programme lead - Healthy Hospital	0.6 wte band 8b until end Aug 2019	NHSE & ICS	Existing Post									
		1 wte band 8b	Cancer Al	51,337		77,005		77,005		77,005	Review need - ? Embedded within Trusts		
1.2	SYB Clinical Leads for QUIT	0.3 wte, costed at top of band 9	Cancer Al	23,094		39,590		39,590	Review need				Same as consultant costs
1.3	Project manager	0.5 wte for 15 months	ICS	24,260		12,130	Review after 15 months						
1.4	Consultant in PHM	Variable	ICS	Existing Post									
1.5	Admin support for system leadership	From within existing admin support	ICS	Existing Posts									
1.6	Comms and engagement		YCR	15,142		22,712							ICS employed post funded by YCR

			2019/20		2020/21		21/22		22/23		23/24		
		WTE/ banding	**Funded by**	**£**	**Funded by**	**£**	**Funded by**	**£**	**Funded by**	**£**	**Funded by**	**£**	
2	**Hospital Trust Leadership and Coordination**												
2.1	Executive Sponsor	Existing Posts - Contribution in kind	Trust - from within existing capacity										
2.2	Trust QUIT senior manager/nursing lead												
2.3	Trust Clinical Lead												
2.4	Clinical and managerial champions in each directorate / service												
2.5	Healthy Hospital Programme Managers (Acute and mental health)	7.2 wte Band 8a and 1 wte band 7 (plus 1 band 7 funded by NottsCC)	ICS	272,850		467,743	Acute & MH Trusts	467,743		467,743		467,743	Plus direct costs & overheads funded by Trusts
2.6	Admin support for HH programme manager and hospital based stop smoking service (Acute and mental health)	7.95 wte band 3	ICS	118,222		202,666	CCGs/ NHSE	202,666		202,666		202,666	Not yet known what proportion of funding for inpt SS coming from NHSE each year
3	**Hospital based specialist stop smoking expertise**												
3.1	Stop smoking managers - Acute Trusts	5.4 wte band 6	ICS	80,246		240,737	CCGs/ NHSE	240,737		240,737		240,737	Includes 10% for direct costs and over heads, Not yet known what proportion funded by NHSE. NB:- SSM 30% clinical - in B'ness case assumes this **30% would support staff who wish to quit – for which funding from NHSE starts in 2021/22**
3.2	Specialist stop smoking advisors - Acute Trusts - inpatients	20 wte band 3	YCR	218,172		683,205	CCGs/ NHSE	683,205		683,205		683,205	

			2019/20		2020/21		21/22		22/23		23/24		
		WTE/ banding	**Funded by**	**£**	**Funded by**	**£**	**Funded by**	**£**	**Funded by**	**£**	**Funded by**	**£**	
3.3	Specialist stop smoking advisors - Acute Trusts - outpatients	8.4 wte band 3	YCR	75,713		235,551	CCGs	235,551		235,551	NHSE	235,551	
3.4	Stop smoking manager - mental health trusts	2.8 wte band 6	ICS	41,609		124,826	CCGs/ NHSE	124,826		124,826	NHSE	124,826	
3.5	Specialist stop smoking advisors - mental health trusts - inpts	8 wte band 3	YCR	57,836		224,334	CCGs/ NHSE	224,334		224,334	NHSE	224,334	
	Specialist stop smoking advisors - mental health trusts - community	8 wte band 3	YCR	57,836		224,334	CCGs	224,334		224,334	NHSE	224,334	
4	**Hospital Based Pharmacotherapy**												
4.1	Acute Trusts - Inpatients and TTAs		Acute Trusts	196,209		825,420	Trusts/ NHSE	825,420		825,420	NHSE	825,420	Assumes 4 week TTA, with CCGs funding 1 week of TTA
	Mental Health Trusts		MH Trusts	Not yet calculated			CCGs/ NHSE	Not yet calculated			NHSE		
4.2	Outpatients - Acute and mental health		CCGs	Not yet calculated							NHSE		

			2019/20		2020/21		21/22		22/23		23/24		
		WTE/ banding	**Funded by**	**£**	**Funded by**	**£**	**Funded by**	**£**	**Funded by**	**£**	**Funded by**	**£**	**WTE/ banding**
5	**Community Stop Smoking Services**												
5.1	Stop smoking specialist advisor support post discharge and for outpatients referred from Hospital		LAs	To be locally determined			LA /NHSE	To be locally determined			NHSE		
5.2	Pharmacotherapy post discharge (continuation after TTAs) plus dispensing costs plus one week of TTA costs	Costs for post discharge for acute admissions only included	CCGs	180,944		1,040,693	CCGs/ NHSE	1,040,693		1,040,693	NHSE	1,040,693	Assumes that Trusts give 4 week TTA and CCGs fund one week of it
	Total		Plus £20k in 2019/20 for e-learning	1,403,765		4,433,077		4,408,816		4,369,227		4,292,221	

CCG's Contribution Broken Down by CCG							
	% admissions	**2019/20**	**2020/21**	**21/22**	**22/23**	**23/24**	Assumes Trusts give four week TTA and CCGs fund one week of that
CCG funded							
Barnsley	19%	43,635	194,665	86,023	86,023		19/20 and 20/21 one week of inpt TTA plus community stop smoking drugs. From 21/22 outpt and community MH SSSAs
Bassetlaw	7%	8,575	73,296	32,390	32,390		
Doncaster	22%	40,013	231,269	102,198	102,198		
Rotherham	17%	17,074	175,546	77,574	77,574		
Sheffield	35%	71,647	365,918	161,700	161,700		
Total		180,944	1,040,693	459,885	459,885		
CCG/NHSE funded							
Barnsley	19%			625,109	625,109		Inpt drug costs, community drug costs and inpt SSSA and SSS manager Acute and MT Trusts
Bassetlaw	7%			235,368	235,368		
Doncaster	22%			742,652	742,652		
Rotherham	17%			563,713	563,713		
Sheffield	35%			1,175,038	1,175,038		
Total				3,341,880	3,341,880		
Total							
Barnsley		43,635	194,665	711,132	711,132		
Bassetlaw		8,575	73,296	267,758	267,758		
Doncaster		40,013	231,269	844,850	844,850		
Rotherham		17,074	175,546	641,288	641,288		
Sheffield		71,647	365,918	1,336,738	1,336,738		
Total		**180,944**	**1,040,693**	**3,801,766**	**3,801,766**		

Appendix Seven Health Inequalities Impact Assessment

(Please complete each area)	What key impact have you identified?			Comments
	Positive Impact	Neutral impact	Negative impact	
Human rights	X			Patients understanding increased : - That nicotine is the product they are addicted to, but the major harm comes from the other elements of the cigarette. - There are effective treatments for nicotine addition Pts thus in better position to make informed choices
Age		X		Programme available for all ages. Nationally the highest smoking rates are in adults aged 25 – 34. Need to ensure that we continue efforts to decrease the taking up of smoking in the first place by young people. By supporting parents to quit we will be decreasing exposure the second hand smoke to children and decreasing smoking as a norm. We need to monitor quit rates by age to ensure that we are not adversely taking away resources from Community Stop Smoking Services that are working with young adults.
Carers	X			Reduction in exposure to second hand smoke if person they care for is successfully supported to quit
Disability	X			Smoking is an effective treatment for some underlying causes of disability eg COPD. Will need to ensure that the support is offered in a way that people with sight or hearing difficulties can still easily access. The mental health and learning disability pathways will need to ensure they are delivered by people experience d with working with those client groups and in client friendly ways. Smoking rates are very high in people with SMI.
Sex	X			Nationally more men than women smoke, so the programme may help more men than women due to higher underlying prevalence of smoking in men.
Race		X		Smoking prevalence varies between different races. The programme will need to ensure that it meets varying culture and language needs.
Religion or belief		X		
Sexual orientation		X		
Gender reassignment		X		
Pregnancy and maternity	X			Decrease exposure to second hand smoke. Smoking cessation support for pregnant women is being covered in the Better Birth work stream.
Deprivation	XXX			Smoker rates are much higher in people living in deprived areas. In England, the gap in smoking prevalence between those in routine and manual occupations and those in other occupations has widened, significantly, since 2012. Non elective admission rates are higher in people from deprived areas, so there is potential for the programme to have a positive impact on decreasing the inequalities in smoking rates and deprivation.

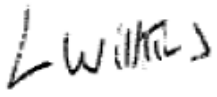
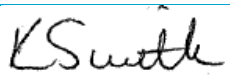
South Yorkshire and Bassetlaw QUIT Programme

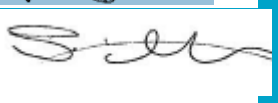
PRIVACY AND USE OF PERSONAL DATA

For full details on how we use your information please visit
https://yorkshirecancerresearch.org.uk/privacy/

ABOUT YOU

Please complete in Calibri font size 10

Surname (Principal Applicant first)	**Forename**	**Title**	**Current post & %FTE**	**% FTE on this project**	**Email address**	**Signature** (All applicants MUST sign)
This application is being made on behalf of the South Yorkshire and Bassetlaw Integrated Care System (SYB ICS). The SYB ICS covers Barnsley, Bassetlaw, Doncaster, Rotherham and Sheffield. Details of all of the NHS Trusts, CCGs, Local Authorities and Community Stop Smoking Services involved are given in section 3 of the attached business case.						
Wilkins	Lisa	Dr	Consultant in Public Health Medicine, SYB ICS	0.7 initially decreasing to 0.2	Lisa.wilkins2@nhs.net	
Burrows	Caroline	Ms	QUIT Programme Manager, SYB ICS	0.6	Carroline.burrows@nhs.net	
Smith	Karen	Ms	Prevention Programme Manager – QUIT project management support, SYB ICS	0.5	k.smith60@nhs.net	
Jenkins	Richard	Dr	SRO QUIT programme, SRO Provider Development, SYB ICS, Chief Executive Barnsley Hospital NHSF Trust	SRO	Richard.jenkins4@nhs.net	
Jessop	Julia	Ms	Programme Director, SYBND Cancer Alliance	Members of QUIT Oversight Group	Julia.jessop@nhs.net	
Burrows	Julia	Ms	Director of Public Health, Barnsley Council, Lead DPH for QUIT	Members of QUIT Oversight Group	juliaburrows@barnsley.gov.uk	

Stevens	Helen	Ms	AD Comms and Engagement, SYB ICS		helen.stevens11@nhs.net	
Mills	Jackie	Ms	Director of Finance, NHS Sheffield CCG	Member of QUIT Oversight Group and host for the YCR funding if application successful	jackiemills@nhs.net	
Cleary - Gray	Will	Mr	Chief Operating Officer, SYB ICS		Will.cleary-gray@nhs.net	

Host Organisation/Dept.	**South Yorkshire and Bassetlaw Integrated Care System**			
Principal Applicant address	722 Prince of Wales Road			
	Town/City	Sheffield	**Postcode**	S9 4EU
Principal Applicant tel.	0114 3051716			
Personal Assistant name	Jane Anthony	**Personal Assistant tel.**	0114 3051905	
Personal Assistant email	Jane.anthony1@nhs.net			
	If the application is successful, as the ICS is not a statutory body, the YCR funding would be hosted by NHS Sheffield Clinical Commissioning Group. Sheffield Clinical Commissioning Group will distribute the funding to the relevant partners subject to confirmation from the ICS QUIT team that the organisation is meeting their milestones and KPIs. Sheffield CCG's Director of Finance will be a member of the QUIT Oversight Group.			
Funding host	**NHS Sheffield Clinical Commissioning Group**			
Funding host address	722 Prince of Wales Road, Sheffield, S9 4EU			
Responsible officer	Jackie Mills, Director of Finance			
Contact details	Jackiemills@nhs.net, 0114 3051269			
Personal assistant	Carol Henderson, carol.henderson2@nhs.net			

ABOUT YOUR PROJECT

Project title	**South Yorkshire and Bassetlaw QUIT Programme**		
Proposed start date	Dec 2019	Project length (months)	Ongoing Funding requested for 16 months
Total amount requested	2019/20 £424,698 2020/21 £1,390,137 Total £1,814,835		

Project milestones and patient benefit timeline diagram
Please show the project milestones and delivery of patient benefit in a graphical representation e.g. Gantt chart

Further information on the delivery of the programme is given in the 'Implementing the SYB Programme' section of the business case (section 4). The timelines for each Trust are still under discussion, so there may be some changes to the timelines given for when delivery of the interventions will commence in each Trust. If this affects the start dates of the posts potentially funded by Yorkshire Cancer Research, the funding would not be drawn down until the posts holders commence work.

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Table four Implementation time lines	2019								2020				
Key events	**May**	**Jun**	**July**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**April**	**May**
1 B'ness case considered by **ICS System Health Board**													
2 B'ness case considered **Yorkshire Cancer Strategy Group and then their Board**													
3 Recruitment of: • SYB ICS Clinical lead • Healthy Hospitals Programme Manager by each Trust & Admin support • SYB Comms and Engagement post													
4 Commencement of above posts													
5 Co-design of **QUIT communications plan**													
6 Implementation of communications plan													
7 Co-design of: • Patient pathways & clinical guidelines • Information leaflets and posters • Policies for e-cigs, provision of NRT and varenicline • Training programmes and e-learning modules • Metrics data set, data collection and evaluation methodology													
8 Clinical guidelines approved by Trust Governance structures													
9 Identification of programme management support within Trusts in each directorate													
10 Identification of Trust clinical and managerial champions													
11 Training of Trust champions													
12 LA planning with community stop smoking services to **ensure adequate capacity in community stop smoking services**													
13 Acute Trusts:													
• **Recruitment of hospital based specialist stop smoking advisors (SSSAs) and Hospital Based Specialist Stop Smoking Managers** **1 = BHNFT, DBTH, STH & SCH**						**1**	**TRFT**						
• **Commencement of hospital based SSSA and stop smoking manager** **1 = BHNFT, DBTH, STH , SCH**								**1**	**TRFT**				
• **Awareness raising and training for wider staff**					**BHNFT , DBTH, STH & SCH**								
							TRFT						
• **Patients and staff start receiving QUIT intervention** **Site smoke free**									**BHNFT, DBTH, STH & SCH**				
										TRFT			
14 Mental Health Trusts													
• **Recruitment of SSSAs and Stop Smoking Manager** **2 – SH&SC 3 – other mental health trusts (TBC)**						**2**	**3**						
• **Commencement of hospital based SSSA and Stop Smoking Manager**								**2**	**3**				
• **Awareness raising and training for wider staff**					**SH&SC**								
							SWYFT, RDASH. Notts						
• **Patients and staff start receiving QUIT intervention**									**SH&SC**				
										SWYFT, RDASH. Notts Healthcare			
15 Collection of metrics for evaluation													

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FULL PROJECT DESCRIPTION

Project title	**South Yorkshire and Bassetlaw QUIT Programme**

Project background and details.
Please complete these sections in Calibri font size 10 with 1.5 line spacing
Max 15 pages.

A brief overview of the programme is given below. Details are given in the supporting **business case**, which was **supported in principle by the ICS's Health Executive Group on 11 June,** subject to a couple of organisations still needing to take the business case through their internal governance process.

A. Treating tobacco dependency is a key priory for the South Yorkshire and Bassetlaw Integrated Care System (SYB ICS)

Smoking is the single largest cause of ill health and preventable death in England. It accounts for **half of the health gap** between the poorest and most affluent communities and is a major contributor to the 15 – 20 years gap in life expectancy between people with a severe mental health illness and the general population.

Smoking is the single **biggest avoidable risk factor for cancer**. Tobacco smoke is estimated to be responsible for 15% of cancers in the north of England and 27% of all cancer deaths. For South Yorkshire, Bassetlaw and North Derbyshire Cancer Alliance this is **1,670 cancers** and **1,432 cancer deaths attributed to smoking each year**.[1]

An estimated **213,000 adults in SYB smoke**. The adult prevalence of smoking is significantly higher in Barnsley and Doncaster than the national average. The **standardised mortality rate for deaths attributable to smoking** per 100,000 is **53% higher in South Yorkshire than the English average.**

The British Thoracic Society estimates that **25% of people admitted to hospital are current smokers. Smoking rates** for people admitted to or using **mental health secondary care services** are even **higher** than those for acute trusts **(approximately 60% of people admitted and 40% of people on the severe mental illness register smoke).** People with mental health conditions who smoke, also tend to smoke more heavily and intensively, so the impact of smoking disproportionately impacts on their health compared to other smokers. The Tobacco Plan for England (2017) set out the need for urgent action in inpatient and community mental health settings to reduce the stark difference in smoking rates, and ensure people with a mental health condition are not left behind in the move towards a smoke free generation.

Embedding the treatment of tobacco dependency in secondary care is a **priority** for the South Yorkshire and Bassetlaw Integrated Care System (SYB ICS) and the attached business case sets out proposals for a SYB wide **QUIT programme that covers both Acute Trusts and Mental Health Trusts.** Smoking in pregnancy is being covered within the ICS maternity work stream and is not considered in this business case.

B. What is the QUIT Programme?

QUIT is an **evidence based programme,** based on the **Ottawa model and NICE Public Health Guidance 48 Smoking: Acute, Maternity and Mental Health Services.** It also draws on the recently implemented **CURE** programme in Greater

[1] Source – NCRAS. Figures for SYBND cancer alliance do not include data for Bassetlaw, North Derbyshire and Hardwick CCG areas as it has not been possible to disaggregate data to this population level.

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Manchester and the evidence base of **embedding bespoke smoking cessation intervention (delivered by mental health staff) within mental health services** for people with **mental ill health**, where **12 months** quit rates of **15% can be achieved for community mental health patients.**[2]

While Greater Manchester have demonstrated that the Ottawa model can be successfully delivered in Acute Trusts, **South Yorkshire and Bassetlaw have the opportunity to be a forerunner** and show **how the model can be adapted for NHS Mental Health Trusts**. We are **committed to sharing this learning** and will develop an **implementation resource website,** similar to the CURE website[3], **that people across the country will be able to access.**

QUIT is in line with key objectives within the NHS Long Term Plan. It will be implemented in **all acute and mental health trusts in South Yorkshire and Bassetlaw.** This covers a population of approximately **1.5 million** people in Barnsley, Bassetlaw, Doncaster, Rotherham and Sheffield.

C. What is the intervention?

QUIT is a **comprehensive secondary care treatment programme**, where active **smokers will be:**

- **systematically identified on admission** to hospital
- provided with **nicotine replacement therapy** and **other smoking cessation pharmacotherapies**
- **advised to stop smoking**
- seen while in hospital by **specialist stop smoking advisors**
- and referred to community stop smoking services for **ongoing stop smoking support.**

The approach recognises that **smoking is an addiction**; **reframing the way we view smoking as a chronic relapsing medical condition that can be treated, rather than a lifestyle choice.**

Patients will also be identified in outpatients and **A&E** and given **brief advice** and **signposted to community stop smoking services**. **Hospital based stop smoking advisors** will **support priority outpatient pathways,** especially those that may lead to surgery and cardiology, respiratory and cancer services. **Parents of patients on paediatric wards** and **Trust staff** wishing to quit will also be supported.

Following discharge from an Acute Trust admission, the patient's ongoing tobacco dependency treatment and support will be provided by the Local Authority commissioned **community stop smoking services**. All of the SYB smoking cessation services offer support to patients wishing to use e-cigarettes as an aid to quitting.

The model for QUIT **within mental health services** is that for people with severe mental ill health, identification, assessment and bespoke smoking cessation interventions will be provided by **secondary care specialist stop smoking advisors within the mental health service for both inpatients and patients accessing a range of mental health services in the community**. We will explore the pros and cons of different models of **improving access and use of e-cigarettes on mental health inpatient wards**, including provision of free vaping products, and the provision of e-cigs post discharge for

[2] https://www.thelancet.com/journals/lanpsy/article/PIIS2215-0366(19)30047-1/fulltext#

[3] thecureproject.co.uk

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patients having ongoing support from the mental health stop smoking advisors. The use of e-cigarettes will be a specific focus within the **evaluation.**

D. What will the benefits of the programme be?

For Yorkshire Cancer Research:

- Opportunity to sponsor the systematic treatment of the largest risk factor for cancer in residents in South Yorkshire and Bassetlaw.
- To be part of a programme that will be a forerunner for the treatment of tobacco dependency in mental health settings and look at ways of increasing access to e-cigarettes for mental health patients. Recognition as a partner in the learning from this work that we would want to share across the country.
- Full recognition of being a partner in all the QUIT related publicity and materials, helping increase YCR brand recognition in a health care economy that has:
    - A population of 1.5 million
    - 5 Acute Trusts and 4 Mental Health Trusts, 5 Clinical Commissioning Groups and 5 Local Authorities
    - Has 72,000 staff across health and social care
- Just from the Acute Trust adult inpatient perspective we are anticipating asking just under 200,000 inpatients a year about their smoking status, with nearly 38,000 being smokers and being referred to the specialist stop smoking advisors.
- The four Acute Trusts (excluding Sheffield Children's Hospital) combined have 3 million outpatient appointments per year.
- Thousands of people in contact with secondary care mental health services per year. 36,000 per year for Sheffield Health and Social Care NHS Foundation Trust alone.
- Recognition on the QUIT website, which will have both patient and professional pages and be accessed via the SYB ICS website. Links from the QUIT pages to YCR website can be included.
- Opportunity to build relationships with all the SYB ICS organisations.

For South Yorkshire and Bassetlaw:

The **benefits of implementing** the evidence-based SY&B QUIT programme will be:

- Significant reductions in the numbers of people who smoke in SY&B
- Improved health outcomes for our residents and staff
- Saved lives
- Reduction in incidence of cancer
- Significant reductions in smoking related hospital admissions and readmissions
- Reduction in health inequalities
- Reduction in the premature mortality and morbidity gap, attributable to smoking, for people with mental ill health and the population overall
- Improvements in mental health
- Contributing to significant savings to health and wider social economy

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- And opportunities for positive news stories about local coordinated action together for the benefit of the health of our communities.

Based on an estimated 37,853 spells[4] in **SYB acute hospitals** (excluding Sheffield Children's Hospital) being for patients **who smoke** at time of admission and a smoking prevalence rate in those patients of 20%, if we had the same baseline and outcomes as seen in Ottawa, implementing QUIT would lead to:

- **2,271 lives saved at one year**
- **2,347 readmissions to acute trusts within 30 days prevented**
- **4,429 readmissions to acute trusts within a year prevented**
- **5,678 6 month quits**
- **£7.1m saving from acute trust readmissions alone within a year**[5]
- **£273k savings from A&E attendances within 30 days.**

In addition to the well-established benefits of **increased life expectancy and improved physical health**, **stopping smoking in people with mental illness** is associated with[6]:

- **Reduced depression, anxiety, and stress**
- **Improved positive mood and quality of life**
- **More disposable income.**

Receiving care in a smokefree setting can **support mental health recovery:**

- Smokefree settings help to **protect** people who are non-smokers from **secondhand smoke** and from **initiation into smoking**; for ex-smokers, smokefree settings can help to protect them from **relapse.**
- The provision of tobacco dependence treatment, during an admission to a smokefree hospital, **increases the chances of quitting**. The longer the admission in smokefree settings, the higher the quit rate.
- The service user is **less likely to be readmitted** if provided with tobacco dependence treatment and follow-up support.
- If the service user does not quit during the current admission, there is an **increased chance they will make a subsequent quit attempt** following discharge.
- Smokefree inpatient settings, if implemented properly, increase the likelihood that the **ward environment will be less disruptive** and, when accompanied by staff training, is associated with a significant decrease in physical violence.
- Smokefree settings also mean that clinical time, previously spent on facilitating smoking, can be used to focus on **promoting health and wellbeing.**

[4] Non elective admissions, transfers and elective admissions to Acute Trusts, LOS 0 and ≥1, (Day cases and Maternity excluded), aged > 15 years, Assumes 20% spells smokers, full year activity, SYB CCG patients only

[5] Based on estimated number of readmissions prevented, with mean admission cost £1,603 and A&E of £160. (2017/18 Department of Health Reference Costs average for non-elective hospital admission)

[6] Smoking cessation and smokefree policies: Good practice for mental health services, National Centre for Smoking Cessation and Training (NCSCT), March 2018

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We know that people with a mental health condition tend to smoke more heavily and intensely, so their health is disproportionally affected compared to smokers without a mental health condition, due to the greater exposure to carbon monoxide and other toxins present in tobacco smoke. Thus **people with mental health conditions have the most to gain from stopping smoking** or if they are not ready to quit, from decreasing their cigarette consumption or switching to e-cigarettes.

It is more difficult to quantify the outcomes from the mental health element due to the lack of comparator studies to inform the predictions. Based on an estimated 2,775 admissions to mental health trusts and a 60% smoking rate, there are **1,665 people who smoke admitted to mental health trusts per year. There are many more in contact with secondary care mental health services in the community.** As noted above, Sheffield Health and Social Care NHS Foundation Trust alone had over **36,000 people** who had one or more contacts with the Trust in the **last 12 months**.

E. Evaluation

A standard set of **process metrics** will be co-designed with Trusts, LA Tobacco Leads and Stop Smoking Services, Yorkshire Cancer Research and collected by Trusts and Stop Smoking Services.
This will be supported by qualitative stakeholder feedback (including staff, patients and family members) and monitoring of outcome measures such as:

- Increase in number overall recorded quits in SYB
- Increase in the number of staff members who quit
- Decrease in prevalence of overall adult smoking and in routine and manual workers
- Reduction in smoking attributable hospital admissions and mortality

There will be a particular focus in the mental health element on the evaluation of the use of e-cigarettes.

F. Funding

This application asks **Yorkshire Cancer Research** to fund the **Trust based specialist stop smoking advisors** needed to implement the QUIT programme **from December 2019 to March 2021.** This is a total of:

- 28.4 wte posts for the Acute Trusts (band 3)
- 16 wte posts for the Mental Health Trusts (band 3)

Plus 0.7 wte SYB communications and engagement post (band 5) for the same time period.

The **business case** sets out how **partners across the South Yorkshire and Bassetlaw Integrated Care System will contribute to the funding of the QUIT programme during 2019/20 and 2020/21** and also a **sustainability plan** for after the Yorkshire Cancer Research funding would cease until, and as, NHSE funding comes on line.

The **ICS Health Executive Group** (the decision making body of the ICS) **agreed the business case** in principle on 11 June, recognising that some organisations have yet to take it through their own internal governance arrangements.

The five **Directors of Public Health** have all given a **commitment that they will ensure that there will be sufficient community based stop smoking specialist advisors to meet the increased demand from referrals from acute trusts.**

In summary **during 2019/20 and 2020/21**:

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- **South Yorkshire, Bassetlaw and North Derbyshire Cancer Alliance pays for:**
  - The SYB QUIT Programme Manager
  - The SYB QUIT Clinical Leads

2019/20	2020/21
£74k	£116.6k

- **ICS Transformation Funding covers the cost of:**
  - Healthy Hospital Programme Manager for each Acute and Mental HealthTrust
  - Hospital based Stop Smoking Manager for each Trust
  - Admin support for the Healthy Hospital Programme Manager and Hospital Stop Smoking Service
  - A part time SYB Project Manager for 15 months (0.5 wte)
  - Set up costs for the development of the online training modules and other shared materials
  - And provides contribution in kind for senior communications and engagement advice/supervision, admin support, Consultant in Public Health Medicine and analytical support via the Hosted Clinical Networks.

2019/20	2020/21
£547.5k	£1.06m

- **Acute and Mental Health Trusts cover the costs of:**
  - Pharmacotherapy while the patient is an inpatient and for 3 weeks of a 4 week TTA (drugs that the patients takes home) and for their own staff trying to stop smoking
  - Direct costs – eg printing of leaflets, CO monitors, signage
  - Contributions in kind for areas such as:
    - Clinical and managerial leadership
    - Comms and engagement expertise
    - Staff training and ongoing support
    - Pharmacy staff time
    - IT support
    - Staff asking smoking status, recording CO levels, provision of very brief advice, offering and providing NRT, referral and liaison with specialist stop smoking advisors

2019/20	2020/21
£196k	£825k
Plus inpt mental health pharmacotherapy/e-cig costs	

- **Local Authorities cover the costs of:**
  - The additional community based stop smoking advisors required.

2019/20	2020/21
Tobe locally determined	

- **CCGs fund:**
  - Pharmacotherapy:
    - One week of the Trust's 4 week TTA
    - Post discharge from an admission for acute and mental health patients
      - The additional drug and dispensing costs above the current Stop Smoking Service pharmacotherapy budget.
    - For mental health community patients

2019/20	2020/21
£181k	£1.04m

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Total investment:

	2019/20	2020/21	
Total	£1.42m	£4.43m	
ICS partners	£999k	£3.04m	Plus mental health pharmacotherapy costs and additional community stop smoking advisors
YCR	£424k	£1.39m	

In summary the **sustainability plan** is:

From 2021/22 as the **NHSE funding starts becoming available to CCGs** that:

- In light of the reductions in admissions expected due to people stopping smoking, CCGs **growth forecast for acute admissions for 21/22 onwards will reduce**, '**releasing' the funding** to commission the **Trust based Specialist Stop Smoking Service Managers, Advisors, Admin Support and inpatient and community pharmacotherapy costs**. This will be **part funded by the NHSE funding** as it is incrementally introduced.
- **CCG picking up these costs is dependent on Trusts having demonstrated good levels of implementation during 2020/21.**
- If Trusts continue to have a CQUIN that covers NRT costs, this would need to be factored in.
- **Trusts** pick up the funding of the **Healthy Hospital Programme Managers**.
- **Local Authorities** continue to **ensure and fund sufficient capacity within community Stop Smoking Services** but receiving their **share of the NHSE funding** as this is incrementally introduced.

G. Governance, service users and local stakeholder engagement

- Each Trust has identified an **Executive Sponsor** and a **QUIT Lead**.
- Two **SYB QUIT Clinical Leads** will be appointed, one for acute trusts and one for mental health.
- A **QUIT Oversight Group** will be established, chaired by the QUIT SRO (Dr Richard Jenkins, CE Barnsley NHSF Trust), with executive representatives from the key stakeholders. We see Yorkshire Cancer Research as a key member of the group.
- We have an established **SYB QUIT Steering Group** with representation from Trusts and Local Authority Tobacco Leads. The terms of reference and membership of the group will be reviewed and the more detailed planning work will be undertaken in short term task and finish groups.
- CCG links have been through the CCG CQUIN leads, who will be re-invited to join the steering group.
- Each Trust will have a **local steering group**, many of these are already established.
- A **service specification** for Acute Trusts and a separate one for Mental Health Trusts will be developed.
- **Local Authorities**, as commissioners of the local community stop smoking services, will **amend the Community**

QUIT Oversight Group
SRO - Dr Richard Jenkins (chair), CE Barnsley Hospital NHSF Trust
QUIT Exec Sponsors from each Trust
SYB QUIT Clinical Leads
Sheffield CCG Director of Finance – Jackie Mills
Lead Director of Public Health – Julia Burrows
Cancer Alliance Programme Director – Julia Jessop
Yorkshire Cancer Research Representative
PHE Programme Manager for Tobacco – Scott Crosby
SYB ICS QUIT Programme Manager – Caroline Burrows
SYB ICS Consultant in PHM – Dr Lisa Wilkins
SYB QUIT Project Manager – Karen Smith
SYB AD Comms & Engagement – Helen Stevens

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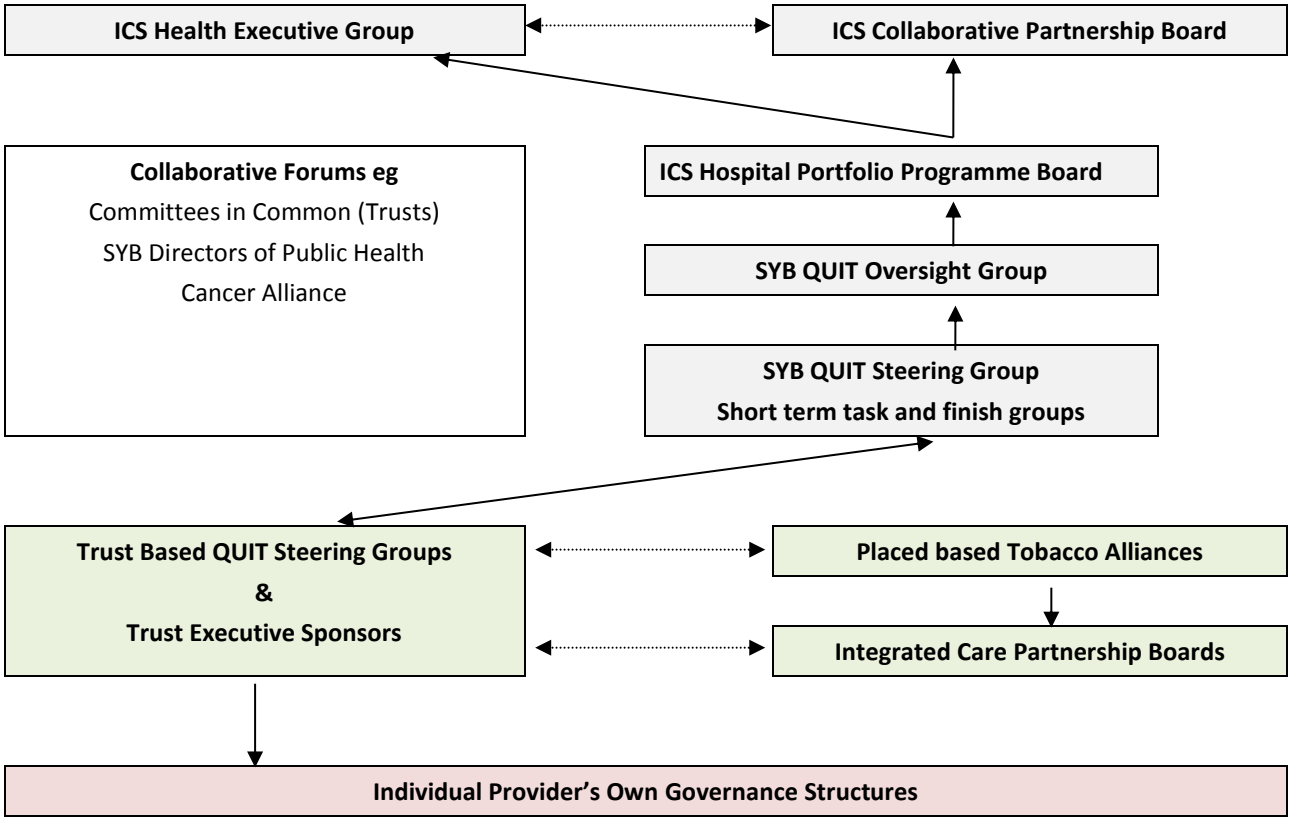
Stop Smoking Service specifications and contracts to take account of the additional follow up activity and if they are the employer of the Trust based posts.

- **Each Trust / service provider** retains **responsibility for the governance of their own service**.

QUIT Programme Governance



H. Patient and public engagement:

- The ICS Programme lead for QUIT has already sought the advice of the **ICS Citizen's Panel** who gave their full support to the quit programme. The Panel will be regularly updated and asked for advice at relevant stages of the roll out of the quit programme.
- As part of the engagement on the NHS Long Term Plan a number of **public focus groups** are planned, the QUIT programme will be included within the discussions around the prevention elements of the Long Term Plan.
- Some Trusts have already undertaken some **social media surveys** with their patients and public, and received strong support for smoke free sites and providing support to help patients stop smoking.
- Patients' views and feedback, via **Trust's existing engagement channels**, will be sought throughout implementation and contribute to the evaluation.

I. Cross referencing the business case to required information

Detailed information is provided in the attached business case. The relevant sections of the business case are indicated below.

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	Information included within section:
Background information including existing data to demonstrate need for service, how the service is consistent with local and national policies, strategies and evidence base	Introduction (p11) Background and evidence base (p12)
Aims and objectives	Overview and Benefits of the SYB QUIT Programme (p18)
Outcomes	Overview and Benefits of the SYB QUIT Programme (p18) Return on Investment (p53)
Target audience, areas and settings	Overview and Benefits of the SYB QUIT Programme (p18) Implementing the SYB programme (p23) Modelling of patient numbers, pharmacotherapy uptake and quit rates (p38)
Details of service plans	Implementing the SYB programme (p23) Modelling of patient numbers, pharmacotherapy uptake and quit rates (p38) Appendix Four Number of Specialist Stop Smoking Advisors Needed in the Trusts (81)
Details of evaluation plans	Measuring the success of the programme (p37)
Monitoring and reporting requirements	To be developed with YCR
Recruitment and staffing plans	Implementing the SYB programme for programme management staffing (p23) Number of specialist stop smoking advisors needed and Appendix four (p81) Community Stop Smoking Services (p45)
How service users and local stakeholders will be involved at all stages of service development, delivery and evaluation	See above and: Governance Section (p66) Communications and engagement (p26)
How the service will link with existing services and initiatives	The QUIT programme will build on existing work and services occurring in Place[7] to support a reduction in smoking prevalence. All five places have a community stop smoking service commissioned by the local authority. They also prioritise wider tobacco control initiatives, coordinated through local tobacco alliances. See Community Stop Smoking Services section
Yorkshire Cancer Research marketing and communications requirements	To be developed in discussion with YCR.

[7] Within SYB we refer to 'Places' as being the local health and care economy and communities in each of our five areas of Barnsley, Bassetlaw, Doncaster, Sheffield and Rotherham.

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Legal and governance requirements	Governance section (p66)
Risks and mitigations	Risks section (p65)
Sustainability plans	Sustainability plan (p63)
References and supporting literature	Detailed within Business case Main references: • RCP Hiding in plain sight Treating tobacco dependency in the NHS. A report by the Tobacco Advisory Group of the Royal College of Physicians. 2018 • Reid RD, Mullen KA, Slovinec D'Angelo ME, Aitken DA, Papadakis S, Haley PM, et al. Smoking cessation for hospitalized smokers: an evaluation of the "Ottawa Model". Nicotine Tob Res. 2010;12(1):11-8. • Mullen KA, Manuel DG, Hawken SJ, et al. Tob Control Published Online First: 2016. doi:10.1136/tobaccocontrol- 2015-052728 • Smoking Cessation Intervention for People with Severe Mental Illness. https://www.thelancet.com/journals/lanpsy/article/PIIS2215-0366(19)30047-1/fulltext • *Smoking cessation and smokefree policies: Good practice for mental health services, National Centre for Smoking Cessation and Training (NCSCT), March 2018* • *NICE PH Guidance 48: Smoking: Acute, Maternity and Mental Health Services https://www.nice.org.uk/guidance/PH48* • *Greater Manchester CURE project - http://thecureproject.co.uk*
Any potential IP that might arise	None
Justification of costs	Table sixteen (p58) Implementing the SYB programme - Clinical and programme management (p23) Pharmacotherapy costs (p48) Number of specialist advisors – Trusts and Community services (45)

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PROJECT COSTINGS

PLEASE CONSULT THE INFORMATION FOR APPLICANTS DOCUMENT BEFORE STARTING THIS SECTION

Please see business case for estimated costs of the full programme and how the costs will be split across partners of the SYB ICS. The costs given below are for the funding application to YCR only.

SALARY REQUESTED FOR APPLICANTS AND STAFF

ONLY include salaries of applicants when they are a directly incurred cost of this project (see Information for Applicants)

Staff costings (including NI and superannuation)

Name and job title	Grade and %FTE	Year 1 (£)	Year 2 (£)	Year 3 (£)	Year 4 (£)	Year 5 (£)	TOTAL (£)
Specialist stop smoking advisors:							
Acute Trusts (1)	28.4 wte band 3	267,168	835,233				1,102,400
Mental Health trusts	16 wte band 3	105,157	407,880				513,037
Comms and Engagement Post – SYB ICS	0.7 wte band 5	15,142	22,712				37,854
TOTAL SALARY COSTS		387,466	1,265,825				1,653,291

(1) Costed at top of band 3, (£25,493). As we are wishing to have a 7 day service in acute Trusts, we have added 10% time with 70% supplement (Sunday) and 15% of time with 35% supplement (Saturday) in line with NHS Agenda for Change pay scales to the Acute Trust costings. The mental health service will be 5 days a week so no out of hours supplements have been added.

IF COSTINGS ARE NOT TOTALLED ACCURATELY YOUR APPLICATION MAY NOT BE CONSIDERED

NON-SALARY PROJECT COSTS

Please see Information for Applicants for our costing policy

Individual costs of £3000 or over must be itemised and/or a quote provided

Cost details	Year 1 (£)	Year 2 (£)	Year 3 (£)	Year 4 (£)	Year 5 (£)	TOTAL (£)
As some Trusts may choose not to directly employ the hospital based specialist stop smoking advisors but have an in reach service from the community stop smoking service we have added 10% on top of the salary costs to cover the community stop smoking services expenses of employing extra staff (eg staff training, HR, corporate overheads, travel, phone, estates). Some of the community stop smoking services are small providers who would not be able to absorb these costs.						
Acute Trust SSSA	26,717	83,523				110,240
Mental Health Trust SSSA	10,516	40,788				51,304
TOTAL COSTS	37,232	124,311				161,544

IF COSTINGS ARE NOT TOTALLED ACCURATELY YOUR APPLICATION MAY NOT BE CONSIDERED

SUMMARY OF TOTAL COSTS

Total salary costs	1,653,291	**PLEASE CONFIRM YOU HAVE CHECKED YOUR COSTINGS (E.G. IN EXCEL)**
Total non-salary project costs	161,544	
OVERALL TOTAL (must match total provided in Section 2)	1,814,835	Yes

IF COSTINGS ARE NOT TOTALLED ACCURATELY YOUR APPLICATION MAY NOT BE CONSIDERED

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ACCEPTANCE OF AWARD CONDITIONS AND POLICIES FOR AWARDS

- I shall be actively engaged in, and in day-to-day control of, the project.
- We have read The Charity's current Award Conditions and Policies for Awards. If our application is successful we agree to abide by them.

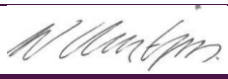
Signature of Principal Applicant	
Date	12 June 2019

This application MUST be submitted via the Principal Applicant's Line Manager or Head of Department AND the officer responsible for administrating any award granted.

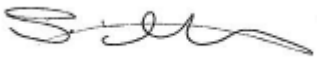
Each should sign the following declaration:

- I confirm I have read the application and that, if awarded, the work will be accommodated and administered in the Organisation/Department in accordance with the Award Conditions and Policies for Awards.
- The **projects and costings** quoted are correct and in accordance with the normal practice of this Organisation.

HEAD OF DEPARTMENT/LINE MANAGER

Title	Mr	**Name**	Will Cleary-Grey	
Job title	Chief Operating Officer			
Organisation	South Yorkshire and Bassetlaw Integrated Care System			
Postal Address				
Address line 1	722 Prince of Wales Rd			
Town/City	Sheffield			
Postcode	S9 4EU			
Phone number	0114 3051905			
Signature		**Date (dd/mm/yyyy)**	12/06/2019	

ADMINISTRATIVE AUTHORITY

Title	Ms	**Name**	Jackie Mills	
Job title	Director of Finance			
Organisation	NHS Sheffield Clinical Commissioning Group			
Postal Address				
Address line 1	722 Prince of Wales Rd			
Town/City	Sheffield			
Postcode	S9 4EU			
Phone number	0114 3051269			
Signature		**Date (dd/mm/yyyy)**	12/06/2019	

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NHS
Barnsley
Clinical Commissioning Group

GOVERNING BODY

11 July 2019

QUALITY HIGHLIGHTS REPORT

PART 1A – SUMMARY REPORT

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

	Name	*Designation*
Executive Lead & Author	M Tune	Chief Nurse (Acting)

3.	**EXECUTIVE SUMMARY**
	To provide the July 2019 Governing Body with the agreed highlights of the June 2019 Quality & Patient Safety Committee. The information provided is in addition to the monthly performance report and ongoing risk management via the Assurance Framework and Risk Register. Three quality issues are highlighted and rated: • Red – Discharge Medication Audit • Amber – Individual Funding Request application of policy • Green – Goldthorpe Medical Practice CQC Good Rating
4.	**THE GOVERNING BODY / COMMITTEE IS ASKED TO:**
	• Note the Quality Highlights identified
5.	**APPENDICES**
	• Appendix A – Quality Highlight Report

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, 6.1 & 9.1
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?	*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*

Appendix 1 Quality Highlight Report

Issue	Consideration	Action
BHNFT Discharge Medication Audit	Provisional findings from this audit found that 42.5% of the 299 discharge letters reviewed showed that the TTO section was either missing data or considered incomplete or incorrect. The patient safety risks are evident and this also increases the workload within GP practices.	The final audit report needs to be considered and an action plan agreed between both the CCG and BHNFT Medical Director to remedy this risk.
Individual Funding Requests	Ongoing challenges related to the implementation of the Individual Funding Request Policy, especially for tonsillectomies, at BHNFT which have negative impact on patient experience of care.	The Associate Medical Director continues to work with the Medical Director BHNFT to resolve these remaining challenges – agenda item BHNFT Clinical Quality Board 8th August 2019.
Positive CQC Inspection Reports	Goldthorpe Medical Practice achieved a rating of Good overall and across all domains.	The CCG has written to the practice to congratulate all staff on receiving the Good rating and to thank the staff for their continued efforts to provide high quality services for the people of Barnsley.

Green = positive assurance
Amber = concern being monitored, for information
Red = articulated risk or escalation

NHS
Barnsley
Clinical Commissioning Group

GOVERNING BODY

11 July 2019

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	Paige Dawson	Governance, Risk & Assurance Facilitator

3. EXECUTIVE SUMMARY

Introduction

This report presents to the Governing Body a number of matters, specifically:

- Governing Body Assurance Framework
- 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. In line with the new Corporate Calendar the Governing Body will now receive the full Assurance Framework (GBAF) at every other meeting with a summary being brought to intervening meetings. In line with these reporting timescales a summary of the GBAF is therefore presented to the July 2019 meeting of the Governing Body (Appendix 1). There are currently no risks on the GBAF 2019/20 rated as 'red' extreme risk.

Corporate Risk Register

The *Corporate Risk Register* is a mechanism to effectively manage the current risks to the organisation. Governing Body receives the full Risk Register twice a year (September and March) with exception reports brought to intervening meetings. This report therefore provides the Governing Body with an exception report of the Corporate Risk Register (Appendix 2).

Red (extreme) risks:

There are currently 5 extreme risks on the CCG's Risk Register which have been escalated to the Assurance Framework as gaps in assurance against risks on the Assurance Framework. The risks are:

	• Ref CCG 18/04 (rated score 16, 'extreme') - If the health and care system in Barnsley is not able to commission and deliver out of hospital urgent care services which have sufficient capacity and are effective in supporting patients in the community to avoid the need for hospital attendance or non-elective admission there is a risk that non- elective activity will exceed planned levels potentially leading to (a) failure to achieve NHS Constitution targets (with associated reputational damage, and (b) contractual over performance resulting in financial pressure for the CCG. • Ref 18/02 (rated score 16 'extreme') - If the CCG and BMBC do not develop a collaborative commissioning approach underpinned by shared values there is a risk that BMBC commissioned services will not meet the requirements and aspirations of the CCG for the people of Barnsley leading to increased health inequalities and poorer health outcomes. • Ref CCG 14/10 (rated score 16 'extreme') – Risks resulting from not being able to attract and retain a suitable and sufficient Primary Care clinical workforce • 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). If improvement in Yorkshire Ambulance Service (YAS) performance against the ARP response time targets is not secured and sustained, there is a risk that the quality and safety of care for some patients could be adversely affected *Additions / Removals* • At its meeting on 20 June 2019 Quality and Patient Safety Committee agreed the inclusion of a new risk in relation to a CQC inspection of White Rose Medical Centre (19/03). • As its meeting on 04 July 2019 Finance and Performance Committee agreed the inclusion of a new risk regarding eMBED giving notice on their contract to provide IT and BI support from April 2020 (19/04).
4.	**THE GOVERNING BODY IS ASKED TO:**
	• Review the summary of the GBAF for 2019/20, and consider whether the risks are appropriately described and scored, and whether there is sufficient assurance that they are being effectively managed • Identify any additional positive assurances relevant to the risks on the GBAF • Review the extract of the Corporate Risk Register to confirm all risks are appropriately scored and described, and identify any potential new risks • Note the new risks in relation to White Rose Medical Centre CQC report (19/03) and EMBED giving notice on their contract (19/04).
5.	**APPENDICES**
	• Appendix 1 – GBAF 2019/20 • Appendix 2 – Corporate Risk Register summary

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*

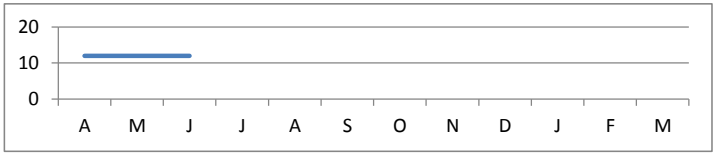
04/07/2019

NHS Barnsley CCG Governing Body Assurance Framework 2019-20

PRIORITY AREA 1: URGENT & EMERGENCY CARE	*Delivery supports these CCG objectives:*		PRINCIPAL THREATS TO DELIVERY
• Increased clinical assessment of calls to NHS 111 & CAS • Enhanced front door clinical streaming • Delivery of ambulance targets / conveyance with zero tolerance of delays over 30 minutes • Delivery of 4 hour A&E standard • Improved patient flow and reduce length of stay • Free up hospital beds - Reduce non-elective activity (90% by Sept 2018, 95% March 2019) • Enahance Same Day Emergency Care, increasing the proportion patients discharged on the day of attendance • Continue to deliver reductions in DTOC • Reduce A&E by default selections on the DOS	Highest quality governance		If partners locally and across the ICS 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
	High quality health care	✓	
	Care closer to home	✓	
	Safe & sustainable local services	✓	
	Strong partnerships, effective use of £	✓	
	Links to SYB STP MOU		
	8.4. Urgent and Emergency Care		

Committee Providing Assurance	**FPC**	*Executive Lead*	**JW**	*Clinical Lead*	**SK**

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



Date reviewed	**Apr-19**

Rationale: Likelihood currently judged to be 'possible' given current pressures and challenges across the urgent care system and the developing nature of plans to deliver outcomes of the national urgent care review. Consequence is judged as major due to the potential impact on patient care.

Key controls to mitigate threat:	**Sources of assurance**	**Rec'd?**
Operational planning templates 2019/20 were submitted to NHSE in April 2019. All activity plans are in line with forecast demand, have been agreed through contracting arrangements and are reflected in signed contracts.	Plan submitted to NHSE in line with required deadlines and the CCG have worked with NHSE to inform the final assurance process. Final feedback and confirmation of assurance and sign off of plans by NHSE/I and the ICS is currently awaited.	In progress
Barnsley UEC Delivery Board meets monthly, with representation from the CCG, to ensure oversight of performance and planning for urgent care locally and ensure delivery of urgent care standards including local system wide planning for winter and other seasonal pressures.	CCG Associate Medical Director and Director of Strategic Planning and Performance represent the CCG as members of the local delivery board. UEC Delivery Board winter plan submitted to NHSE October 2018 and assured November 2018. Evaluation of Winter 2018/19 took place at the Delivery Board in April and recognised the successes in delivering key standards and maintaining performance over the period. UEC Delivery Board Performance Dashboard is in place enabling all key performance and activity information from across partners to be reviewed by the Board and for actions to be agreed to address any areas of concern. Operational performance of UEC services in 2018/19 was strong including A&E, LoS, DTOC and Ambulance Handovers.	Ongoing

Urgent and Emergency Care Steering Board is in place as the UEC Programme Board of the South Yorkshire and Bassetlaw Integrated Care System. Representation in place for the UEC Delivery Board partners on the Steering Group and Commissioner Reference Group.	Barnsley UEC Delivery Board are represented by Barnsley CCG Director of Strategic Planning and Performance and Barnsley Hospital Deputy Director of Nursing (Operations) ensuring Barnsley place is contributing to system developments. SYB UEC Steering Board has agreed priorities which all places are signed up to deliver locally. Oversight by the SYB Steering Board and locally through the UEC Delivery Board. Successful procurement of a new Integrated Urgent Care/Clinical Advice (111) service with delivery commencing from April 2019 increasing access to clinical advice and linking with local services.	Ongoing
The CCG is developing a clear, prioritised delivery plan, to improve the out of hospital service offer and ensure that more people are able to be cared for and treated at home or in a community setting without the need for an hospital attendance or admission.	Draft Plan has been developed and project documentation including project plans are being produced for sign off. NEL Group has been established to oversee delivery of priority projects and this will feed into SMT and QDG.	In progress
Urgent Care Services are in place and continuing to deliver improvements to already strong performance and enabling the ongoing delivery of planning priorities.An Integrated extended hours and out of hours primary care services (IHEART 365) is in place with contracts for both elements of service delivered by Barnsley Healthcare Federation.	New IUC/CAS is in place and increasing access to clinical advice Primary Care Streaming is in place with a navigation function signposting people away from ED where appropriate. A&E waiting time perofmance is consistently high, length of stay low and flow good through and out of hospital ensuring low levels of DTOC Ambulatory Care/SDEC pathways are in place including Clinical Decsion Unit, Acute Frailty Unit, Ambulatory Medical Assessment Clinic, Surgical Assessment Unit and Childrens Assessment Unit	Ongoing
Performance reports to Finance and Performance Committee and Governing Body on the delivery of constitution standards and CCG Improvement and Assessment Framework. Twice yearly assurance reports provided to Governing Body.	Monthly reporting through the Integrated Performance Report to Finance and Performance Committee and bi-monthly to Governing Body	Ongoing

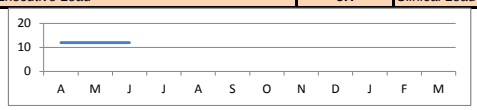
Gaps in assurance	**Positive assurances received**
Gaps in control	**Actions being taken to address gaps in control / assurance**
RR 15/07: If improvement in Yorkshire Ambulance Service (YAS) performance against the ARP response times targets is not secured and sustained, there is a risk that the quality and safety of care for some patients could be adversely affected.	Regular consideration of YAS incident reporting by QPSC and GB to understand the frequency and severity of incidents associated with ambulance response.
RR 18/04: If the health and care system in Barnsley is not able to commission and deliver out of hospital urgent care services which have sufficient capacity and are effective in supporting patients in the community to avoid the need for hospital attendance or non-elective admission there is a risk that non- elective activity will exceed planned levels potentially leading to (a) failure to achieve NHS Constitution targets (with associated reputational damage, and (b) contractual over performance resulting in financial pressure for the CCG	Activity levels are monitored on an ongoing basis through contract/performance management arrangements. NEL activity has been reviewed and work commenced to identify opportunities to support more patients at home to avoid the need for emergency hospital admission.

04/07/2019 **NHS Barnsley CCG Governing Body Assurance Framework 2019-20**

PRIORITY AREA 2: PRIMARY CARE	Delivery supports these CCG objectives:		PRINCIPAL THREATS TO DELIVERY
Delivery of 'GP Forward View' and 'Forward View - Next Steps for Primary Care' to: Deliver investment into Primary Care Improve Infrastructure Ensure recruitment/retention/development of workforce Address workload issues using 10 high impact actions Improve access particularly during the working week, more bookable appointments at evening and weekends. Every practice implements at least 2 of the high impact 'time to care' actions Deliver delegated Primary Care functions to be confirmed via mandated internal audit reviews Develop and maintain PCN with 100% coverage by 30 June.2019 and support the transition and further development of the PCNs	Highest quality governance		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 -Primary Care Networks do not embed and support delivery of Primary Care at place -Not having quality monitoring arrangements embedded in practice -Inadequate investment in primary care Independent contractor status of General Practice
	High quality health care	✓	
	Care closer to home	✓	
	Safe & sustainable local services	✓	
	Strong partnerships, effective use of £	✓	
	Links to SYB STP MOU		
	8.3. General Practice and primary care		

Committee Providing Assurance	**PCCC**	*Executive Lead*	**JH**	*Clinical Lead*	**NB**

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



Date reviewed	**Apr-19**

Rationale: Likelihood has been scored at 3 (possible) but will be kept under review. Consequence has been scored at 4 (major) because there is a risk of significant variations in quality of and access to care for patients if the priorities are not delivered.

Key controls to mitigate threat:	**Sources of assurance**	**Rec'd?**
Support practices to complete HEE Workforce Analysis tool. Ensure all practices install APEX and use this for capacity and demand assessment. This will also help to inform the workforce requirements. Those practices not utilising the APEX tool will be required to use the National Workforce Tool for monitoring workforce data.	All practices have now completed the HEE tool to allow the CCG to create a workforce baseline. The workforce data was been presented to September 17 BEST meeting supported by Mark Purvis from HEE. All practices (with 1 exception) has agreed to install and use the APEX tool. The installation process is monitored via the SYB D2 Group to ensure compliance and rigorous monitoring. APEX use is to be incentivised through the 2019/20 PDA to maintain workforce data.	In progress
Additional investment above core contracts through PDA delivers £4.2 to Barnsley practices to improve sustainability and attract workforce to the Barnsley area	Ongoing monitoring of PDA (contractual / QIPP aspects via FPC, outcomes via PCCC).	Ongoing
Optimum use of BEST sessions	BEST programme and Programme co-ordination being led by BHF	Ongoing
Development of locality working through the establishment of PCN's	6 local Clinical Networks have been agreed with the support of a single super Primary Care Network worked by the GP Federation. These are co-terminous with previous CCG and Local Authourity localities (submission completed) and signing up to the new Network Framework Agreement and Network Contract DES. This supports the transition and development of formal Primary Care Networks to deliver the primary care elements of the NHS Long Term Plan. Meetings are set for the year to ensure that the PCNs are able to meet regularly.	In progress
BHF - Existence of strong federation supports Primary Care at Scale	BHF contract monitoring, oversight by PCCC	Ongoing
Practices increasingly engaging with voluntary and social care providers (e.g. My Best Life) Social Prescribing - My Best Life is a successful programme supporting the people of Barnsley to work towards self care. This service has now extended to include high intensity users.	Monitored through PDA Contract monitoring of the My Best Life Service My Best Life's contract is monitored regularly. The 2019-20 PDA ensures that each practice continues to have a "My Best Life Champion". Social Prescribing is a key element in the Long Term Plan and a new cohort of Link Workers will support PCNs to deliver the requirements.	Ongoing
Programme Management Approach of GPFV & Forward View Next steps	GPFV assurance returns submitted bi-monthly to NHSE. Further update to PCCC in June 2018 to report on GPFV progress from 2017/18. GPFV update submitted to PCCC in June 2018 as planned.. GPFV assurance reports are submitted to NHSE monthly. Regular updates on progress are reported to PCCC as per PCCC work plan.	Ongoing
Care Navigation roll out - First Port of Call Plus	BHF contract monitoring, oversight by PCCC, also included in GPFV assurance returns	Ongoing
Engagement and consultation with Primary Care (Membership Council, Practice Managers etc.)	NHS England 360 Stakeholder Survey results shared with stakeholders and published on the CCG website. 18/19 results to be reported to Membership Council Spring 2019. Results show that BCCG stakeholders have a high level of satisfaction with the CCG's leadership & engagement.	Ongoing
SY Workforce Group in place; STP has a workforce chapter developed in collaboration with CCG's, HEE, providers and Universities. BCCG has a Workforce Manager in post who will ensure that Primary Care workforce is accounted for within all workforce discussions. This member of staff also represents Barnsley at SYB level so that the entire Barnsley CCG area workforce has representation.	BCCG is represented on the group. BCCG is represented on all workforce groups. Reporting is via PCCC for Primary care.	Ongoing

Gaps in assurance	**Positive assurances received**
None identified	
Gaps in control	**Actions being taken to address gaps in control / assurance**
RR 14/10:If the Barnsley area is not able to attract & retain a suitable & sufficient Primary Care clinical workforce there is a risk that: (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.	The CCG and BHF work with member practices to address any gaps/ variance and to develop a workforce plan going forward. Actively exploring option of international recruitment with 16 practices expressing an interest. BHF looking to host a number of these GPs if the initiative goes forward. Practices encouraged to look at skill mix with innovative recruitment. Recruitment of phase 2 Clinical Pharmacist

04/07/2019 **NHS Barnsley CCG Governing Body Assurance Framework 2019-20**

PRIORITY AREA 3: CANCER

- Preventing cancer incidence
- Reduced Inequalities especially those diagnosed at emergency admission.
- Improved cancer diagnosed rates at stage 1 or 2
- Early Diagnosis - Implement rapid assessment and diagnosis pathways for lung, prostate, colorectal and Upper GI cancers
- Improve care and treatment - implement new cancer waiting times system
- Improve Patient Experience along pathways and LWBAC
- Positive Experience at EOL
- Deliver Survivorship Program (LWABC) including recovery package and stratified pathways
- Commissioning for Value adopted if appropriate
- Achieve 8 waiting time standards including the 62 day referral-to-treatment cancer standard.

Delivery supports these CCG objectives:	
Highest quality governance	✓
High quality health care	✓
Care closer to home	✓
Safe & sustainable local services	✓
Strong partnerships, effective use of £	✓

Links to SYB STP MOU

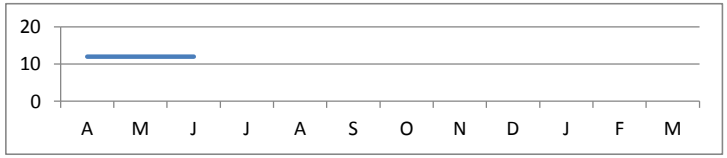
8.6. Cancer

PRINCIPAL THREATS TO DELIVERY

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 partner 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 and performance, the CCG will not secure full access to cancer transformation funding which would impact negatively on securing improvements to services for people Living With and Beyond Cancer (LWABC) and improving 62 day target and 8 WT standards .
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.

Committee providing assurance	**FPC**	*Executive Lead*	**JB**	*Clinical Lead*	**Dr H Kadarsha**

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



Date reviewed	**Apr-19**

RATIONALE: Likelihood has been scored at 3 (possible) but will be kept under review. Consequence has been scored at 4 (major) because there is a risk of significant variations in quality of and access to care for patients if the priorities are not delivered. A number of areas may not deliver due to workforce capacity and funding affected if performance is not met.

Key controls to mitigate threat:	**Sources of assurance**	**Rec'd?**
Programme Governance arrangements		
Barnsley wide cancer group? SYB cancer alliance?	How reported back into CCG?	
Steering Group: On track. CCG Contracting process: Reporting requirements relating to cancer A&E attendance and Vague Symptoms included in acute contract for 19/20. 5-10 year Strategy: Macmillan possible funding withdrawn. BHNF/CCG working towards a solution. The CA Demand and capacity modelling will provide future trajectories; CCG /CRUK producing practice profiles and improvement plans to drive ED improvment at locality and practice level - these will be used to support PCN ED specification implementation and locality working; ED and screening and stakeholder meeting held to gain wider identification of priorties; Workforce: MDT workshop: Using learning from the Cheshire and Merseyside models, the High Quality Services workstream of the CA will define scope and feed into CDGs. Pilots will be set up in each local trust and act as a vehicle for sharing learning.	HQS implementation group established, to develop and monitor quality priorties including CDG aim to reduce clinical variation and define quality measures for the CA programme. CCG will continue supporting at ICS/CA level via membership of group and CE CCG and Deputy Director representation at CA board. Steering group meeting monthly and produces monthly programme assurance and risk register that is approved by steering group and shared with CA. This group monitors programme delivery and updates shared wtih CCG SRO monthly. An 6 monthly assurance report approved by CCG governing body May 2019. 5 Primary care cancer measures within PDA are monitored by PC commissioning committee and 1/4 reporting via PDA monitoring process led by PC team; contracting process ensures controls in place for BHNFT and STHT performance and contractural totals. This is reported to CCG via Finance & Performance committee.	

62 Day Waits		
current CCG performance for Q4 is 84.2% (target 85%) and BHNFT on track to meet Q4 target. Introduction of timed pathway for prostate and lung started and on track. The colorectal pathway is due to start by June 2019 and upper GI timed pathway planning working group in place by August 2019.	Performance is reported to CCG via Finance & Performance committee and via CA board reporting arragements. CCG meets BHNFT cancer lead monthly to monitor performance and gain assurance about improvement actions to address pathways; Steering group meeting monthly and produces monthly programme assurance and risk register that is approved by steering group and shared with CA. This group monitors programme delivery and updates shared wtih CCG SRO monthly . CCG attends BHNFT CPIG group and raises assurance points that are adressed via the action log process.	
Prevention		
Be Cancer SAFE: links established with PHE colleagues; Locality Dearne Team and BME and Polish populations. Joint BCS/Macmillan Health & Wellbeing Hub proposal submitted to BMBC market, awaiting feedback. Risky behaviours CQUIN: BHNFT and SWYPFT on target to deliver all parts including year-end targets. Screening: stakeholder workshop to be held April '19 to identify priority areas and gaps. Lynch screening: Paper to MT due 03/04/19. On track for 01/04/19 changeover date. Public health: Alcohol CleaR assessment being taken to Health and Wellbeing Board in April, slides to be shared at following BCSG	Assurance is via monthly cancer programme assurance process that ensures programme is on track and lack of progress addressed. The BCS work is reported to CCG via contractural process, via leads attendance at CCG Steering Group and bi-monthly assurance meetings with BCS by CCG cancer programme lead.	
Early Diagnosis		
Timed pathways: Lung (green rating): ED pathway discussed and progress to mirror GP pathway. Prostate (green rating): agreement of Triage protocol and process with all clinical teams. Referral system set up for GPs to refer using a RAS. Colorectal (red rating): No clinical agreement about safety of triage, meeting 03/04/19 to resolve. Timed pathway start delayed for potential of 2 months. Vague Symptoms: Pathway shared via BEST website, with primary care, secondary care and LMC. SEA: Signed-up practices reminded to submit SEAs, further comms due mid-March to submit SEA and to apply for funding agreement. 5 practices submitted. FIT - lower GI pathway: Kits out w/c 04/03/19. Audit on awareness/implementation to be undertaken; communication being sent regularly to primary care.	Assurance is via monthly cancer programme assurance process that ensures programme is on track and lack of progress addressed. CCG attends CA monthly ED group and reports back to CCG actions and ensures actions agreed are adopted via CCG governace routes including reporting and gaining approval at MT for vague symptoms pathway and lower GI pathway implementataions. Lower GI pathway implementation Assurance is via monthly cancer programme assurance process that ensures programme is on track and lack of progress addressed. CCG attends CA monthly ED group and reports back to CCG actions and ensures actions agreed are adopted via CCG governace routes including reporting and gaining approval at MT for vague symptoms pathway and lower GI pathway implementataions. Lower GI pathway implementation monitored via QIPP monthly highlight reports .	
Better treatment and care		
Waiting times: With CA agree external support for demand and capacity work; continue rolling out timed pathway to reduce pressure on system. Quality Surveillance self-assessment: Results presented at QDG and shared with BHNFT. Improvement action and monitoring process to be agreed. Teledematology : CCG MT agreed 1 year Pilot , engagement survey to practices to ascertain preferred equipment option and general feedback distributed.	Assurance is via monthly cancer programme assurance process that ensures programme is on track and lack of progress addressed. CCG attends CA monthly operational group and reports back to CCG actions and ensures actions agreed are adopted via CCG governace routes including reporting and gaining approval at MT and clinical forum . Tele dermatolgy pilot is reported via QIPP governace reports . Quality Surveillance self-assessment reported to CCG quality and safety committee annually and exceptions raisedevia this route .	
LWABC		

e-HNA/Care planning: Live pilot continues, currently 25 e-hna care plans completed in breast. Still awaiting CSW roles to be advertised. Treatment summaries: All templated completed in the 3 tumour sites. Test work outstanding. Supported self management: The Well has moved and will reopen 1st April. HOPE course had poor attendance due to patient illness. Anxiety management was well-attended. Risk stratified pathways: Clear pathways in place and being agreed regionally and locally –some delays still on local completion. Information: Macmillan Information will go in the new Well/ hopefully with Be Cancer Safe on the market and in outlying areas of Barnsley. Engagement and Project Governance: Dr Edgar and Sara Andrews looking at how the CCR template work can be improved and benefit patients. Project evaluation: evaluation work on-going with the Regional LWABC programme and the local evaluation including Anxiety management review of courses. Primary care: work on-going with discussions with Dr Edgar/ Dr Kadarsha and Dr Balac and how best to support primary care.	5 Primary care cancer measures within PDA are monitored by PC commissioning committee and 1/4 reporting via PDA monitoring process led by PC team; the Barnsley LWABC steering group governace framework and LWABC Leads membership of CA LWABC programme ensures programme reported to CCG. LWABC is a cancer measures within PDA that is monitored by PC commissioning committee and 1/4 reporting via PDA monitoring process led by PC team;	
End of Life		
SWYPFT's Palliative/EoL Care: awaiting next EoL strategy group meeting to progress action plan 18/04/19. EpaCCs: Surveys to practices who have / have not undertaken training produced and distributed to encourage sign up and ascertain possible mobilisation issues. Macmillan ANP for Care homes: Post-holder continuing to roll out project across South neighbourhood. Expected to move to 2 high admission care homes mid-April 19	reporting is via CCG being member of EOL strategy group and having responsibilty to ensure strategy action plan on track. CCG reporting of Care homes ANP work plan gained by attending 1/4 implementation group and via CCG care homes programme governance.	
Communication and engagement		
Patient Engagement Screening: Preparing for screening week (10-16 June 2019). Primary Care Education: Hot Topic sessions due to start 2/5 – Oncological emergencies and long term effects of cancer treatment, Dr Caroline Lee undertaking, paper invite given out at BEST, will be promoted in Primary care news. Patient Engagement: March; Promotion of BeCancerSafe breakfast meetings. Promotion of BeCancerSafe team runner up award. A cancer care navigation tool has been developed by BCS and is being worked on via BCSG.	Assurance is via monthly cancer programme assurance process that ensures programme is on track and lack of progress addressed; Macmillan post eduactional events reported via evaluation reporting process and bi-monthly reporting process to Macmillan ensures on track and monthly meetings between Macmillan GP and CCG CL for cancer. The CCG via CA established communcation and engagement group ensures actions and reporting are to CCG and via monthly reporting for the cancer programme assuarance reporting.	

Gaps in assurance	**Positive assurances received**
Lack of GP engagement with Programme deliverables will hinder progress	Communication in plan to ensure GP engaged – a variety of methods will be used to minimise risk. Cancer steering will monitor at each meeting and action as required.
MDT effectiveness – restructure may breach guidelines and standards	Cancer Alliance supporting process to ensure trust not penalised
Lack of Patient and Public Engagement will hinder programmes progress	Engagement plan to be produced to mitigate risk. Cancer steering will monitor at each meeting and action as required
Diagnostics capacity unable to meet increased demand	CCG working with Cancer alliance CCG's to identify future demand and capacity gaps; pressure points and mitigating actions; ICS demand and capacity workstream working on identifying mitigating actions

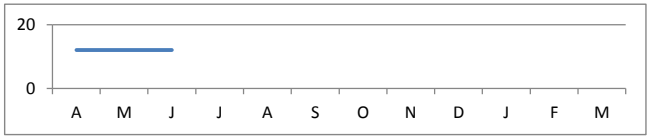
Timed pathways implementation not delivered to timescale - risks of clinicians not engaged Colorectal delayed due to clinical safety assurance issues.	Assurance reporting in place to mitigate risk; delivery groups set up to mitigate risk. BHNFT working with clinicians to agree solution.
EPaCCS not adopted by all GP practices leading to no improvement EOL choices for patients	Palliative care team working with practices to embed; Best event January team delivered training
Practices not completing SEA's and action plans leading to no reduction in early diagnosis rates	CRUK targeting each practice . CCG to remind practices of local funding agreement
Gaps in control	**Actions being taken to address gaps in control / assurance**

04/07/2019 **NHS Barnsley CCG Governing Body Assurance Framework 2019-20**

PRIORITY AREA 4: MENTAL HEALTH	*Delivery supports these CCG objectives:*		PRINCIPAL THREATS TO DELIVERY
Increase the number of children and young people receiving evidence-based treatment to improve their emotional health and wellbeing - the access target to be achieved in 2019/20 is 35% By Q4 2019/20 to improve access to psychological therapies (IAPT) to 22% of the local prevalent population and to 25% by 2021. Improve the IAPT moving to recovery rate to an ambitious targets of 60% acknowledging the national target is 50% 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 Reduce the numbers of suicides in Barnsley to the national average as a minimum Continue to Improve perinatal mental health Develop a South Yorkshire and Bassetlaw sustainable regional ASD /ADHD diagnosis and treatment service for adults Meet the Mental Health Investment Standard (MHIS) Improve access to healthcare and deliver annual physical health checks for the population - the target to be achieved for 2019/20 is 60% of those patients on the GP SMI Register 66.7% of people with dementia aged >65 should receive a formal diagnosis.	Highest quality governance		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 and that delivery of the five year forward view for Mental Health will not be achieved.
	High quality health care	✓	
	Care closer to home	✓	
	Safe & sustainable local services	✓	
	Strong partnerships, effective use of £	✓	
	Links to SYB STP MOU		
	8.5. Mental Health		

Committee providing assurance	**FPC & QPSC**	*Executive Lead*	**PO**	*Clinical Lead*	**Dr M Smith**

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



Date reviewed	**Apr-19**

Rationale: Likelihood set as 4 (likely) because delivering the recommendations of the five year forward view of mental health is dependent upon additional financial resources and a fully trained, accessible workforce. IAPT services have been successfully tendered and the new service commenced from 1 August 2018 which is delivering a more ambitious programme. In order to increase access to Mental Health services, the capacity of the mental health services needs to be increased, primarily by increasing the workforce. There are limited, accredited training courses available locally which limits the ability of the service to grow. The South Yorkshire and Bassetlaw ICS MH/LD Board have estsablished a workforce strategy group for South Yorkshire collaborating closely with Health Education England
Consequence set as 3 (moderate) because the mitigated actions outlined will enable mental health services to provide, good quality outcomes and be in a state of readiness to effectively utilise the additional resources as and when they become available. NB Rising clinical need is escalated and responded to.

Key controls to mitigate threat:	**Sources of assurance**	**Rec'd?**
Recurrent investment to implement the local transformation plan (improving children and young peoples emotional wellbeing).	Quarterly Assurance reports / feedback to NHS England; monitored by C&YPT(Children and Young Peoples Trust) ECG (see note 2). ECG minutes to F&P Committee.	Ongoing
Perinatal Mental Health - continue to implement the specialist perinatal health team and to fund the specialist mental health midwife post at BHNFT.	ICS Reporting Framework. Action notes to JCU for info. Regular updates to Governing Body	Ongoing
Service provider developing robust workforce plans in conjunction with Health Education England National Workforce Strategy.	MHFYFV Dashboard, monitored via Adult Joint Commissioning Group (see note 1)	Ongoing

Increase the commissioning of ASD / ADHD services to 50% of the local evidence based prevalence. To develop a south Yorkshire and Bassetlaw regional ASD / ADHD diagnostic and treatment service. Additional investment in the 0ver 11 ASC pathway has been agreed to improve the waiting and access times on this pathway (waiting times are 2.5 years as at 30/4/2019)	ICS Reporting Framework. Successful Paper to May Governing Body re increased resource awaiting service mobilisation Progress monitoring by AJC Group (see note 1 below)	Ongoing
Continue to promote the local social prescribing service	Monitored via Adult Joint Commissioning Group (see note 1)	Ongoing
Successful IAPT re tender with a new ambitious service specification for a new service in place from 1st August 2018.	Oversight by F&PC, reporting into Governing Body. New IAPT service is fully implemented and all national IAPT targets are consistenmtly achieved.	Complete
Barnsley will bid for monies for 24 hour liaison compliance in Wave 2 funding round (during 2019) as advised by NHS England, Crisis Care Concordat Group keeps multiagency focus.	Monitored via Adult Joint Commissioning Group (see note 1)	Ongoing
Note (1) - Adult Joint Commissioning group minutes go to F&PC for information. It reports into the Health & Wellbeing Board which is attended by the CCG CO and Chair and minutes go to GB. *Note (2) - the Childrens & Young People's Trust ECG minutes go to F&PC for information. It reports via TEG to H&WB which is attended by the CCG Chair and CO and minutes go to GB. Specific issues may be raised with GB via quarterly Children's Services updates.*		

Gaps in assurance	**Positive assurances received**
	Local Transformation Plan refreshed annual (October) and quality assurance reports to NHSE. Latest Assurance report (March 2019) gained a 'fully confident' rating of delivery from the NHS E Assurance panel
Gaps in control	**Actions being taken to address gaps in control / assurance**

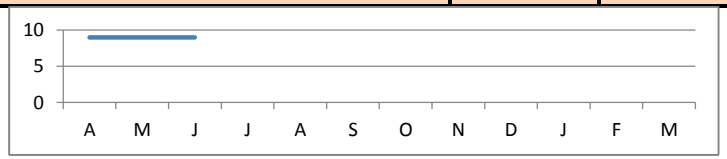
04/07/2019

NHS Barnsley CCG Governing Body Assurance Framework 2019-20

PRIORITY AREA 5: INTEGRATED CARE SYSTEM (ICS)	*Delivery supports these CCG objectives:*		PRINCIPAL THREATS TO DELIVERY
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 Integrated Care System. CCG contributions to system wide working & enabling work streams: Leadership and programme support	Highest quality governance	✓	The effectiveness of the ICS will be undermined if any of the member parties is unable to sign up to the system MOU, the direction of travel, and the mechanisms for collective decision making. The effectiveness of commissioning at place level across the full range of CCG priorities could be detrimentally affected if uncertainty re the future of commissioning across the system leads to disengagement or loss of capacity or direction locally.
	High quality health care	✓	
	Care closer to home	✓	
	Safe & sustainable local services	✓	
	Strong partnerships, effective use of £	✓	
	Links to SYB STP MOU		
	8.7 Workforce; 8.8 Digital & IT; 8.9. Development of Integrated Care in Place & System; 8.10. Commissioning reform; 8.11. Sustainable Hospital Services Review		

Committee Providing Assurance	**ICS CPB JCC of CCGs**	*Executive Lead*	**LS**		**NB**

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



Date reviewed	**Apr-19**

Rationale: Likelihood has been scored at 3 (possible) because individual organisation will be required to deliver on their statutory duties and may prioritise these over partnership commitments. Consequence has been scored at 3 (moderate) because whilst we would not be able to harness the full benefits of integrated health and care the commissioning and provision of health and care services for Barnsley people would continue.

Key controls to mitigate threat:	**Sources of assurance**	**Rec'd?**
Collaborative Partnership Board (CPB) provides strategic direction and oversight of the ICS, while the Joint Commissioning Committee of CCGs facilitates collective commissioning decisions over defined areas.	Minutes of both CPB and JCCC of CCGs are taken through the Governing Body	Ongoing
ICS Memorandum of Understanding signed by all parties in place outlining sign up to direction of travel in system and in place, recognising journey to local Integrated care partnerships	ICS MOU signed off by Governing Body and all Parties to the ACS for 17/18. MOU for 2018/19 between NHSE/I and ICS agreed and signed off by 1 October 2018. ICS go Live October 2018.Integration agreements between place and system developed(from October 2018).	Oct-18
Clear governance arrangements in place to enable to ICS to make both collective commissioning and provider decisions through the Joint Committee of Clinical Commissioning Groups (JCCC) and Providers Committee in Common (CiC)	Minutes of both CPB and JCCC of CCGs are taken through the Governing Body. Governing Body receives and signs up to ICS governance arrangements for Level 3 ICS from April 19	Dec-18

The ICS has a clear management structure with sufficient capacity and resources to take forward its transformation programmes on behalf of the system.	Agreement of 2018/19 ICS nationally allocated transformation funding and partner contributions and sign off of 2018/19 ICS budget. Revised ICS Executive Management Team in place.	Jul-18
Work underway to identify 2019/20 commissioning priorities to be taken forward across the ICS footprint with JCCC oversight and potentially delegation of joint decision making subject to agreement of partner CCGs.	Paper setting out 2019/20 ICS commissioning priorities and collaborative commissioning arrangements agreed in principle by BCCG Governing Body March 2019. proposals for delegation of decision making to JCCC to br brought to a future GB.	
Collective approach to decision making in relation to the Hospital Services Review in place within the Barnsley partnership and across the ICS.	Hospital Services Review received both by ICS Collaborative Partnership Board and by Barnsley CCG Governing Body. Governing Body agreed to the publication of the Strategic Outline Case October 2018.	Jun-18

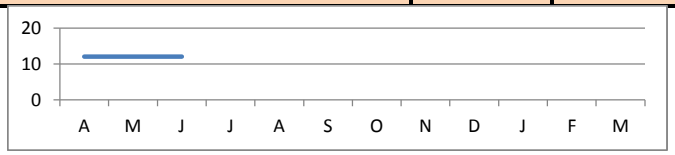
Gaps in assurance	**Positive assurances received**
Gaps in control	**Actions being taken to address gaps in control / assurance**

04/07/2019 **NHS Barnsley CCG Governing Body Assurance Framework 2019-20**

PRIORITY AREA 5.2: INTEGRATED CARE AT PLACE LEVEL	*Delivery supports these CCG objectives:*		PRINCIPAL THREATS TO DELIVERY
Development of Integrated Care Partnership (ICP) in Barnsley bringing Barnsley providers and commissioners together to plan and deliver care. This will include - • Development of primary care networks and the supra-network • Development of neighbourhood action plans that deliver better use of estates, support co-production and integration • Population health management including PHMU, integrated care outcomes framework and local profiles and needs assessments that support neighbourhood prioritisation • Development of a place-based workforce strategy • Integrated commissioning with BMBC • Service specification for the out-of-hospital model of care • Strategic outline case for integrated care in Barnsley • Set out how the local health system will specifically reduce health inequalities by 2023/24 and 2028/29	Highest quality governance	✓	• Financial pressure on individual organisations leads to reduced involvement/investment in the partnership working • Constraints within the current legislative and regulatory framework limit progress with partnership working despite the clear direction of travel set out in the 5YFV and NHS LTP. NHS England is consulting on possible legal changes but these are unlikely to come into effect for at least 3 yrs • Political uncertainty in part due to Brexit. Possibility that there will be a new government that has different policy objectives for the NHS although the main opposition parties are supportive of integration a different administration may take a different approach. • Local public and political support because of a misunderstanding of the ambition of integrated health and care, partly because of the term "accountable care", which has previously been used in the NHS, is associated with an American model of privatised health and care and partly because of association with changes through the hospital services review • Maturity of the local provider partnership, financial and operating pressures in the system affect their ability to implement transformational change • Capacity to constructively engage all relevant stakeholders in the development of integrated care and to deliver the cultural and behavioural change required (both staff and service users) • Failure to demonstrate the impact and benefits of new ways of working in order to generate support and increase engagement • Limited local leadership capacity, particularly for Primary Care Networks • Ability of candidates to recruit into new primary care network roles
	High quality health care	✓	
	Care closer to home	✓	
	Safe & sustainable local services	✓	
	Strong partnerships, effective use of £	✓	
	Links to SYB STP MOU		
	8.7 Workforce; 8.8 Digital & IT; 8.9. Development of Accountable Care in Place & System; 8.10. Commissioning reform; 8.11. Sustainable Hospital Services Review		

Committee Providing Assurance			**TBC**
Risk rating	Likelihood	Consequence	**Total**
Initial	3	4	12
Current	3	4	12
Appetite	3	4	12
Approach	**Tolerate**		

Executive Lead	**JB**



Clinical Lead	**NB**

Date reviewed	**Feb-19**

Rationale:
- Likely impact due to possibility of adverse local media coverage, potential slippage leading to a key objective not being met and potential for external challenge
- Likely as it is possible that the impacts could recur occasionally

Key controls to mitigate threat:	**Sources of assurance**	**Rec'd?**
Oversight of process by CCG Governing Body	Routine reporting of progress into Governing Body meetings (public and private) and discussions at development sessions	Ongoing
Primary care engagement	Series of BEST events focussed on emerging guidance for primary care networks and the right model for Barnsley	Completed
Engagement with the Membership Council and Local Medical Committee to gain support for integrated care objectives and primary care network proposals	Membership Council agreed to strategic direction at the meeting held on 3 July 2018	Completed
Local partnership governance arrangements	The CCG is a member of the Integrated Care Partnership and Delivery Groups and leads the Strategic Estates Group and Workforce Transformation Group. PHMU is forming.	Ongoing

Aligned resources	Place-based workforce lead appointed and transformation funding secured from HEE to support workforce modelling and strategy development. Commissioning team staff are aligned to integrated care priorities (Frailty, CVD and neighbourhoods) and there is agreement to align with BHF to support the development of PCNs and the supra-network.	Ongoing
Independent legal advisors appointed	Record of legal advice requested and received to date.	Completed.
Engagement with national bodies	Discussions with the Systems Transformation Group and New Business Models team at NHS England for Horizon Scanning and facilitating networking with other leading edge systems.	Ongoing
Staff engagement	Briefings have taken place. LS is attending team meetings to provide updates on the development of the ICS and ICP.	Ongoing
Communications and engagement	Communications leads from across the partners have co-produced a communications and engagement place that has been signed off by ICPG.	Ongoing

Gaps in assurance	**Positive assurances received**
Gaps in control	**Actions being taken to address gaps in control / assurance**
18/02; If the CCG and BMBC do not develop a collaborative commissioning approach underpinned by shared values there is a risk that BMBC commissioned services will not meet the requirements and aspirations of the CCG for the people of Barnsley leading to increased health inequalities and poorer health outcomes.	• Escalation of CCG concerns to BMBC senior management • Escalation via SSDG and health & wellbeing board

04/07/2019

NHS Barnsley CCG Governing Body Assurance Framework 2019-20

PRIORITY AREA 6: EFFICIENCY PLANS

- Free up hospital beds
- Best value across all CCG expenditure
- Reduce avoidable demand
- Reduce unwarranted variation in clinical quality and efficiency
- Cut the costs of corporate services and administration - plan to deliver 20% reduction in running costs in 2020/21
- Financial accountability and discipline for all trusts and CCGs

. Plan for and deliver control total for 2019/20

Delivery supports these CCG objectives:	
Highest quality governance	✓
High quality health care	✓
Care closer to home	✓
Safe & sustainable local services	✓
Strong partnerships, effective use of £	✓

Links to SYB STP MOU

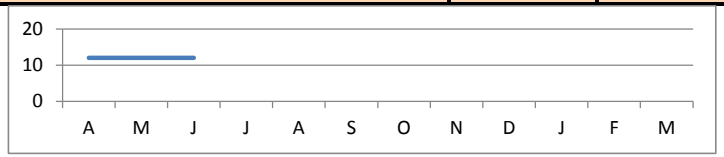
8.2. Managing demand and demand management
8.1. Efficiency programmes

PRINCIPAL THREATS TO DELIVERY

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.

Committee Providing Assurance	FPC	*Executive Lead*	RN	*Clinical Lead*	Various

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



Date reviewed	Apr-19

Rationale: Likelihood currently judged to be 'possible' but will be kept under review. Consequence judged to be 'major' in light of potential impact on statutory duties, performance ratings, and organisational reputation.

Key controls to mitigate threat:	Sources of assurance	Rec'd?
Structured project management arrangements in place to support delivery	F&PC scrutinised proposed monitoring on an ongoing basis & made recommendations to GB	Ongoing
QIPP Delivery Group continues to be in place to maintain oversight of the QIPP programme	Progress reports to QIPP Delivery Group The CCG has plans identified against the 2019/20 QIPP target and these will be closely monitored with updates provided through QDG/F&P/GB. Work has commenced on identification of 2020/21 QIPP.	Ongoing
Clinical Forum provides clinical oversight of projects	Monthly reports to Finance & Performance Committee and Governing Body	Ongoing
Continued development and review of the CCG's Demand Management Programme (high value scheme)	Continual improvements and assessment of modelling of activity related schemes	Ongoing
	Ongoing engagement with primary care and secondary care to support delivery of activity related schemes	Ongoing
Continued development and review of the CCG's Medicines Optimisation QIPP 2018/19 to deliver prescribing efficiencies (high value scheme)	Clinical Pharmacists and Medicines management team continue to engage with Primary care and a validation of all efficiencies reported as delivered is undertaken within the Medicines Management team.	Ongoing

Gaps in assurance	Positive assurances received

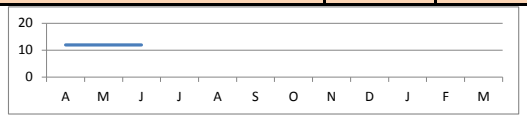
Gaps in control	Actions being taken to address gaps in control / assurance

NHS Barnsley CCG Governing Body Assurance Framework 2019-20

PRIORITY AREA 7: TRANSFORMING CARE FOR PEOPLE WITH LEARNING DISABILITIES AND / OR AUTISTIC SPECTRUM CONDITIONS	*Delivery supports these CCG objectives:*		PRINCIPAL THREATS TO DELIVERY
Transform the treatment, care and support available to people of all ages with a learning disability, autism or both so that they can lead longer, happier, healthier lives in homes not hospitals by: -Reduce inappropriate hospitalisation and lengths of stay to be as short as possible - Improve access to healthcare and deliver annual physical health checks (eg cervical screening) -Invest in community teams -Ensure all children with learning disabilities, autism or both receive Community Care, Education and Treatment Review (CETR) if appropriate - Ensure all adults with learning disabilities, autism or both receive Community Care and Treatment Review (CTR) as appropriate -Increase uptake on annual health checks and learn from learning disability mortality reviews	Highest quality governance		If the CCG and its partners are unable to provide focussed case management and wrap around services there is a risk that: -People with a learning disability or autistic spectrum conditions will enter hospital inappropriately -There will be difficultly discharging current patients - Potential prohibitively high cost of meeting needs - Inability of current provider market to meet needs - Difficulty in ensuring that the quality of care is high - Insufficient funding to ensure the appropriate level of care within the community
	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	**FPC & QPSC**	*Executive Lead*	**PO / AR**		**Dr M Smith**

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



Date reviewed	**Apr-19**

Rationale: likelihood assessed as 4 'likely' because the local market is not sufficiently developed to enable all aspects of the transforming care plan to be delivered. Consequence judged to be moderate (3) because in terms of direct impact higher levels of care are viewed as 'safer' but longer term promoting independence and quality of life is compromised, hence this focus by NHSE.

Key controls to mitigate threat:		**Rec'd?**
A Complex Case Manager for Transforming Care patients has been in post from May 2019. The postholder will enusre CTR's and CETR's will be undertaken in a timely manner to ensure clients receive the most appropriate care in environments as close to Barnsley as possible.	JCU reports to Finance & Performance Committee with any Quality issues escalated to Quality & Patient Safety Committee.	May-19
Appropriate services are being developed within Barnsley, where apprpriate, to enable some of the most complex patients to return to Barnsley and be cared for within the local community		Jun-19
Strong partnership arrangements with Calderdale, Wakefield and Kirklees (Transforming Care Partners CKWB) which will continue despite realignment of reporting footprint (Barnsley now to be reported with South Yorkshire & Bassetlaw)		Ongoing
Development of LD Strategic Health & Social Care Improvement Group to maintain oversight of key legislation inc LEDER learning and transforming care		Ongoing
Detailed plans, with timescales, are being developed for each patient identified within the Transforming Care cohort, to return these patients to appropriate local community settings as quickly and as safely as possible to improve their life outcomes		
A Barnsley Learning Disabilites Strategic Group has been established in April 2019 to continue the principles within the TCP programme - the CCG is represented on this multi-agency group by the Head of Commissioning (Mental Health, Children's and Maternity)		Ongoing

Gaps in assurance	**Positive assurances received**
Gaps in control	**Actions being taken to address gaps in control / assurance**
	Quarterly meetings with NHS England Spec Comm, who commision the existing placements for this cohort of patients, to determine progress made, worekign towards discharge
	Quarterly assurance reports to be presented to Management Team outlining progress being made towards discharge of patients to the local community

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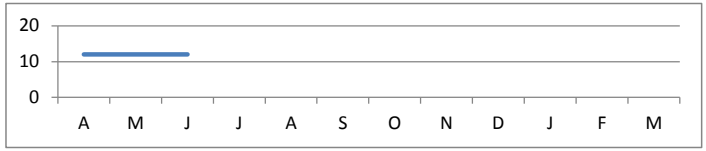
NHS Barnsley CCG Governing Body Assurance Framework 2019-20

PRIORITY AREA 8: MATERNITY	Delivery supports these CCG objectives:		PRINCIPAL THREATS TO DELIVERY
Continue to implement the Saving Babies' Lives care bundle to further reduce still birth, neonatal deaths, maternal deaths and brain injuries. Implement the SYB LMS (Local maternity service) - - Improve maternity safety, choice and personalisation - Liaise closely with the local MVP (Maternity Voice Partnership) to ensure local women are able to influence and shape the delivery of future services	Highest quality governance		1/ Dependent upon implementing the outcomes of the Hospital Services Review 2/ Lack of investment in additional staff resources to enable 'continuity of carer' 3/ Dependent on ICS maternity services therefore failure of the ICS providers to integrate working practices fully to implement the LMS 4/ Lack of staff rotation between hospital and community based services may reduce the likihood of fully delivering continuity of carer
	High quality health care	✓	
	Care closer to home	✓	
	Safe & sustainable local services	✓	
	Strong partnerships, effective use of £	✓	
	Links to SYB STP MOU		
	8.5.		

Committees providing assurance	**FPC & QPSC**	*Executive Lead*	**PO**	*Clinical Lead*	**Dr M Smith**

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



Date reviewed	**Apr-19**

Rationale: Likely primarily due to the staffing issue inherent in delivering continuity of carer and there are no additional funding streams available.
Consequence is moderate because this is primarily a local issue which will potentially result in the late delivery of the key objective within the better birth recommendations of delivering the 'continuity of carer.'

Key controls to mitigate threat:	**Sources of assurance**	**Rec'd?**
3 Continuity of carer midwifery teams have been established focusing on smoking cessation, under age pregnancy and substance misuse	NHSE LMS assurance process	Ongoing
CQB for each provider reports to Q&PSC	Yorkshire and Humber maternity dashboard (enables benchmark)	Ongoing
Governing Body oversight	Reporting into QPSC, minutes to Governing Body with specific issues escalated by the Quality Highlights Report	Ongoing
the local based maternity plan includes increasing the choice of where to give birth from the current two oprions avaialble to the recommended three options (consultant led, home and midwifery led)		Ongoing
enhanced specialist smoking cessation support for women who smoke during pregnancy will be provided		Ongoing

Gaps in assurance	**Positive assurances received**
	In 2017/18 BHNFT benchmarked well positive update to June Governing Body. NHS England positively assured the SY&B ICS Maternity Plan in the assurance round in December 2018

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

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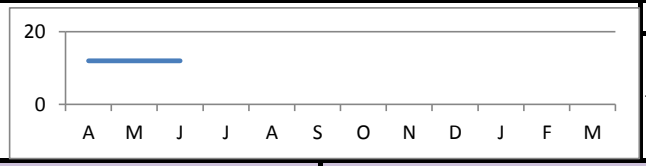
NHS Barnsley CCG Governing Body Assurance Framework 2019-20

PRIORITY AREA 9: DIGITAL AND TECHNOLOGY	*Delivery supports these CCG objectives:*		PRINCIPAL THREATS TO DELIVERY
1. Development of a system wide shared care record 2. Ensure the delivery of the GP IT Operating Model to: - Comply with mandatory core standards re: interoperability and cyber security - Support the transition to HSCN from N3 - Support the roll out of Windows10 to secure system security from cyber attack - Support the implementation and roll out of the NHS App, eConsultaion. APEX, GPIT refresh of IT equipment, Govroam - Support the wider use of digital technology as described within the Long Term Plan - Comply with the transition from GPSoC to GP IT Futures - Working closely with the SY&B digital and IT workstream to deliver the digital road map	Highest quality governance		Capacity and leadership system at place - The contract for GP IT and Corporate IT support is nearing its end - Lack of IT technical input into projects and programmes of work - Primary Care colleagues fatigued with the amount of IT work scheduled - Short timelines to deliver projects - Supplier and equipment delays - contructive and timely engagement by system partners to deliver a SCR by 20/21
	High quality health care	✓	
	Care closer to home	✓	
	Safe & sustainable local services	✓	
	Strong partnerships, effective use of	✓	
	Links to SYB STP MOU		

Committees providing assurance				*Executive Lead*	**JB**	*Clinical Lead*	**JH**
Risk rating	Likelihood	Consequence	**Total**			**Date reviewed**	**Apr-19**
Initial	4	3	12			Rationale: Likelihood has been scored at 4 but will be kept under review. Consequence has been scored at 4 because of the eMbed contract situation.	
Current	4	4	12				
Appetite	3	4	12				
Approach	**Tolerate**						

Key controls to mitigate threat:	**Sources of assurance**	**Rec'd?**
Barnsley IT Strategy Group	Monthly meetings to review SCR progress and refresh Digitial Roadmap. Minutes to GB	Pending
Barnsley CCG Operational IT Group	Monthly meetings to review progress of the delivery of key projects and programmes. Updates to GB and PCCC	Pending
GP IT and Corporate IT service commissioned from eMBED		Pending
Redcentric become the commissioned service to maintain HSCN		

Gaps in assurance	**Positive assurances received**
Governance process to be established for the IT groups	
Gaps in control	**Actions being taken to address gaps in control / assurance**
Lack of technical support to ensure deliverables are robust	CCG has some resource to obtain additional support if required
Link with the IT Strategy group and the CCG Operational Group	Linkage through shared membership
Incomplete information available from NHS Futures regarding future work	

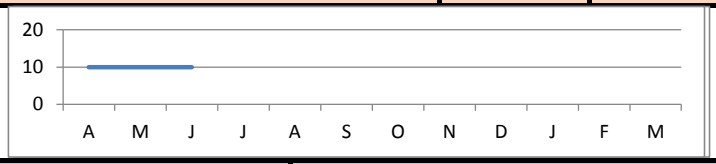
04/07/2019

NHS Barnsley CCG Governing Body Assurance Framework 2019-20

PRIORITY AREA 10: COMPLIANCE WITH STATUTORY AND REGULATORY REQUIREMENTS	*Delivery supports these CCG objectives:*		PRINCIPAL THREATS TO DELIVERY
• Delivery of all the CCG's statutory responsibilities • Deliver statutory financial duties & VFM • Improve quality of primary & secondary services (inc reductions in HCAI, ensuring providers implement learning from deaths, and reductions in medication errors); • Involve patients and public; • Promote Innovation; • Promote education, research, and training; • Meet requirements of the Equality Act; • Comply with mandatory guidance for managing conflicts of interest • Adhere to good governance standards.	Highest quality governance	✓	If the CCG fails to deliver its statutory duties, due to weaknesses in its corporate governance and control arrangements, it will result in legal, financial, and / or reputational risks to the CCG and its employees.
	High quality health care	✓	
	Care closer to home	✓	
	Safe & sustainable local services	✓	
	Strong partnerships, effective use of £	✓	
	Links to SYB STP MOU		
	Section 7 'Governance, Accountability, & Assurance'		

Committee Providing Assurance	**Various**	*Executive Lead*	**RW**	*Lay / Clinical Leads*	**MG,MT,NBa, NBe, CM**

Risk rating	Likelihood	Consequence	**Total**
Initial	2	5	10
Current	2	5	10
Appetite	3	4	12
Approach	**Tolerate**		



Date reviewed	**Apr-19**

Rationale: Likelihood is 'unlikely' as arrangements now well established. Consequence is catastrophic due to very significant quality, financial & reputational impact of failure.

Key controls to mitigate threat:	**Sources of assurance**	**Rec'd?**
Overall: Constitution, Corporate Manual, Prime Financial Policies, and suite of corporate policies	Audit Committee provides oversight, supported by internal & external audit reports & opinions, LCFS work etc	Ongoing
Governing Body & Committee Structure underpinned by clear terms of ref and work plans	GB members sit on Committees. All Committee minutes taken to GB and significant issues are escalated. Committees produce annual assurance reports for the GB.	Ongoing
Management Structure - responsibilities clearly allocated to teams and individuals	Management action monitored by regular senior management team meetings. SMT decisions with a financial consequence reported through F&PC.	Ongoing
Finance: Budgetary control, contract monitoring & QIPP monitoring arrangements. Scheme of Delegation requires SMT approval for spending commitments <£100k and GB approval over this level..	Financial Plan signed off by GB each year. Monthly finance report to FPC and GB; internal & external audit reviews and opinions; GB formally adopt annual report & accounts.	Ongoing
Performance monitoring arrangements	Integrated Performance Reports to FPC provides assurance across all NHS Constitution pledges. Summary reports to GB.	Ongoing
Quality: comprehensive and well established arrangements in place to monitor, assure and improve the quality of all commissioned services including Clinical Quality Boards, Quality Assurance visits, benchmarking, Primary Care Quality Improvement Tool, outcomes from CQC inspections in both primary and secondary care, review of serious incidents and never events, complaints & compliments, review of FFT, nurse leads for safeguarding adults & children who represent the CCG on the local safeguarding boards.	Reporting of all relevant information to the Quality & Patient Safety Committee, with assurance to Governing Body through Quality Highlights reports and sharing of minutes.	Ongoing

Patient & Public Involvement: strategy in place, well established Patient Council and OPEN network, close working with healthwatch, co-ordination of activity with partners, appropriate engagement & involvement re service changes, membership of consultation institute, active patient reference groups locally.	Oversight by Equality & Engagement Committee. Assurance to Governing Body via minutes and monthly PPI Summary reports. In 2017/18 Internal Audit Reviews and NHSE assurance process also provided assurance re robustness of our arrangements.	Ongoing
Equality: EDS2 used to ensure compliance with PSED requirements; Equality Action Plan monitored vie E&D Group and E&E Committee; E&D Lead; E&D training provided to all staff; EQIA policy in place and EQIAs attached to GB papers where appropriate; Staff survey results considered & acted upon; HR policies approved & embedded.	Progress monitored by Equality, Diversity & Inclusitivity Group and reported quarterly to Equality & Engagement Committee. Assurance to GB via E&E Committee Minutes and annual assurance report. Summary of key actions on CCG website each year.	Ongoing
Conflicts of Interest: standards of business conduct policy in place & compliant with statutory guidance; registers of interests maintained & published; declared conflicts managed in meetings and / or during procurements; online training provided to key staff; oversight by Audit Committee; Conflicts of Interest Guardian in place; PCCC has delegated authority where GB cannot make decisions.	Oversight by Audit Committee. Regular reports to GB. Declarations at every Committee and GB meeting. Annual IA review of arrangements. NHSE Quarterly self certification process.	Ongoing
Information Governance: strategy & policies in place, SIRO / Caldicott Guardian identified, training provided for all staff, information asset register in place, committee report & business case template prompts consideration of IG issues. GDPR action plan in place.	DSP Toolkit (formerly IG Toolkit) compliance achieved every year. Reporting via IG Group==>QPSC==>GB.	Ongoing
Risk Management: Risk management framework (GBAF and RR) provides assurance that risks have been identified and are being managed	GBAF and Risk register updated monthly and considered at all Committees and meetings of the GB	Ongoing
Health & Safety and Business Continuity Group established to oversee compliance with statutory Fire & Health & Safety requirements	Annual Report & update reports taken to Audit Committee.	Ongoing
MAST: Statutory & Mandatory training programme in place for all staff, inc GB members, as well as IPR reviews, development sessions for Governing Body inc conflicts of interest, risk management & assurance etc	L&D team provides dashboard which is considered by management team on a regular basis.	Ongoing

Gaps in assurance	**Positive assurances received**
Gaps in control	**Actions being taken to address gaps in control / assurance**
RR 14/15 Discharge medication risks related to poor or incomplete D1 discharge letters	Audit of discharge letters currently underway. Outcomes will be considered by Quality & Patient Safety Committee.

RISK REGISTER – June 2019

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)	5	Monthly
Likely	4	Major	4	Amber	High Risk	(8- 12)	19	3 mthly
Possible	3	Moderate	3	Yellow	Moderate Risk	(4 -6)	4	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 18/04	1,2, 3, 5,6, 8	If the health and care system in Barnsley is not able to commission and deliver out of hospital urgent care services which have sufficient capacity and are effective in supporting patients in the community to avoid the need for hospital attendance or non-elective admission there is a risk that non- elective activity will exceed planned levels potentially leading to (a) failure to achieve NHS Constitution targets	5	4	20	Regular review of activity data as part of contract and performance management and monitoring arrangements. Other data reviewed and analysed to identify new opportunities to reduce non elective activity e.g. NHS Rightcare Packs, Dr Foster data etc. A&E Delivery Board is established (Barnsley Urgent and Emergency Care Delivery Board) with responsibility for delivering improvements to urgent care services and achieving related targets. CCG funding identified to	Director of Strategic Planning & Performance (Finance & Performance Committee)	Contract and Performance Monitoring	4	4	**16**	06/19	**June 2019** Ongoing development of plans to reduce attendance and admissions related to falls and fractures and from Care Homes. **May 2019** Growth has been included in provider contracts for 2019/20 with plans also in place to ensure patients are supported outside of hospital where	07/19

			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**
		(with associated reputational damage, and (b) contractual over performance resulting in financial pressure for the CCG.				support winter planning and resilience with a specific focus on avoiding A&E attendance and reducing emergency admissions. CCG commissioned Out of Hospital Services in place e.g. Intermediate Care & Rightcare Barnsley, Neighbourhood Nursing, BREATHE, IHEART Non-Elective commissioning group established to identify priorities to address opportunities in Non – Elective Activity and contribute to QIPP plans.							appropriate to mitigate further potential growth **April 2019** Year-end out turn is expected to remain above plan. Growth has been included in the 2019/20 contracts and operational plan and work continues to finalise the work programme for 2019/20 to manage NEL activity growth	
18/02	1,2, 5,6	If the CCG and BMBC do not develop a collaborative commissioning approach underpinned by shared values there is a risk that BMBC commissioned services will not	4	4	16	Escalation of CCG concerns to BMBC senior management Escalation via SSDG and health & wellbeing board To be raised and discussed at H&W Board development Session (August 2018)	LS (SSDG	Added to the Corporate Risk register in context of long standing and frequently articulated concerns with respect to a basket of	4	4	**16**	06/19	**June 2019** The CCG and BMBC are working on proposals to set up a Joint Commissioning Board. **February 2019** BMBC and the	07/19

			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**
		meet the requirements and aspirations of the CCG for the people of Barnsley leading to increased health inequalities and poorer health outcomes.						BMBC commissioned services notably: 0-19 Health Checks Weight management & smoking cessation					CCG have agreed to develop a proposal for a JCB and take that through their respective governance mechanisms for consideration. **December 2018** Explore potential of a Joint Commissioning Board with BMBC.	
CCG 14/10	2, 5, 6	If the Barnsley area is not able to attract & retain a suitable & sufficient Primary Care clinical workforce there is a risk that: (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	**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 and Primary Care workforce Strategy is in development. Links have been developed with the Medical School to enhance attractiveness of Barnsley to students The CCG continues to invest in primary care capacity.	Senior Primary Care Commissioning Manager. (Primary Care Commissioning Committee)	Governing Body	**4**	**4**	**16**	06/19	**June 2019** Network Contract DES has a number of options for additional staff to support general practice within the emergent PCN/Local Clinical Networks. **May 2019** 2019-20 PDA agreed and is now with GP practices. Recruitment of	07/19

			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**
		quality healthcare services (d) Patients services could be further away from their home.				The PDA enables practices to invest in the sustainability of their workforce. The successful PMCF (now known as GP Access Fund) has enabled additional capacity to be made available outside normal hours via the iHeart Barnsley Hubs. BHF is also actively developing physicians associates roles. The CCG has funded 15 Clinical Pharmacists to provide support to all Practices in Barnsley. Approval was given to the recruitment of a second cohort of 7 clinical pharmacists & 2 technicians in March 2019. The CCG has also funded 14 Apprentices to provide additional capacity in Primary Care. The PDA requires Practices to submit a workforce baseline assessment to the CCG on a quarterly basis. This will be monitored via the Primary Care Quality Improvement Tool to identify any capacity issues or pressure points.							Clinical Pharmacists completed. No change to risk **April 2019 –** Recruitment is in progress for the clinical pharmacists. PDA review of attainment for 2018-19 is underway. No change to risk score. **March 2019** – GB approved recruitment of a second cohort of clinical pharmacists at its meeting on 14.3.19. No change to risk score. **February 2019 –** No changes to report **December 2018**	

			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**
						GP Forward View includes a section on workforce, with additional funding being made available to support Primary Care sustainability.							No updates to report	
14/15	1, 5, 6	There are two main risks: 1. Scant or absent information relating to why medication changes have been 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	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) 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.	Head of Medicines Optimisation (Quality & Patient Safety Committee)	Risk Assessment & audit of discharge letters	3	5	**15**	06/19	**June 2019** Final BHNFT audit report and action plan are still awaited with July 19 production date given (APC June 19). Primary Care Nov/Dec 2017 D1 re-audit report was considered by APC June 19 meeting and will be taken to Q&PSC. **April 2019** Final audit report and action plan have not yet been received. Provisional audit results were presented at a D1	07/19

			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**
		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. 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											Summit meeting held on 31st January 19. The MMT are following up with BHNFT in respect of a timeframe for production of the report **February 2019** Provisional D1 audit results discussed at Jan 19 meeting which showed some improvement on previous audits. These results were presented at a D1 summit on 31st Jan 19. BHNFT have advised APC that full audit results have been collated and finalising the final audit report.	

			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**
		reconciliation is not sufficiently robust.												
CCG 15/07	1,5, 6	If improvement in Yorkshire Ambulance Service (YAS) performance against the ARP response time targets is not secured and sustained, there is a risk that the quality and safety of care for some patients could be adversely affected.	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.	Chief Nurse (Acting) (Quality & Patient Safety Committee)	Risk Assessment	3	5	**15**	06/19	**June 2019** There is a lack of assurance of progress as the meeting where performance is discussed and challenged has not happened since November 2018. Meetings due to resume July 2019. Performance information received by the CCG does not cover all intelligence that is triangulated at the above meetings. There has been 1 serious incident reported May 2019 – death of patient with delay in treatment significant factor **April 2019**	07/19

			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**
													Not able to provide assurance around the timeframe for improvement for ambulance response times. However, progress continues to be monitored via Urgent & Emergency Care Transformation Delivery Board and at the Y&H 999/111 Contract Management Board meeting. **February 2019** Continue to work with other CCG's (Sheffield lead commissioner) to improve flow of quality monitoring data and ensure quality indicator data measured accurately and consistently. Concerns remain	

			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**
													in relation to ambulance response with appropriate resources in a time frame that is appropriate to the patient's needs.	

Added June 2019

CCG 19/03		If there is not an adequate and rapid response from White Rose Medical Practice to the areas identified by CQC in their recent inspections there is a risk that the Practice does not meet contractual and service requirements potentially leading to: Practice remaining in 'special measures'; Poor quality or unsafe services for the people of Barnsley; Reputational /brand damage.	2	5	10	There is an action plan in place as required by the CQC and CCG to achieve compliance no later than 6 months from date of publication of reports Progress against the action plan is to be monitored by the CCG's Primary care team. QPSC and PCCC are both fully sighted on the issues and the action plan. Regular update reports will be provided CQC will re inspect within 6 months of publication of report	JH (Exec Lead) SK (Clinical Lead) (Quality & Patient Safety Committee)	CQC inspection	2	5	10			

Added July 2019

			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 19/04		If the transition to new delivery arrangements for IT, IG and BI services is not managed effectively and/or unsuitable arrangements are not in place by March 2020 there are a range of risks including: • Core functions of the CCG (Contract and Performance Management) will be adversely impacted. • The CCG would be at risk of non-compliance with IG regulations and the Law.	4	4	16	• Ongoing EMBED service and contract management meetings. • The CCG is working with other partners across South Yorkshire and Bassetlaw to develop a revised specification model. • South Yorkshire and Bassetlaw Working Group has been established to consider options and plan transitions. • Working with EMBED to clarify assets, employees, 3rd contracts and activity data. • Ongoing liaison with NHS England	Director of Strategic Planning & Performance Finance and Performance Committee	Expiry of EMBED existing contract	3	4	**12**	06/19		09/19

		• Non delivery of the GP IT Operating Model, the Local Digital, Roadmap, and other digital and technology elements of the LTP.				Regional Team								

NHS
Barnsley
Clinical Commissioning Group

GOVERNING BODY

11th July 2019

LD Forensic Outreach Liaison Service (LD FOLS)

PART 1A – SUMMARY REPORT

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

	Name	Designation
Executive / Clinical Lead	Lesley Smith	Chief Officer
Author	Patrick Otway	Head of Commissioning (Mental Health, Children's, Maternity and Specialised Commissioning)

3. SUMMARY OF PREVIOUS GOVERNANCE

The matters raised in this paper have been subject to prior consideration in the following forums:

Group / Committee	Date	Outcome
Management Team	14.5.19	Urgent decision by Chief Officer and Chair, to commission the LD FOLS service and to commit to fund the service

4. EXECUTIVE SUMMARY

In summer 2018, as part of the TCP programme, it was agreed at a West Yorkshire STP/ICS level that a Learning Disability Forensic Outreach Liaison Service (LD FOLS) should be developed and that Leeds CCG will lead on the commissioning of an LD FOLS for West Yorkshire and Barnsley (due to Barnsley being part of the CKWB TCP footprint and LD service provision being by SWYPFT). SWYPFT are the lead provider for this service and as such have had consistent representation at the FOLS workstream.

Discussions in relation to the LD FOLS service have taken place at the CKWB TCP Board, at which Barnsley CCG are represented by colleagues at BMBC. These discussions were not relayed to the CCG nor any CCG member made aware as it was mistakenly thought by the Barnsley Local Authority representation on the Board that CCG personnel directly received the CKWB Board papers / documents.

	The LD FOLS workstream group developed a Service Specification (attached) which was initially based on the £471,000 pump-priming funding received from NHS England, although this service originally had a cost envelope of £1.8m. However, this proved difficult to do as it significantly limited the service due to the financial envelope being reduced from the £1.8m to the £471,000 to be funded by NHS E. In February 2019 the decision was taken at the WY TCP ESG (West Yorkshire Transforming Care Programme Executive Steering Group) that the Leeds Director of Commissioning would contact the relevant CCG's to commit funding from the CCG based on the £1.8m financial envelope. All CCG's except Barnsley communicated their commitment to fund their share of the £1.8m – based on this Barnsley's commitment would be £166,784 p.a. There is an expectation from NHS England that CCG's, via their STP / ICS, will commission an LD FOLS service, therefore not being included may affect the TCP RAG rating, but more importantly, it would mean that Barnsley patients would not be able to use the LD FOLS service. A consequence of this could be that the CCG would fail to achieve its TCP trajectories for 2019/20, a trajectory that is already falling under the scrutiny of the NHS England regional team. Leeds CCG (lead commissioners for the LD FOLS service) have been pressing Barnsley CCG since the February 2019 meeting to either commit to the funding of their share of the FOLS service or to confirm they did not want to commission the service. A response was delayed to enable Barnsley CCG to gather the required knowledge about the service to enable an informed decision to be taken. Due to the imminent start of the service and the contracts being drafted, a response from Barnsley CCG became urgent. In accordance with the CCG's Constitution and Standing Orders an urgent decision was therefore taken on 14 May 2019 on behalf of Barnsley CCG's Chief Officer and Chair, to commission the LD FOLS service and to commit to fund the service Governing Body by the CCG's at the cost of £166,784 per annum. Standing Orders require that this urgent decision be brought back to the next meeting of the Governing Body for ratification.
5.	**THE GOVERNING BODY IS ASKED TO:**
	• Ratify the urgent decision taken by the Chair and Chief Officer to commission the LD FOLS service and to commit to the recurrent funding of £166,784 p.a.
6.	**APPENDICES / LINKS TO FURTHER INFORMATION**
	• Appendix 1 – LD FOLS Service Specification

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:	4.1
2.	**Links to CCG's Priority Areas**	**Y/N**
	1 - Urgent & Emergency Care	
	2 - Primary Care	
	3 - Cancer	
	4 - Mental Health	Y
	5 - Integrated Care System (ICS)	
	6 - Efficiency Plan	
	7 - Transforming Care for People with Learning Disabilities and / or Autistic Spectrum Conditions	
	8 - Maternity	Y
	9 - Compliance with Statutory and Regulatory Requirements	
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?	
3.2	**Consultation and Engagement**	
	Has Comms & Engagement Checklist been completed?	*NA*
	Is actual or proposed engagement activity set out in the report?	
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*

SCHEDULE 2 – THE SERVICES

A. Service Specifications

This is a non-mandatory model template for local population. Commissioners may retain the structure below, or may determine their own in accordance with the NHS Standard Contract Technical Guidance.

Service Specification No.	TBA
Service	Community Forensic Learning Disability Service (FOLS)
Commissioner Lead	Kashif Ahmed – Head of Commissioning (Mental Health & Learning Disabilities) NHS Leeds CCG
Provider Lead	Sue Threadgold – Deputy Director South West Yorkshire Partnership NHS Foundation Trust
Period	3 year contract
Date of Review	6 months - June 2019

1.0 Population Needs

1.1 National/local context and evidence base

1.1.1 In May 2011 a BBC Panorama programme highlighted both physical and mental abuse taking place at Winterbourne View Hospital that was privately run by Castlebeck Ltd in South Gloucestershire. The Department of Health carried out a full review into what happened at Winterbourne View Hospital along with a wider review of over 150 hospitals and care homes that provided services for people with learning disabilities. The review indicated that failings were widespread within the operating organisation (Castlebeck) but importantly also evident across the wider care system.

1.1.2 The Department of Health published Transforming Care, a National Response to Winterbourne View Hospital and the Concordat: Programme of Action in December 2012. The Concordat and 63 actions detailed within the review seek to address poor and inappropriate care for people with a learning disability and/or autism, who may also have mental health needs or behaviour that challenges.

1.1.3 In October 2015 NHS England, ADASS and the Local Government Association (LGA) published a Transforming Care national implementation plan and associated service model – Building the Right Support. This national plan set out measures to develop community services and close inpatient facilities for people with a learning disability and/or autism who display behaviour that challenges, including those with a mental health condition.

1.2 Local Care Partnerships:

1.2.1 Part of Building the Right Support included the development of 48 transforming care partnerships (TCPs) across England. TCPs are made up of clinical commissioning groups, NHS England's Specialised Commissioners and Local Authorities.

1.2.2 Transforming care will mean that fewer people will need to go into hospital for their care. This means that we can close hundreds of hospital beds across England. To do this we are making sure that services in the community are much better.

1.2.3 For people who do need to go into hospital though we want to make sure that they are as close to where they live as possible. This means that in some areas of the country new hospital services need to be developed at the same time as community support.

1.3 Forensic community support – national context

1.3.1 The community forensic functions described below are focussed on the provision of community-based support to people with a learning disability and/or autism who display behaviour that can lead to contact with the criminal justice system (such as fire-setting, physically aggressive/violent or sexually inappropriate behaviour).

1.3.2 The Reed and Bradley reports (1992, 2009) outlined clear principles of support for people with a learning disability who offend, including through the provision of support and treatment in the community rather than in hospital settings, early identification of people in the criminal justice system and appropriate community-based treatment and support packages for those at risk, as well as other community disposal options (such as community orders) as an alternative to secure settings or prison.

1.3.3 The Transforming Care programme, and the relevant underpinning policy (Building the right support and the national service model for people with a learning disability and/or autism who display behaviour that challenges) builds on this previous policy and approach with the aim of developing community capacity that meet the needs of people with a learning disability and/or autism who display behaviour that challenges, including behaviour that can lead to contact with the criminal justice system. The aim is for a reduction (from October 2015) in the number of people in secure inpatient settings by 2019 of between 25% and 40%.

1.3.4 The service model describes how people with a learning disability and/or autism who come into contact with the criminal justice system, or those at risk of such contact, often 'fall through the gaps' of existing provision; often excluded from mainstream mental health or forensic services because of their learning disability and/or autism, and excluded from learning disability services because they are considered too able or too high risk, or because they have autism but do not have a learning disability.

1.3.5 The functions of the community-based provision required described in this model service specification provide preventative, reactive and evidence based interventions through a combination of specialist risk assessment and management, face to face therapeutic interventions and support, as well as support, training and consultancy to other services to meet the needs of this group. A core element of this provision is about the facilitation of smooth and effective discharge from secure inpatient settings and release from custody.

1.3.6 This function of community support is reliant on interdependencies across the local geography to ensure that needs of the population as a whole are met, either by providing the intervention directly or by supporting colleagues to provide interventions as needed. These interdependencies include links with mainstream services, which can support the various needs that the person has – for example, mainstream mental and physical health services, drug and alcohol provision and care and support to address childhood trauma.

1.3.7 Whilst supporting people in the community through effective risk management, there is a need to balance supporting people to take risks within a supportive, evidence based risk management structure whilst ensuring that they are protected from potential harm and that the community is kept safe. Services delivering the functions of support described here will also need to take into account the legislation around supporting the rights of the victims of crime.

This model service specification has been structured

1.4 Prevalence – Learning Disability & Autism Population

1.4.1 There are an estimated 1.2 million people in England, of which 286,000 are children and young people under the age of 18, with a learning disability (Emerson et al. 2012). This means that roughly 20 people in every thousand have a learning disability (2-3% of the general population). The majority live their lives without support from specialist learning disability services – for instance, of the roughly 1 million adults with a learning disability, it is estimated that 189,000 (21%) (Emerson et al. 2012) are known to learning disability services.

1.4.2 There are an estimated 700,000 people with autism in England (Brugha et al. 2012) of which 125,000 are children and young people under the age of 18 (Baird et al. 2006). This means that roughly 11 people in every thousand have autism (1.1% of the general population). It is estimated that 44%-52% of people with autism also have a learning disability (Emerson et al. 2010).

1.5 Those who display behaviour that challenges

1.5.1 Challenging behaviours are generally understood to be exhibited by 10-15% of adults with learning disabilities known to services (approx. 22-34,000 people), whilst often peaking between the ages of 20-49 (Emerson et al. 2001). A further 40,000 of children under the age of 18 are believed to display challenging behaviour (Emerson et al 2014).

1.5.2 As set out in Challenging Behaviour: A Unified Approach (Royal College of Psychiatrists, et al, 2007, p.14) challenging behaviour is behaviour "of such an

intensity, frequency or duration as to threaten the quality of life and/or the physical safety of the individual or others and is likely to lead to responses that are restrictive, aversive or result in exclusion".

1.6 Those in contact with the criminal justice system

1.6.1 There are an estimated 1.2 million people in England, of which 286,000 are children and young people under the age of 18, with a learning disability (Emerson et al. 2012). This means that roughly 20 people in every thousand have a learning disability (2-3% of the general population). Of the adult population, it is estimated that 189,000 (21%) (Emerson et al. 2012) are known to learning disability services. Studies to screen for learning disability in police custody suites, probation services and prisons all suggest prevalence of 5-10% (higher in youth justice). Based on the current prison population, this could mean there are about 6,000 people with a learning disability in prison (Landman, 2016).

1.6.2 There are an estimated 700,000 people with autism in England (Brugha et al. 2012) of which 125,000 are children and young people under the age of 18 (Baird et al. 2006). This means that roughly 11 people in every thousand have autism (1.1% of the general population). It is estimated that 44%-52% of people with autism also have a learning disability.

1.6.3 It is difficult to accurately estimate how many people with a learning disability and/or autism are involved in the various elements of the criminal justice system. This is due to a number of factors, including those people with a learning disability and/or autism who are not identified or recognised within the criminal justice system and an inconsistency in data collections and terminology (e.g. 'learning disability' and 'learning difficulty').

1.6.4 In addition, prevalence and incidence studies often focus on those known to services and do not always take account of those people who may be known to police but not prosecuted or where incidents have not been reported. Many of those people who are admitted to secure inpatient settings may not have previously been known to adult services prior to their contact with the criminal justice system, and may not have received a formal diagnosis of learning disability and/or autism until admission to hospital.

1.6.5 National data should therefore be applied with caution and attempts to establish a more robust understanding of local populations should be undertaken in partnership with relevant criminal justice agencies. However, to give some context, it has been estimated that between 5 and 10% of those people known to learning disability services have had contact with parts of the criminal justice system (Murphy, 2015). Nationally, if those known to learning disability services number 189,000, those in contact with the criminal justice system will number approximately 8,500 to 19,000 people, equating to approximately 200-400 per million population.

1.6.6 This will represent a wide range of people, behaviour and levels of contact with the criminal justice system, and the majority will not require specialist and/or forensic support and would not be described as high risk or at risk of serious offending behaviours. Many will be able to access non-specialist community services, albeit with support; others may be more appropriately

supported by community learning disability teams or enhanced/intensive support services. This will be dependent on a number of factors including the capacity and skill-set of other teams, but also on individual need and circumstance - e.g. the ability and capacity of the person to benefit from offender/treatment programmes.

1.7 Within the secure inpatient population

1.7.1 The Assuring Transformation data (as at 30/09/2016) tells us that, nationally, there are around 1,300 people with a learning disability and/or autism currently in secure forensic inpatient settings. 975 inpatients are in services under Part Three of the Mental Health 26 Act ("patients concerned in criminal proceedings or under sentence"). Of these 975, 605 are restricted patients, with Ministry of Justice involvement. This can mean, as part of conditional discharge arrangements, there are additional restrictions required to be in place in the community.

1.7.2 Some people under a civil section may be detained in secure settings where they pose an equivalent level of risk to others. For example, those who have been diverted away from the criminal justice system as a result of criminal justice agencies not taking the case through the courts, or discontinuing proceedings once it is seen that the person is already in hospital.

1.7.3 Current policy (see Building the right support) anticipates a reduction of 25-40% in secure hospital settings by March 2019, with local areas using no more than 20-25 beds per million population. This equates to 215 -440 fewer people in secure settings, and there is a need for increased forensic capacity within the community to support this ambition – both supporting transitions out of secure inpatient settings, as well as in preventing future admissions.

1.8 Prevalence per 1 million population

1.8.1 Taking all of the above into consideration, all things being equal and what we know of existing 'distinct' community forensic teams for people with a learning disability, we would expect that for every 1 million general population, a community forensic support function would likely need to be able to support:

• An active caseload of between 40-60 people (plus a monitoring caseload and support to wider services), plus

• Those people being discharged from secure care. (Capacity requirements will vary dependent on number of people currently in inpatient care and in line with the current policy ambitions to reduce overall inpatient numbers).

1.8.2 Not all of these individuals will require support from FOLS. The caseload for each area will vary, dependent on local factors such as: -

- levels of support that local teams (such as community learning disability or autism teams) can offer before support from a FOLS is needed
- how many people are out of area and in need of support to return to the

area
- complexity of individuals on caseload, as well as average episode of care and support period.

1.9 West Yorkshire & Barnsley Sustainability Transformation Programme/Integrated Care System (STP/ICS)

There are 3 Transforming Care Partnerships:

- Leeds TCP: NHS Leeds CCG and Leeds City Council
- Calderdale Kirklees Wakefield Barnsley (CKWB) TCP: Calderdale CCG, Kirklees CCG, Wakefield CCG, Barnsley CCG and Local Authorities
- Bradford TCP: NHS Bradford/Airedale & Bradford City CCGs and Bradford Council

2.0 Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

Domain 1	**Preventing people from dying prematurely**	
Domain 2	**Enhancing quality of life for people with long-term conditions**	✓
Domain 3	**Helping people to recover from episodes of ill-health or following injury**	
Domain 4	**Ensuring people have a positive experience of care**	✓
Domain 5	**Treating and caring for people in safe environment and protecting them from avoidable harm**	✓

2.2 Local defined outcomes

Though delivery of the service model we will aim to:-

- support discharges by providing transitional and ongoing support where appropriate to the forensic cohorts on the TCP list.
- improve resilience and capability of providers and mainstream services
- prevent placement breakdown and hospital admission
- improve efficiency of current capacity in West Yorkshire (reducing length of stay and thereby contribute towards the overall reduction of secure and locked rehab provision.
- further develop clinical pathways within the existing provision to meet the needs of those with LD

- develop community provision to allow individuals with LD/autism to move from low and medium secure estate into the community, and to move from community care to independent living. This will support the development of consistent community provision in line with national guidance.
- further develop recovery and outcomes focused services through greater partnership working with service users and carers.

2.3 Monitoring Requirements Quarterly:

- number of referrals
- destination of referrals
- response time (Key Performance Indicators) – referral to first contact (24hrs)
- type of intervention (Advice, joint working, clinical interventions, training, other)
- average length of support/involvement
- active case load
- number of hospital admissions prevented (include case studies)
- service user feedback
- community provider feedback.

3.0 Scope

3.1 This service specification relates to Forensic Outreach Liaison Service (FOLS) for West Yorkshire STP/Integrated Care Services (ICS) footprint, excluding Harrogate but includes Barnsley.

3.2 The aim of this Community-based Forensic Support function is to reduce or safely manage behaviour amongst people with a learning disability and/or autism which may put members of the public at risk, and would thereby otherwise lead to contact with the criminal justice system or admission to a secure hospital. Throughout delivery of all elements of the functions of support detailed below there should be a focus on prevention and early intervention through collaboration with other services.

This should be achieved through six core functions of support:

- forensic risk assessment and management of risk in the community to ensure public safety and safety of the individual
- delivery of offence-specific therapeutic interventions (e.g. to prevent sexual/violent offences)
- case management of the most complex cases
- support and training to other agencies providing day to day support to this group
- consultancy and advice to system partners
- in-reach support to ensure safe and timely discharge.

3.3 Each of these functions are described in more detail in appendix one, and include some suggested outputs and outcomes.

3.4 Each local area should have a dynamic register (as described in the national service model) which at a population level will inform the commissioning of support services and at an individual level will identify those who display behaviours that can be described as challenging (for example, who present an active and high risk to others/members of the public or themselves) and where this behaviour has led to contact with the criminal justice system, or where there is risk of this (i.e. relating to behaviours which could be construed as an offence or are viewed as pre-cursors to more serious offending behaviours). The aim is to improve service design and enable early identification and intervention.

3.5 The provider will work closely with the commissioner at an operational and at a strategic level to develop and maintain this dynamic register. Actions will be in accordance relevant Information Governance policies. This may include the sharing of salient information from active caseload to identify at earliest stage those individuals who are at risk of admission to inpatient services, leading to agreed action to be taken to avoid unnecessary admission or to ensure in-reach and earliest return to community. On the basis of the dynamic register, the provider will accept referrals from the commissioner as required.

3.2 Aims and objectives of service

A specialist forensic learning disability and/or autism service, focused on a sub-set of the population (i.e. those with forensic needs which cannot be met by existing local mental health, forensic or learning disability/autism services; including those who may pose the most significant risk to others or who demonstrate the most serious offending behaviours). This should function as a tertiary level service, operating over a large geography and working closely with more local mental health and learning disability/autism services.

3.2.1 The main aim of the FOLS service is to support men and women aged 18 years and above who have a learning disability or autism or both that have come into contact with the criminal justice system or admission to a secure hospital setting.

3.2.2 The Forensic Outreach Liaison Service (FOLs) will work with the Local Community Learning Disability Teams (including the Intensive Support Teams) and Mental Health Teams to support individuals who display offending behaviour more effectively within the community, safely managing risk and avoiding contact with the criminal justice system or admission to secure hospital where possible.

3.2.3 The FOLs Team will support a more effective approach to case management of these individuals with Learning Disability or autism or both already within secure services, by safely supporting the service user's discharge into the community and reducing pressure on secure beds.

3.2.4 The service will aim to both prevent admission to secure services for those with Learning Disability or autism or both, as well as support admission where this is the most appropriate option for people. In supporting those people who are admitted to a secure hospital, the focus will be on supporting the process of discharge from point of admission, reducing length of stay and ensuring full consideration of alternative options (e.g. treatment programmes) that could instead be offered in a community setting rather than in hospital.

3.2.5 Proactive prevention work both at point of admission to secure service will and earlier in the pathway through proactive and partnership working with community based services is a key part of the service model.

3.2.6 The service will support a reduction in secure Learning Disability Beds through provision of a service which supports those with Learning Disability and/or autism or both.

3.2.7 Currently in secure services to manage pathways through the service and to ensure support is offered in the .least restrictive environment, moving to community care where at all possible.

3.2.8 In the community following discharge from a period in secure services to prevent readmission to secure care and ensure individuals are effectively supported in the community.

3.2.9 In the community having been referred due to offences or offending behaviour that represents a risk to the general public and who potentially may require admission to secure care.

3.2.10 It is expected that the service will provide Consultation, advice, risk assessment and some training and will operate on a Monday/Friday 9am – 5pm model. As the funding increases there will be an incremental increase in service delivery.

3.2.11 The initial service delivery (until 31st March 2019) will focus on supporting service users discharge from Medium or Low Secure Hospital either into an alternate hospital setting which is less restrictive or into community provision.

3.2.12 The FOLS Team will prioritise service users who have an identified discharge date on the Transforming Care Tracker before March 2019. Further details on service delivery will follow as implementation progresses but the service will be working towards provision of the whole model as detailed in this document.

4.0 Service description/care pathway

Core service functions will include:-

- forensic/ specialist risk assessment and formulation, risk management and liaison
- early intervention and advice supporting the Local Community Learning

Disability Team including Intensive Support Teams and mental health teams

- care pathway management for those with a Learning Disability and or autism or both currently in secure services to manage pathways through the service and to ensure support is offered in the least restrictive environment, moving to community care where at all possible. This will involve some secondary case management and care-coordination under CPA by the service, but the FOLS service will focus on supporting primary and secondary services to support directly rather than duplication of provision
- robust and specialist long term case management, through provision of support to those both in discharged from secure services
- undertake referrals to other agencies
- in-reach to secure inpatient settings across the STP supporting transition into appropriate alternate provision whether step down, rehab, or transition into the community
- will provide appropriate liaison with offender health pathways where appropriate
- support appropriate admissions to secure hospital and continue to be actively involved with the patient journey with a focus on rehabilitation and recovery and a return to the community attending CPA and Care and Treatment Reviews
- due to the current financial envelope the FOLS Team are unable to provide a crisis response. The team will focus on the priority patients – (see Aims and Objectives). Post March 2019, the teams' role in crisis response will be reviewed and based upon the existing services already in situ in local areas
- the FOLS team will work with people, their carers and services to increase their understanding of factors associated with offending risk, challenging behaviour and need for support. All people will be supported to collaboratively developing a care plan which will include a contingency plan if in crisis. When at full staffing the FOLS will deliver a service 7 days a week 8am to 8pm. Out of the core working hours of 9am-5pm, the FOLS will provide a responsive, intensive and accessible service to people withi the FOLS caseload which will include access to an on call practitioner for consultancy, advise and if appropriate, signpost to services including the local rea crisis teams, Emergency Duty Teams and police.
- delivery of effective offence specific interventions, psychosocial interventions, substance misuse interventions. Interventions will address

for example physical violence, sexual violence, fire-setting – both group and individual, and include treatments that address underlying emotional regulation problems; including facilitating social group/peer support networks to address issues of social isolation

- vocational and employment support, through close working with a network of housing and wider third sector partners.
- provide advice and support to service users, carers and other agencies.
- consultation and liaison for Multi Agency Public Protection Arrangements (MAPPA panels) and other services
- training and support to secure services and community services across the Sustainability Transformation Programme (STP)/Integrated Care System (ICS).

5.0 Pathway

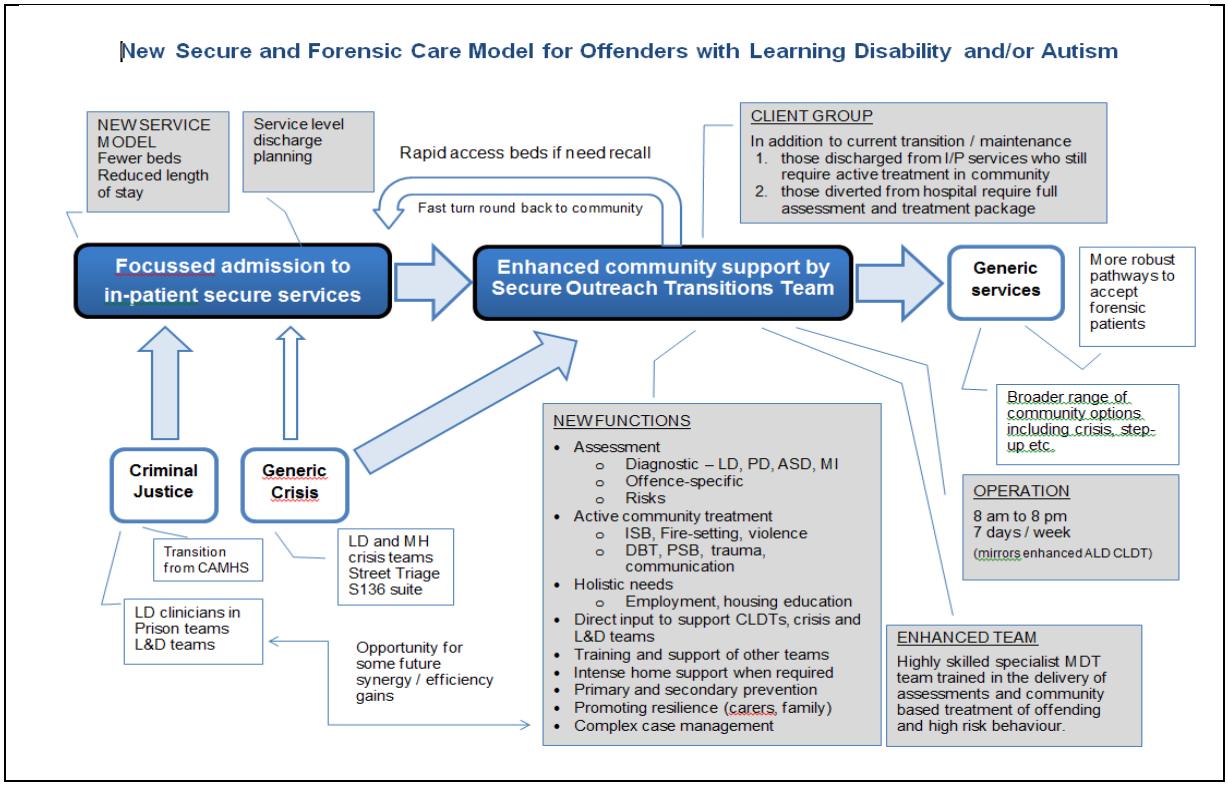
5.1 Facilities within West Yorkshire currently include both Medium and Low secure in-patient Learning Disability services. The development of a Community Forensic Learning Disability service will allow Lead Provider to provide a seamless range of services ensuring that all patients receive the right level of intervention and support in the right setting to manage their mental health problems and risks arising from these effectively.

The Pathway would include:

- secure care to community team for variable period dependent on risks, aim for 6- 12 months but longer if required before full transition to Community Learning Disability Service
- prison to community dependent on timely notification pre-release and scope to work up a discharge package
- joint management of existing community cases exhibiting significant risk concerns referred up if required. Alternative would be provision of risk management advice
- in an ideal case would be a joint working model with local care-coordinators in place but a degree of active involvement dependent on nature of risks is sought. We would provide additional Multi-Disciplinary Team expertise and medical oversight.

5.2 Proposed staffing model

See detail and costing below


New Secure and Forensic Care Model for Offenders with Learning Disability and/or Autism
NEW SERVICE MODEL
Fewer beds
Reduced length of stay
Service level discharge planning
Rapid access beds if need recall
Fast turn round back to community
CLIENT GROUP
In addition to current transition / maintenance
1. those discharged from I/P services who still require active treatment in community
2. those diverted from hospital require full assessment and treatment package
Focussed admission to in-patient secure services
Enhanced community support by Secure Outreach Transitions Team
Generic services
More robust pathways to accept forensic patients
Broader range of community options including crisis, step-up etc.
Criminal Justice
Generic Crisis
Transition from CAMHS
LD and MH crisis teams Street Triage S136 suite
LD clinicians in Prison teams L&D teams
Opportunity for some future synergy / efficiency gains
NEW FUNCTIONS
Assessment
Diagnostic – LD, PD, ASD, MI
Offence-specific
Risks
Active community treatment
ISB, Fire-setting, violence
DBT, PSB, trauma, communication
Holistic needs
Employment, housing education
Direct input to support CLDTs, crisis and L&D teams
Training and support of other teams
Intense home support when required
Primary and secondary prevention
Promoting resilience (carers, family)
Complex case management
OPERATION
8 am to 8 pm
7 days / week
(mirrors enhanced ALD CLDT)
ENHANCED TEAM
Highly skilled specialist MDT team trained in the delivery of assessments and community based treatment of offending and high risk behaviour.

Community Forensic LD Service			
		Proposal	
		WTE	Total Annual Cost
Consultant (with on call)		1.00	138,023
Specialty Doctor (with on call)		1.00	101,997
Team Manager (Band 7)		1.00	52,410
Advance Nurse Practitioner (Junior Dr type functioning) Band 8A		1.00	64,080
Advance Nurse Practitioner (Offending Behaviour) Band 7		2.00	110,061
Mental Health Practitioners (Nursing/OT/Social Work) Band 6		6.00	280,065
1 x MHP working 8pm to 8am Monday to Friday & 24/7Sat & Sun		3.69	199,340
Band 4		2.00	58,669
Band 3 (Peer workers)		4.00	102,107
Psychologist Band 8A		1.00	61,023
Psychology Assistant (Delivering Intervention) Band 4		1.00	27,937
SaLT Band 7		1.00	52,410
Admin Band 4		1.00	27,937
Admin Band 3		1.00	24,311
Non-Pay			
Drugs	10000		
Laptops	22,000		
Remote Access	1,320		
Mobiles	4,400		
Travel	69,888		
Medical training	2,000		
Other Non pay	5,000		
			114,608
Total Annual cost		**26.69**	**1,414,983**
Indirect + overhead			379,274
Total Annual cost			**1,794,257**

5.2 Workforce competencies

5.2.1 The functions of community forensic support should be delivered by both health and social care professionals, providing a collaborative multi-disciplinary approach to support that is focused on supporting people through a combination of the right specialisms and expertise, within the broader

context of the individual's whole life, including, their family and the community in which they live and work. Regardless of configuration, services should be able to demonstrate that practitioners have the necessary pre-requisite competencies, consistent with any recommendations by Health Education England.

5.2.2 The provider should also employ people with a learning disability and/or autism and their families as experts by experiences for specific roles such as peer support lead, as quality checkers, as trainers and in the recruitment of staff.

Staff members will have:

- knowledge, skills and experience of effective working with people with learning disabilities and/or autism
- knowledge, skills and capability to work with the forensic population of people with a learning disability and/or autism
- knowledge and skills to conduct assessment of risk (including risk to others and to self) and in the management of risk
- the ability to recognise and manage emerging risks and to provide interventions to reduce risks to self and others
- in-depth knowledge of the relevant legal frameworks relevant to working with people with a learning disability/autism, including the Mental Health Act and Mental Capacity Act
- knowledge and understanding of the criminal justice system and related agencies, including the police, liaison and diversion, court, prison, MAPPA and the probation service
- knowledge of the management of common psychiatric comorbidities associated with this group such as personality disorder, substance misuse and significant mental health issues
- knowledge of the management of past/childhood trauma and ability to provide specific therapeutic interventions to address this.

5.2.3 It is important to note that this sort of support and intervention be recognised as a challenging and occasionally traumatic area of work for staff whose effectiveness will be reliant on good access to support, training and ongoing supervision.

6.0 Population covered

6.1 The FOLS will initially prioritise cohorts on the TCP Programme to ensure local system achieve their trajectories. The following table represents numbers from TCP lists from each area (see Appendix 2).

7.0 Any acceptance and exclusion criteria and thresholds

7.1 Acceptance

Adults aged 18 years and over and who have a diagnosis of a learning disability and/or Autistic Spectrum Disorder or both.

- patient's ready for discharge from Medium or Low Secure Care into a less restrictive hospital or community setting
- subject to Ministry of Justice (MoJ) restrictions and are conditionally discharged
- subject to licence conditions with a mental health disorder
- subject to Community Treatment Orders (CTO)
- not subject to statutory supervision requirements but whose needs indicate a need for the Forensic Outreach Liaison Service
- early identification of risk factors for vulnerability, mental health problems and offending and of supporting protective factors and of those who are identified as coming into contact (or potential contact) with the criminal justice system
- the decision to accept a patient for management and intervention by FOLS is based on a comprehensive risk assessment and consideration of how the potential risk and recovery needs identified can be safely and optimally managed, typically as part of a wider multi-agency approach.

7.2 Exclusion Criteria

- patients under the age of 18 years old
- service users who present a grave and immediate risk or serious risk to the general public and must be managed in prison or a high/medium/low secure setting
- patients who present with disturbed or challenging behaviours during episodes of mental disorder and require admission to hospital under the Mental Health Act for Assessment and Treatment which can be supported by the Community Learning Disability Teams or Intensive Support Teams
- patients who do not have a forensic risk history or have historic offending behaviour but the risks do not remain relevant to the current care and risk management plan. Where a patient is not at risk of coming into contact with the criminal justice system.

8.0 Interdependence with other services/providers

8.1 Partnership approach

8.1.1 In the delivery of the new service South West Yorkshire Partnership Foundation Trust (SWYPFT) as the Lead Provider will seek to work in partnership with Bradford District Care NHS Foundation Trust and Leeds and York Partnership NHS Foundation Trust (L&YPFT) to ensure there is consistent provision across the STP/ICS footprint.

8.2 Interdependence with other services/providers

8.2.1 The operation of specialist community forensic provision is inherently linked to the delivery of support within mainstream mental health/forensic services, children and young people's services, community and inpatient learning disability services, autism services and enhanced/intensive support services. The provider needs to work collaboratively with other forms of mainstream community or inpatient provision providing support to individuals.

8.2.2 Whichever way the functions of support described in this specification are delivered (dependent on local circumstances), there is a need for working across age groups ensuring a smooth transition from children to adult services. Local all-age pathways will need to be agreed between service providers to ensure a comprehensive and seamless provision of support.

8.2.3 Without a coordinated and joined up approach, progress is likely to be undermined, people will be at risk of falling between gaps in service provision and unintended consequences may ensue. Therefore, the creation of locally agreed support pathways and amendments to existing service specifications will be required.

8.3 The provider of community-based forensic support needs to build, develop and maintain effective operational relationships with a range of organisations, including, but not exhaustively:

- Secure inpatient services
- MAPPA
- Community Safety Teams
- Prison healthcare
- Youth Justice services
- Prisons
- Public health
- Liaison and diversion
- Community teams for people with a learning disability and/or autism
- Social services and other Local Authority departments e.g. housing, education
- Adult mental health and forensic health services
- CAMHS/forensic CAMHS services
- Courts
- Providers of day to day support
- Police
- Probation
- Safeguarding leads
- Crown Prosecution service

8.4 Each local area has a dynamic risk register (as described in the national service model) which at a population level will inform the commissioning of support services and at an individual level will identify those who display behaviours that can be described as challenging (for example, who present an active and high risk to others/members of the public or themselves) and where

this behaviour has led to contact with the criminal justice system, or where there is risk of this (i.e. relating to behaviours which could be construed as an offence or are viewed as pre-cursors to more serious offending behaviours). The aim is to improve service design and enable early identification and intervention.

8.4.1 The Forensic Outreach Liaison Team will ensure that they work closely with South West Yorkshire Partnership NHS Foundation Trust [SWYPFT], Leeds and York Partnership NHS Foundation Trust [LYPFT] and Bradford District Care NHS Foundation Trust and with commissioners at an operational and at a strategic level to maintain the dynamic risk register in each area (Calderdale, Kirklees, Wakefield, Calderdale, Leeds and Bradford) by working collaboratively and co-ordinate with areas in regard to ensuring referrals are captured into the existing registers.

8.4.2 This may include the sharing of salient information from active caseload to identify at earliest stage those individuals who are at risk of admission to inpatient services, leading to agreed action to be taken to avoid unnecessary admission or to ensure in-reach and earliest return to community. Actions will be in accordance relevant Information Governance policies.

8.5 West Yorkshire / Integrated Care System – LD Transformation Plan

8.5.1 The development of Assessment Treatment Units (ATUs) on a WY/ICS footprint is progressing and any new models will require close working between ATUs and FOLs service that potentially prevents admissions and reduces length of stay.

9.0 Applicable Service Standards

9.1 Applicable national standards (e.g. NICE)

9.1.1 To access national standards use the links below:

https://www.england.nhs.uk/resources/building-the-right-support/
https://www.england.nhs.uk/learning-disabilities/natplan/

- harmful sexual behaviour among children and young people, NICE guidelines, September 2016
- autism in adults: diagnosis and management, NICE guidelines, June 2012
- NHS England Care and Treatment Review guidance
- guidance for NHS commissioners on Equality and Health Inequalities legal duties
- challenging behaviour and learning disabilities: prevention and interventions for people with learning disabilities whose behaviour challenges, NICE guidelines, May 2015
- supporting people with a learning disability and/or autism who display

behaviour that challenges, including those with a mental health condition: Service model for commissioners of health and social care services, NHS England, ADASS, LGA, October 2015Mental Health problems in people with learning disabilities : prevention, assessment and management, NICE, September 2016

- antisocial personality disorder: prevention and management, NICE, January 2009, updated March 2013Drug
- use disorders in adults – Quality Standards, NICE, November 2012.

9.2 Applicable standards set out in Guidance and/or issued by a competent body (e.g., Royal Colleges)

9.3 Applicable local standards

10.0 Applicable quality requirements and CQUIN goals

Applicable Quality Requirements (See Schedule 4A-C)

Applicable CQUIN goals (See Schedule 4D)

11.0 Location of Provider Premises

The Provider's Premises are located at: Fieldhead Hospital, Ouchthorpe Lane, Wakefield WF1 3SP

12.0 Individual Service User Placement – N/A

Appendix 1 – Core Aims

Core aims of community-based forensic support:	**A reduction in the number of people with a learning disability and/or autism who require inpatient facilities.** **A reduction in the behaviours of people with a learning disability and/or autism that lead to them coming into contact with the criminal justice system.** **Improved support to people through the criminal justice system**			
Functions of support	Descriptions	Outputs	Outcomes	Outcomes for the person
Forensic risk assessment and management of risk in the community	Specialist forensic risk assessment, and/or training in the assessment of risk and expertise in the management of risks in the community. Detailed assessments are developed in partnership with individuals and families and facilitate the formulation of robust multi-disciplinary risk management strategies. These inform the therapeutic process whilst promoting public safety and emphasising a strong recovery based ethos to support. Delivery of adapted community-based offender/health programmes that meet the needs of people with a learning disability and/or autism (e.g. for substance misuse, social skills or sex offender treatment) that support choice and control alongside positive risk management. Direct and urgent support in a crisis which might otherwise lead to admission to an inpatient setting. Operates flexibly across 24/7 to meet needs.	Risk assessments and management strategies that ensure the wellbeing and safety of all. Innovative solutions to positive risk management. Early identification of those at risk of offending. Co-design and development of individualised and person-centred treatment and support plans that mitigate risk. Meaningful, less restrictive alternatives to hospital admission are in place in the community. Reasonably adjusted mainstream programmes for offenders that meet the needs of people with a learning disability and/or autism. Evidence of the application of MCA (including Best interests and DoLS) being followed and documented for people who may lack capacity.	Risk of harm (to self and others) is reduced. Reduced hospital admissions. Prevention and reduction in offending/forensic behaviours. Reduced use of restrictive interventions. Increased confidence and skills of families and other sources of support in supporting the individual. **Potential measure(s):** Reduction in risk scores relating to: • HCR-20 (Historical Clinical Risk Management -violence risk assessment scheme • SVR-20 (Sexual Violence Risk) HoNOS-LD scores – (Health of the Nation Outcome Scale – Learning Disability) Reduction in numbers of people in hospital settings Increased numbers of people with a learning disability and/or autism accessing programmes for offenders in the community Health Equalities Framework (HEF)	"I am getting expert support from people with the right skills and expertise." "I am supported to be safe and a part of my community." "I am recognised and respected as the person I am." "I understand how the care and support I am getting is responsive to my needs." "I understand what I must do and what I must not do to stay out of trouble" "I know what to do if I am in a situation I know is risky."

Core aims of community-based forensic support:	**A reduction in the number of people with a learning disability and/or autism who require inpatient facilities.** **A reduction in the behaviours of people with a learning disability and/or autism that lead to them coming into contact with the criminal justice system.** **Improved support to people through the criminal justice system**			
Functions of support	Descriptions	Outputs	Outcomes	Outcomes for the person
Delivery of offence-specific therapeutic interventions	Delivery of individual and/or group offence-specific interventions, such as work to prevent sexual or violent offences. This could include offering adapted community orders (with adapted treatment programmes or mental health treatment requirement (MHTR) options) to the courts in partnership with the police, probation and other partners and work with Liaison & Diversion service to inform court and pre-sentence reports.	Development and delivery of community-based interventions that is adapted to meet the needs of this group. Support and expertise to criminal justice system partners. Effective, outcome and evidence based interventions delivered within community settings. Management strategies that ensure the wellbeing and safety of all.	Reduction in behaviour leading to contact with the criminal justice system. Increased treatment options in the community. Reduction in numbers of people in hospital settings Risk of harm (self and others) is reduced. **Potential measure(s):** Quality of life outcome measures (such as improvements in social engagement, meaningful activities, communication, autonomy and control) Number of MHTRs/adapted programmes available for people with a learning disability and/or autism. Numbers of people accessing MHTRs/adapted programmes. Health Equalities Framework (HEF) Patient Report Experience Measures (PREM) Patient Report Outcome Measure (PROM) Recovery Focused Outcome measures	"I am supported to understand and manage my own actions, and to understand the consequences of them." "I understand how the care and support I am getting is responsive to my needs." "I am supported to be part of my community."

Core aims of community-based forensic support:	**A reduction in the number of people with a learning disability and/or autism who require inpatient facilities.** **A reduction in the behaviours of people with a learning disability and/or autism that lead to them coming into contact with the criminal justice system.** **Improved support to people through the criminal justice system**			
Functions of support	Descriptions	Outputs	Outcomes	Outcomes for the person
Case management and interventions	Case management and direct support of individuals with the most complex needs, through delivery of specific therapeutic interventions. Support delivered across a range of settings, such as the person's own home as well as in inpatient facilities.	Co-design, development and delivery of individualised and person-centred treatment and support plans that mitigate risk factors. People are enabled to develop strategies that manage their behaviours. Management strategies that ensure the wellbeing and safety of all.	Reduction in numbers needing to access treatment in a hospital setting. Reduction in behaviour leading to contact with the criminal justice system. Reduction in breakdowns in support. Increased treatment options in the community. Risk of harm (self and others) is reduced. **Potential measure(s):** Quality of life outcome measures LD HoNOS. Health Equalities Framework Recovery Focused Outcome measures.	"I am getting expert support from people with the right skills and expertise." "I am supported to be safe and a part of my community." "I am supported to understand and manage my own actions, and to understand the consequences of them." "I understand how the care and support I am getting is responsive to my needs."

Core aims of community-based forensic support:	**A reduction in the number of people with a learning disability and/or autism who require inpatient facilities.** **A reduction in the behaviours of people with a learning disability and/or autism that lead to them coming into contact with the criminal justice system.** **Improved support to people through the criminal justice system**			
Functions of support	Descriptions	Outputs	Outcomes	Outcomes for the person
Support and training to those providing day to day support	Expert support and training to providers of day to day support in the community (including but not restricted to families, personal assistants, voluntary, community and social care providers), helping with the design of services and supports and facilitating least restrictive settings. Support in the development of contingency plans for crises and relapses.	Increased capacity and capability of community providers, families and others including understanding of the criminal and youth justice systems Support and training resulting in person-centred support and care Staff and family carers are able to identify early signs of risk, and have the skills to address this. Enhanced working across agencies/providers.	Reduction in behaviour leading to contact with the criminal justice system. Reduction in numbers needing to access treatment in a hospital setting. **Potential measure(s):** Number of staff receiving training Staff feedback Quality of life outcome measures Health Equalities Framework Confidence measure of staff/families pre and post intervention	"My family and paid staff are supported and know how to effectively support me." "I am supported to be safe and a part of my community." "My needs are understood and met in ordinary community settings." "My health and social care needs are met/managed in a way that reduces inequality and reflects my choices and wishes." "I have access to service that are reasonably adjusted."

Core aims of community-based forensic support:	**A reduction in the number of people with a learning disability and/or autism who require inpatient facilities.** **A reduction in the behaviours of people with a learning disability and/or autism that lead to them coming into contact with the criminal justice system.** **Improved support to people through the criminal justice system**			
Functions of support	Descriptions	Outputs	Outcomes	Outcomes for the person
Consultancy and advice	Consultancy, support and collaborative working with other services/agencies (such as social care and mental health services, the police, MAPPA, Liaison and Diversion, the courts, probation, youth offending teams, housing and employment) to support pathways away from the criminal justice system where appropriate, or to ensure that an individual's passage through the system is informed and adapted to meet their needs. Including training to frontline staff (e.g. police in custody suites). Collaborative working with the criminal justice system is paramount in the contribution to the assessment, treatment and management of people whilst promoting recovery and being mindful of public safety.	Support and reasonable adjustments ensuring appropriate support for people through the criminal justice system. Criminal justice system partners are better skilled to work with and support people with a learning disability and/or autism. Clear pathways for (appropriate) diversion from the criminal justice system to health and social care services. People are better supported to exercise their rights. Recommendations for community disposal options from people with the right expertise to make recommendations for treatment. Risk assessments and management strategies that ensure the wellbeing and safety of all.	Early intervention and prevention leading to a reduction in numbers offending Fair access to the criminal justice system **Potential measure(s):** Health Equalities Framework (HEF) Quality of Life outcome measures Confidence measures of staff in Criminal Justice System and other services pre and post intervention	"I am supported to understand my legal rights and to access the criminal justice system/ youth justice system." "I have access to service that are reasonably adjusted." "I am respected and listened to." "I am treated fairly in the justice system."

Core aims of community-based forensic support:	**A reduction in the number of people with a learning disability and/or autism who require inpatient facilities.** **A reduction in the behaviours of people with a learning disability and/or autism that lead to them coming into contact with the criminal justice system.** **Improved support to people through the criminal justice system**			
Functions of support	Descriptions	Outputs	Outcomes	Outcomes for the person
In-reach support	Liaison role for individuals, to enable a safe, well-managed and timely return to the community for those being discharged from secure hospital settings and other secure settings. This may be through direct work with individuals or through advising other teams. This should be both about facilitating discharge and following up on patients following discharge, preventing readmissions.	People experience co-ordinated discharge planning There is a clear care pathway for each patient from hospital though to discharge Multiple agencies contribute to meeting peoples' needs in a well-coordinated manner. Responsibilities for delivering effective care and support are transparent Early identification of discharge pathway/placement Discharge from hospitals and return to community living are more successful	Timely return to the community Support and facilitation to least restrictive settings **Potential measure(s):** Reduced length of stay in hospital settings Reductions in readmissions/re-offending Patient Reported Outcome Measures (PROM) Patient Reported Experience Measures (PREM) Quality of life outcome measures (such as improvements in social engagement, meaningful activities, communication, autonomy and control) Personal Outcomes Evaluation Tool (POET)	"I am supported to regain my independence." "I am supported to be safe and a part of my community." "I understand what is happening to me and how my care and support is responsive to my needs."

Appendix One – Population Covered

STP/ICS WY & Barnsley	Specialist Commissioning Cohort Numbers October 2018	Projected discharges Oct 18/March19	Cohort requiring Forensic Outreach Liaison Service in a less restrictive hospital placement prior to March 2019	Cohort requiring Forensic Outreach Liaison Service in community placement prior to March 2019	Adult secure cohort at end of programme (excl. admissions)
Leeds	16	9	5	4	11
Bradford	8	0	0	1	10
Kirklees (NKCCG & GHCCG)	4	0	0	0	4
Calderdale	2	0	0	0	2
Wakefield	5	1	1	0	4
Barnsley	8	1	0	1	7
Grand Total	43	11	6	6	38
STP/ICS WY & Barnsley	**Clinical Commissioning Group [CCG] Cohort Numbers November 2018**	**Projected discharges Oct 2018/March 2019**	**Cohort requiring the Forensic Outreach Liaison Service prior to March 2019**	**Cohort requiring Forensic Outreach Liaison Service in community placement post March 2019**	**CCG TCP Cohort at end of programme (excl admissions)**
Leeds	28	10	3	7	12
Bradford	?	?	1	2	?
Kirklees (NKCCG & GHCCG)	8	2	0	4	6
Calderdale	3	2	0	1	1

Wakefield	3	3	0	0	3
Barnsley	10	6	2	3	4
Grand Total	52	26	6	17	26

NHS
Barnsley
Clinical Commissioning Group

GOVERNING BODY

11 JULY 2019

INTEGRATED PERFORMANCE REPORT

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

	Name	Designation
Executive Lead	Roxanna Naylor / Jamie Wike	Chief Finance Officer / Director of Strategic Planning and Performance
Author	Roxanna Naylor/ Jamie Wike	Chief Finance Officer/ Director of Strategic Planning and Performance

3. SUMMARY OF PREVIOUS GOVERNANCE

The matters raised in this paper have been subject to prior consideration in the following forums:

Group / Committee	Date	Outcome
Finance and Performance Committee	4/7/19	Noted current position and agreed reporting to Governing Body

4. EXECUTIVE SUMMARY

4.1	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 May 2019.
4.2	The reports provide details of the latest performance against key performance indicators and an overview of the financial performance of the CCG up to 31 May 2019.
4.3	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.

4.4	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.
4.5	Performance continues to be generally strong for Barnsley patients with key standards in relation to A&E, Referral to treatment, diagnostics and CHC all being achieved for the latest performance period. Key performance indicator issues which are highlighted within the exception report are: • The number of people entering IAPT services • The number of people waiting longer than 2 weeks to be seen following referral with breast symptoms • The number of people waiting longer than 31days to be seen following referral (Cancer) • The number of people waiting longer than 31 days for subsequent treatment where this is surgery • The number of people waiting longer than 31 days for subsequent treatment where this is radiotherapy • The number of people waiting 62 days from referral to first definitive treatment • The number of people waiting longer than 52 weeks for treatment
4.6	Resource allocations and expenditure presented to the Governing Body in May 2019 did not include the non-recurrent allocation relating to surplus drawdown and associated expenditure of £2m. This has been updated and is presented in Table 1 below. As noted in May 2019 report this drawdown will be utilised to support the development of out of hospital transformation and integration, however in the short term this will be held as part of the contingency to manage in-year emerging risks and mitigate against any risk of 2019/20 efficiency plans. Decisions on plans for deployment of this resource will be considered by Governing Body in September – November 2019. **Table 1** – Resource Allocations updated to include non-recurrent surplus drawdown

Details	Notified Allocation January 2019 - 2019/20	Adjustments to allocations post notification	Revised 2019/20 Allocations (Recurrent)	Revised 2019/20 Allocations non-recurrent	Total 2019/20 Allocations
Programme	400,844	188	401,032	0	401,032
Primary Care Co-Commissioning	38,113	(1,097)	37,016	0	37,016
Surplus drawdown	0	0	0	2,000	2,000
Running Costs	5,529	0	5,529	0	5,529
Total	**444,486**	**(909)**	**443,577**	**2,000**	**445,577**

4.8	The finance report, attached at Appendix 2, provides an assessment of the current financial performance of the CCG up to 31 May, together with the forecasts for the year end. The report contains the headline messages along with monthly financial monitoring.
4.9	At this early stage in the year there is limited data available to allow a robust forecast

	position to be developed; therefore, reports to 31 May reflect a balanced budget position. Consequently, the CCG is forecasting to achieve financial duties and planning guidance requirements, with an in-year balanced budget position. This position is predicated on the delivery of the CCG's efficiency programme and mitigations being identified against any in-year pressures. The Governing Body are asked to note that whilst a balanced budget position is reported emerging risks in the delivery of efficiency plans, acute contracts and prescribing are currently being reviewed and may potentially require immediate action to ensure delivery of financial duties is achieved. Further information on the CCG's financial performance target and risks are set out in Appendix 2. Included in Appendix 2 and 3 is the final actual outturn position and dashboard for the 2018/19 efficiency programme. This shows actual performance against the £11.5m target was achieved; however in-year mitigations were required against planned schemes of £1.2m. The impact of demand management targets not being achieved in 2018/19 is currently being reviewed against 2019/20 plans to ensure mitigating actions can be taken. The efficiency programme position for 2019/20 as at 31 May is that schemes are expected to deliver the £13.1m target, however the risk to delivery against demand management schemes will need to be updated following review. Further updates will be provided through the Integrated Performance Report and QIPP reporting which are standing agenda items of the Finance and Performance Committee and Governing Body.
5.	**THE GOVERNING BODY / COMMITTEE IS ASKED TO:**
	Note the contents of the report including: • 2019/20 performance to date • projected delivery of all financial duties, predicated on the assumptions outlined in this paper. • updated allocations and expenditure position for 2019/20 • the final actual outturn position on the 2018/19 efficiency programme • the current forecast position on the CCG's efficiency programme and the work being undertaken to mitigate against the risks of delivery.
6.	**APPENDICES / LINKS TO FURTHER INFORMATION**
	Performance Section • Appendix 1 – Barnsley CCG Monthly Performance Report to May 2019 **Finance Section** • Appendix 2 – Finance Report 2019/20 – Month 2 • Appendix 3 – 2018/19 QIPP dashboard

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 Priority Areas**	**Y/N**
	1 - Urgent & Emergency Care	Y
	2 - Primary Care	Y
	3 – Cancer	Y
	4 - Mental Health	Y
	5 - Integrated Care System (ICS)	Y
	6 - Efficiency Plan	Y
	7 - Transforming Care for People with Learning Disabilities and / or Autistic Spectrum Conditions	Y
	8 - Maternity	Y
	9 - Compliance with Statutory and Regulatory Requirements	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?	*Section 4*
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
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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.

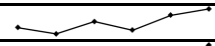
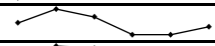
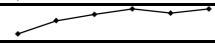
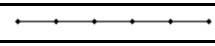
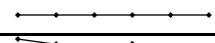
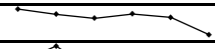
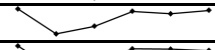
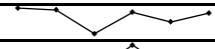
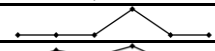
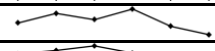
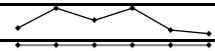
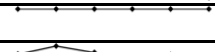
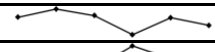
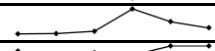
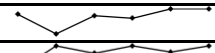
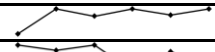
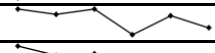
Putting Barnsley people first

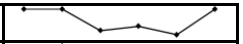
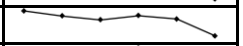
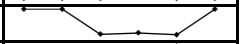
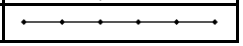
Governing Body Dashboard | Exception Report

NHS
Barnsley Clinical Commissioning Group

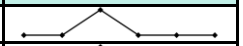
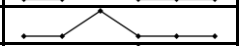
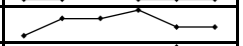
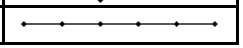
Governing Body Report 2019/20

Performance

Outcomes	Target	Actual Period	Actual YTD	Period	Trend
Improved Access to Psychological Services-IAPT: People entering treatment against level of need	1.67%	1.29%	1.30%	May-19	
Improved Access to Psychological Services-IAPT: People who complete treatment, moving to recovery	50.0%	54.6%	-	May-19	
Estimated diagnosis rate for people with dementia	69.9%	71.4%	71.4%	Apr-19	
CHC eligibility within 28 days	80.0%	90.0%	-	Q4 18/19	
Number of CHC Referrals	-	20	36	May-19	
Number of CHC Referrals Completed Within 28 Days	-	20	35	May-19	
% of CHC Referrals Completed Within 28 Days	80.0%	100.0%	97.2%	May-19	
Percentage of NHS Continuing Healthcare assessments taking place in an acute hospital setting	15.0%	0.0%	-	Q4 18/19	
Number of DSTs Completed in Acute Hospital Setting	-	0	0	May-19	
% DSTs Completed in Acute Hospital Setting	15.0%	0.0%	-	May-19	
% Patient experience of primary care - GP Services	-	81.0%	-	Aug-18	
% Patient experience of primary care - GP Out of Hours services	-	67.7%	-	Aug-18	
% 4 hour A&E waiting times - seen within 4 hours - CCG (Monthly)	95.0%	95.2%	94.9%	May-19	
% 4 hour A&E waiting times - seen within 4 hours (Type 1 BHNFT) (Monthly)	95.0%	95.6%	95.8%	May-19	
% Patients on incomplete non-emergency pathways waiting no more than 18 weeks (Commissioner)	92.0%	94.6%	93.9%	Mar-19	
Number of 52 week Referral to Treatment Pathways Incomplete (Commissioner)	0	0	0	Apr-19	
% Patients waiting for diagnostic test waiting > than 6 wks from referral (Commissioner)	1.00%	0.18%	0.60%	Mar-19	
Cancer - % Patients seen within 2wks referred urgently by a GP	93.0%	93.9%	93.9%	Apr-19	
Cancer - % Patients referred with breast symptoms seen within 2 wks of referral	93.0%	91.9%	91.9%	Apr-19	
Cancer - % Patients seen within 31 days from referral to treatment	96.0%	92.2%	92.2%	Apr-19	
Cancer - % Patients seen within 31 days for subsequent treatment (Surgery)	94.0%	88.9%	88.9%	Apr-19	
Cancer - % Patients seen within 31 days for subsequent treatment (Drugs)	98.0%	100.0%	100.0%	Apr-19	
Cancer - % Patients seen within 31 days for subsequent treatment (Radiotherapy)	94.0%	90.0%	90.0%	Apr-19	
Cancer - % Patients seen within 62 days of referral from GP	85.0%	81.5%	81.5%	Apr-19	
Cancer - % Patients seen from referral within 62 days (Screening Service: Breast, Bowel & Cervical)	90.0%	100.0%	100.0%	Apr-19	
Cancer - % Patients being seen within 62 days (ref. Consultant)	85.0%	100.0%	100.0%	Apr-19	
Category1 - YAS Mean Response Time	07:00	06:49	06:53	May-19	
Category2 - YAS Mean Response Time	18:00	18:38	19:09	May-19	

Proportion of people on Care Programme Approach (CPA) who were followed upwithin 7 days of discharge	100.0%	100.0%	96.7%	Q4 18/19	
Ambulance handover delays of over 30 mins	0	121	273	May-19	
Ambulance handover delays of over 1 hour	0	1	7	May-19	
% Patient experience of primary care - GP Services	-	81.0%	-	Aug-18	
Trolley waits in A&E -zero waits from decision to admit to admissions over 12 hours - BHNFT (Month)	0	0	0	May-19	
Proportion of people waiting 18 weeks or less from referral to first IAPT treatment appointment	95.0%	100.0%	-	May-19	
Proportion of people waiting 6 weeks or less from referral to first IAPT treatment appointment	75.0%	97.2%	-	May-19	
Cancelled operations rebooked within 28 days	0	0	0	Feb-19	

Quality

Outcomes	Target	Actual Period	Actual YTD	Period	Trend
Incidence of healthcare associated infection (HCAI) - MRSA (Commissioner)	0	0	0	Apr-19	
Incidence of healthcare associated infection (HCAI) - MRSA (Provider) - BHFT	0	0	0	Apr-19	
Incidence of healthcare associated infection (HCAI) - C.Diff (Commissioner)	YTD Target - 3	2	2	Apr-19	
Incidence of healthcare associated infection (HCAI) - C.Diff (Provider) - BHFT	YTD Target - 1	1	1	Apr-19	
Number of mixed sex accomodation breaches (Commissioner)	0	0	0	Apr-19	

Barnsley Clinical Commissioning Group

Exception Report 2019/20

Key Performance Indicators by Exception				
Indicator	**Target**	**Actual Period**	**Actual YTD**	**Period Performance**
Improved Access to Psychological Services-IAPT: People entering treatment against level of need	1.67%	1.29%	1.30%	Overall the number of people accessing the service in 2018/19 was in line with the plan. Performance has however been below the target for a number of months. The target has increased for 2019/20 to reflect the planning requirement to expand access to IAPT services to supprt people with long term physical health conditions. Monthly meetings are in place with the provider to support the expansion of the service and increase the numbers accessing IAPT services.
Cancer - % Patients referred with breast symptoms seen within 2 wks of referral	93.00%	91.87%	91.87%	In April 10 of 132 patients seen waited longer than 2 weeks. All of the breaches were at Barnsley Hospital with 7 due to outpatient capacity being inadequate and 3 due to patient choice. As a result of the breaches at Barnsley Hospital the trust also missed this target in April. The CCG continue to work with the Barnsley Cancer Steering Board to ensure adequate capacity is in place and with the Cancer Alliance to improve Cancer performance across all pathways.
Cancer - % Patients seen within 31 days for subsequent treatment (Radiotherapy)	94.00%	90.00%	90.00%	In April 5 of 50 patients waited longer than 31 days for radiotherapy following disagnosis. All of the breaches were at Sheffileld Teaching Hospital with 2 being due to delays for medical reasons and 3 due to patient choice. The CCG continue to work with Sheffield CCG as the lead commissioner and with the Cancer Alliance to improve Cancer performance across all pathways.
Cancer - % Patients seen within 31 days for subsequent treatment (Surgery)	94.00%	88.89%	88.89%	In April 2 of 18 patients waited longer than 31 days for surgery following diagnosis. One of the breaches was at Barnsley Hospital and the other at Sheffield Teaching Hospital. Both were due to elective capacity. As a result of the breaches at Barnsley Hospital the trust also missed this target in April. The CCG continue to work with the Barnsley Cancer Steering Board, with Sheffield CCG as the lead commissioner for STH and with the Cancer Alliance to improve Cancer performance across all pathways.

Cancer - % Patients seen within 31 days from referral to treatment	96.00%	92.24%	92.24%	In April 9 of 116 patients waited longer than 31 days to be seen follwing referral. Of the 9 breaches 4 were at Barnsley Hospital. 2 Lower GI due to Elective capacity, 1 Skin due to medical reasons and 1 Urology to patient choice. The other 5 breaches were at STH. 3 were for Urology due to elective capacity with the remaining 2 for head and neck due to elective capacity. As a result of the breaches at Barnsley Hospital the trust also missed this target in April. The CCG continue to work with the Barnsley Cancer Steering Board, with Sheffield CCG as the lead commissioner for STH and with the Cancer Alliance to improve Cancer performance across all pathways.
Cancer - % Patients seen within 62 days of referral from GP	85.00%	81.54%	81.54%	In April 12 of 65 patients waited longer than 62 days from referral to first definative treatment. All of the breaches involved Inter Provider Transfers to Sheffield Teaching Hospital. 2 were Gynae, 5 Head & Neck, 1 Lung, 2 Upper GI and 2 Urology. The reasons were healthcare provider initiated delays, elective capacity or complex diagnostic pathways. The CCG continue to work with the Barnsley Cancer Steering Board, with Sheffield CCG as the lead commissioner for STH and with the Cancer Alliance to improve Cancer performance across all pathways.
Number of 52 week Referral to Treatment Pathways Admitted (Commissioner)	0	2	2	Two Barnsley patients had waited over 52 weeks before being admitted for treatment in April 2019. The 52 week waits were for Trauma and Orthodaedics, 1 at BMI Thornbury and 1 at Leeds Teaching Hospitals.

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Finance Report 2019/20

Month 2

1 Headline Messages and contents

Headline Messages	Contents	
• At this early stage in the year there is limited data available to allow a robust forecast position to be developed; therefore, reports to 31 May reflect a balanced budget position. • The CCG is forecasting to achieve financial duties and planning guidance requirements, with an in-year balanced budget position. This position is predicated on the delivery of the CCG's efficiency programme and mitigations being identified against any in-year pressures. The Governing Body are asked to note that whilst a balanced budget position is reported emerging risks in the delivery of efficiency plans, acute contracts and prescribing are currently being reviewed and may potentially require immediate action to ensure delivery of financial duties are achieved. Finance and Performance Committee considered risks with initial estimates based on early data received; however work is now ongoing to develop a robust position. The current projections in the 'Most Likely' scenario indicate a potential net mitigation of £729k. Actions are required immediately against non-elective work streams and demand management plans to mitigate against the current risk of non-delivery against targets. The Finance and Contracting Team are working with the Commissioning Team to ensure this work is progressed. Should the forecast position materialise in the 'worst case' prediction further efficiency plans of approx. £1,771k would need to be developed and delivered to ensure financial duties and targets are achieved. Further updates will be provided to the Governing Body as data is reviewed and verified. • Acute contract activity data has been received for Month 2 flex from Barnsley Hospital. Early indications show continued pressures in non-elective activity, however elective and outpatient activity is showing a more significant increase above planned levels. Work is ongoing to review this position and the impact on delivery of planned efficiency schemes. Further updates will be provided once a full review of the position is undertaken. Other acute contract activity data has been received to Month 1, however Sheffield Teaching Hospitals (STH) are moving to a new system for sharing data and there are some reporting issues which may not be resolved for Month 3 reporting. The Finance and Contracting team are working with STH and Sheffield CCG to understand the expected timescales for data flows to commence at the appropriate levels. • Primary Care prescribing data has been received for Month 1 and is showing some pressures which are currently under review with the Head of Medicines Optimisation. This will be closely monitored once further data is received and validated. • Continuing Healthcare continues to be a volatile area of expenditure and work continues to assess the impact of recently agreed high cost placements on the forecast position. • The CCG's Efficiency Programme Management Office (PMO) will continue to monitor and review delivery of the CCG's £13.1m efficiency programme noting the risks to deliver highlighted above. Schemes in the pipeline will be progressed and modelling refreshed on all activity related schemes to ensure forecasts reflect expected levels of delivery. Actual achievement of 2018/19 schemes has resulted in a shortfall in demand management delivery of £1.2m. This achievement against targets will impact significantly on the 2019/20 plans. An urgent review is currently underway and finding will be reported through the PMO, Finance and Performance Committee and Governing Body.	1 2 3 3.1 4	Headline Messages and Content Financial Performance Targets Monthly Finance Monitoring Statement – Executive Summary Detailed Summary Resource Allocation – Detailed Summary Efficiency Programme Delivery 2018/19 – Actual Outturn position

2 Financial Performance Targets

1) Financial Duties

NHS Act Section	Duty	2019/20 Target £'000	2019/20 Actual Performance £'000	2019/20 Actual Achievement
223H (1)	Expenditure not to exceed income	445,615	445,615	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	445,577	445,577	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	0	0	YES
223J(3)	Revenue administration resource use does not exceed the amount specified in Directions	5,529	5,198	YES

2) Financial targets/NHS England Business Rules requirements

Target/Business Rule Requirement	2019/20 Target	2019/20 Actual Performance £'000	2019/20 Actual Achievement
Delivery of in year balanced position	0	0	YES
0.5% Contingency to manage in-year pressures	2,218	2,218	YES

Comments

At this early stage in the year the CCG is forecasting to achieve all financial duties/targets and NHS England (NHSE) Business Rules subject predicated on the delivery of the CCGs efficiency programme and mitigations being identified against any in-year pressures.

It is important to note that whilst the in year position reflects a balanced budget the CCG has a historic surplus held by NHSE. NHSE has approved a drawdown from this resource in 2019/20 of £2m. The historic surplus balance in 2019/20 now totals £12,532k.

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	OUTTURN VARIANCE OVER / (UNDER) £
PROGRAMME EXPENDITURE								
Acute	224,928	250	225,178	37,530	37,530	0	225,178	0
Patient transport	2,122	0	2,122	354	354	0	2,122	0
Mental Health	35,664	439	36,104	6,017	6,017	0	36,104	0
Community Health	47,809	359	48,168	8,409	8,409	0	48,168	0
Continuing Health Care	22,626	0	22,626	3,629	3,629	0	22,626	0
Primary Care Other	58,508	637	59,145	9,658	9,658	0	59,145	0
Primary Medical Services (Co-Commissioning)	37,790	0	37,790	6,415	6,415	0	37,790	0
Other Programme Costs	5,715	(76)	5,640	607	607	0	5,640	0
TOTAL COMMISSIONING SERVICES (INCLUDING PRIMARY CARE RESERVES)	**435,163**	**1,610**	**436,773**	**72,618**	**72,618**	**0**	**436,773**	**0**
Corporate Costs - EMBED/DSCRO	207	0	207	35	35	0	207	0
Corporate Costs - IFR	37	0	37	6	6	0	37	0
NHS Property Services/Community Health Partnerships	694	0	694	116	116	0	694	0
TOTAL CORPORATE COSTS	**938**	**0**	**938**	**156**	**156**	**0**	**938**	**0**
TOTAL PROGRAMME COSTS (INCLUDING PRIMARY CARE RESERVES)	**436,101**	**1,610**	**437,711**	**72,774**	**72,774**	**0**	**437,711**	**0**
RUNNING COSTS								
Pay	3,224	0	3,224	537	537	0	3,224	0
Non Pay	1,790	350	2,140	357	357	0	2,140	0
Income	(166)	0	(166)	(28)	(28)	0	(166)	0
TOTAL RUNNING COSTS	**4,848**	**350**	**5,198**	**866**	**866**	**0**	**5,198**	**0**
CCG Reserves	2,608	61	2,668	0	0	0	2,668	0
NHS England Planning Guidance Reserves	0	0	0	0	0	0	0	0
In Year (Over)/underspend	0	0	0	0	0	0	0	0
TOTAL RESERVES/CONTINGENCY (EXCL. PRIMARY CARE RESERVES)	**2,608**	**61**	**2,668**	**0**	**0**	**0**	**2,668**	**0**
TOTAL EXPENDITURE	**443,556**	**2,021**	**445,577**	**73,641**	**73,641**	**0**	**445,577**	**0**
Programme	401,032	2,000	403,032	66,360	66,360	0	403,032	0
Primary Care Co-Commissioning	37,016	0	37,016	6,415	6,415	0	37,016	0
Running Costs	5,529	0	5,529	866	866	0	5,529	0
RESOURCE ALLOCATIONS	**443,577**	**2,000**	**445,577**	**73,641**	**73,641**	**0**	**445,577**	**0**
SURPLUS/(DEFICIT)	**21**	**(21)**	**0**	**0**	**0**	**0**	**0**	**0**

3.1 Resource Allocation – Detailed Summary

RESOURCE ALLOCATIONS - PROGRAMME, RESERVES & SURPLUS		RECURRENT £000	NON RECURRENT £000	TOTAL £000
Description	Month	£	£	£
Allocations -Final allocation after place-based pace of change	M1	399,162		399,162
Allocations - Other funding after pace of change	M1	1,682		1,682
Allocation - Primary Care Co-Commissioning	M1	38,113		38,113
Primary Care Co-Commissioning (defund indemnity adjustments)	M1	(1,097)		(1,097)
Recurrent changes In Year for 19/20 (identification rule changes)	M1	188		188
Historic Drawdown	M1		2,000	2,000
TOTAL RESOURCE ALLOCATION		**438,048**	**2,000**	**440,048**

RESOURCE ALLOCATIONS - RUNNING COSTS		RECURRENT £000	NON RECURRENT £000	TOTAL £000
Description	Month	£	£	£
2019/20 Allocation	M1	5,529		5,529
TOTAL RESOURCE ALLOCATION		**5,529**	**0**	**5,529**

SUMMARY	£'000	£'000	£'000
Programme	401,032	2,000	403,032
Primary Care Co-Commissioning	37,016	0	37,016
Running Costs	5,529	0	5,529
TOTAL RESOURCE ALLOCATION	**443,577**	**2,000**	**445,577**

Comments

There were no allocation adjustments in Month 2.

4 Efficiency Programme Delivery 2018/19

Category	Project Title	Original Plan	Outturn Month 12 (FOT)	Variance FOT v Plan
		£'000	£'000	£'000
Target QIPP for 2018/19		**11,479**	11,479	
Total Medicines Management		**4,200**	**4,869**	**669**
Total Demand Management		**4,084**	**2,898**	**(1,186)**
Contract Change	Care Navigation	1,317	1,317	-
Contract Change	IAPT service reprocurement	875	875	-
Contract Change	Intermediate Care	375	375	-
Contract Change	Respiratory (BREATHE)	199	(778)	(977)
Contract Change	GP out of hours	186	186	-
Contract Change	Optometry First	132	66	(66)
Contract Change	Diabetes - Activity related (NEL)	64	47	(17)
Contract Change	PEARS (c/fwd from 2017/18)	47	47	-
Total Contract Change		**3,195**	**2,135**	**(1,060)**
Total QIPP Efficiency		**11,479**	**9,902**	**(1,577)**
In Year Mitigation				
Contract Change	Neuro Rehab	-	343	343
Contract Change	Diabetes - Activity related (O/P)	-	68	68
Total In Year Mitigations		**-**	**411**	**411**
Total projects / In year mitigations / Budget Review		**11,479**	**10,313**	**(1,166)**
In-year Budget Review/Mitigations		**-**	**1,166**	**1,166**
Surplus/(Shortfall) after identified efficiencies and in year mitigations			**-**	**-**

Comment

Whilst the actual position on efficiency plans for 2018/19 shows full achievement against the target, in-year mitigations of £1.2m were required due to growth against demand management schemes. This growth will contribute significantly to the ability to deliver against 2019/20 schemes and therefore a full review of activity is currently being undertaken.

2018/19 QIPP Schemes

DEMAND MANAGEMENT

		Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Total YTD	Total 2018/19
Demand Management															
Get Fit First	**Baseline**	8,034	9,488	9,299	8,814	8,631	8,631	9,422	9,332	7,564	8,675	7,856	7,545	103,291	**103,291**
	2018/19	8,021	8,413	7,860	8,234	7,850	7,698	9,051	8,373	7,141	8,896	7,725	7,990	97,252	**97,252**
	Actual Reduction/Increase	-13	-1,075	-1,439	-580	-781	-933	-371	-959	-423	221	-131	445		**-6,039**
	Variance to Baseline	-0.2%	-11.3%	-15.5%	-6.6%	-9.0%	-10.81%	-3.94%	-10.28%	-5.59%	2.55%	-1.67%	5.90%	-6%	
	Actual Cost Reduction/Increase	-£137,646	-£148,310	-£255,402	-£143,370	-£90,966	-£34,047	-£85,343	£19,861	-£34,414	£175,305	£75,520	£66,250		**-£592,559**

Demand Management															
Clinical Thresholds - Procedures	**Baseline**	846	934	1,067	911	1,003	913	986	1,002	751	779	897	768	10,857	**10,857**
	2018/19	839	948	880	869	790	737	880	912	716	772	758	795	9,896	**9,896**
	Actual Reduction/Increase	-7	14	-187	-42	-213	-176	-106	-90	-35	-7	-139	27		**-961**
	Variance to Baseline	-1%	1%	-18%	-5%	-21%	-19%	-11%	-9%	-5%	-1%	-15%	4%	-9%	
	Actual Cost Reduction/Increase	-£58,679	-£30,051	-£367,861	-£125,219	-£375,892	-£455,126	-£266,780	-£358,238	-£138,654	£56,869	-£199,851	£41,988		**-£2,277,494**
											£90k included for OHG coding issues M10/M11				-£2,187,494

Demand Management															
Acupuncture	**Baseline**	312	312	312	312	312	312	312	312	312	312	312	312	3,747	**3,747**
	2018/19	275	245	264	249	258	42	80	51	43	56	45	44	1,652	
	Expected Reduction	0	0	0	0	0	0	-309	-297	-210	-302	-292	-258		**-1,668**
	Actual Reduction/Increase	-37	-67	-48	-63	-54	-270	-232	-261	-269	-256	-267	-268	-2,095	
	Variance to Baseline	-12%	-22%	-15%	-20%	-17%	-87%	-74%	-84%	-86%	-82%	-86%	-86%	-56%	
	Actual Reduction/Increase	-£2,293	-£4,381	-£3,233	-£4,313	-£3,623	-£14,894	-£12,771	-£14,234	-£14,883	-£14,201	-£14,517	-£14,789		**-£118,132**

Demand Management - Get Fit First															
No of referrals from GP to smoking cessation programme		26	15	19	12	23	24	17	37	20	33	16	19		**261**

Demand Management - Get Fit First															
No of referrals from GP to weight loss programme		55	65	43	39	17	51	24	18	16	27	31	21		**407**

BREATHE - RESPIRATORY

		Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Total YTD	Total 2018/19
BREATHE - Respiratory															
Non Elective Admissions for COPD	**Target**	76	77	69	60	46	54	78	76	112	137	93	99	977	**977**
	2018/19	105	101	87	69	84	69	90	91	145	162	129	101	1,233	
	Actual Reduction/Increase	29	24	18	9	38	15	12	15	33	25	36	2	256	
	Variance to Target	38%	31%	26%	15%	83%	28%	15%	20%	29%	18%	39%	2%	26%	
	Actual Cost Reduction/Increase	£54,139	£58,222	£55,004	£2,109	£55,682	£6,128	£22,580	£28,581	£71,560	£69,213	£73,459	£10,032		**£506,712**

BREATHE - Respiratory															
Number of adult respiratory NEW secondary care outpatient appointments at BHNFT	**Target**	162	142	197	195	215	171	212	207	131	237	185	179	2,233	**2,233**
	2018/19	185	193	229	191	139	200	191	155	175	267	206	191	2,322	
	Actual Reduction/Increase	23	51	32	-4	-76	29	-21	-52	44	30	21	12	89	
	Variance to Baseline	14%	36%	16%	-2%	-35%	17%	-10%	-25%	34%	13%	11%	7%	4%	

	Actual Cost Reduction/Increase	£4,851	£10,450	£5,366	-£1,443	-£17,264	£5,981	-£4,913	-£11,569	£9,044	£4,008	£4,149	£2,173		**£10,834**

BREATHE - Respiratory															
Number of adult respiratory FUP secondary care outpatient appointments at BHNFT	**Target**	210	236	259	257	423	324	399	362	210	464	389	302	3,835	**3,835**
	2018/19	235	312	367	298	239	260	301	260	197	480	450	263	3,662	
	Actual Reduction/Increase	25	76	108	41	-184	-64	-98	-102	-13	16	61	-39	-173	
	Variance to Baseline	12%	32%	42%	16%	-43%	-20%	-25%	-28%	-6%	3%	16%	-13%	-5%	
	Actual Cost Reduction/Increase	£2,187	£7,360	£10,167	£3,665	-£17,872	-£6,384	-£9,823	-£10,170	-£1,575	£2,177	£5,606	-£4,098		**-£18,760**

DIABETES

Diabetes - Decrease over two years the number of hospital admissions in people aged over 18 years at Barnsley Hospital with a diagnosis of Diabetes or Specifically Related Conditions by 10% each year															
		Apr-18	**May-18**	**Jun-18**	**Jul-18**	**Aug-18**	**Sep-18**	**Oct-18**	**Nov-18**	**Dec-18**	**Jan-19**	**Feb-19**	**Mar-19**	**Total YTD**	**Total 2018/19**
Ketoacidosis	**Target**	4	8	8	5	5	8	12	14	5	11	8	10	96	**96**
	2018/19	12	6	6	1	9	5	5	7	10	14	19	10	104	
	Actual Reduction/Increase	8	-2	-2	-4	5	-3	-7	-7	5	3	11	0	8	
	Variance to Target	233%	-26%	-26%	-78%	100%	-38%	-57%	-48%	85%	30%	135%	1%	8%	
	Actual Cost Reduction/Increase	£8,890	-£6,506	-£8,375	-£6,533	-£10,614	-£9,005	-£14,026	-£11,050	£6,586	-£1,081	£8,668	-£4,128		**-£47,172**

Diabetes - Decrease over two years the number of hospital admissions in people aged over 18 years at Barnsley Hospital with a diagnosis of Diabetes or Specifically Related Conditions by 10% each year															
Hypoglycaemia	**Target**	0	2	1	0	2	0	0	0	1	0	0	1	6	**6**
	2018/19	0	0	0	0	0	1	0	1	0	0	0	0	2	
	Actual Reduction/Increase	0	-2	-1	0	-2	1	0	1	-1	0	0	-1	-4	
	Variance to Target	0%	-100%	-100%	0%	-100%	100%	0%	100%	-100%	0%	0%	-100%	-69%	
	Actual Cost Reduction/Increase	£0	-£1,917	-£2,437	£0	-£3,396	£467	£0	£1,700	-£2,437	£0	£0	-£1,489		**-£9,509**

Diabetes - Decrease over two years the number of hospital admissions in people aged over 18 years at Barnsley Hospital with a diagnosis of Diabetes or Specifically Related Conditions by 10% each year															
Hyperglycaemia	**Target**	0	1	0	0	2	2	0	0	0	0	0	0	5	**5**
	2018/19	1	2	0	0	2	0	0	0	0	1	1	2	9	
	Actual Reduction/Increase	1	1	0	0	0	-2	0	0	0	1	1	2	4	
	Variance to Target	100%	100%	0%	0%	0%	-100%	0%	0%	0%	100%	100%	200%	80%	
	Actual Cost Reduction/Increase	£3,167	£1,780	£0	£0	-£1,442	-£2,219	£0	£0	£0	£1,555	£1,555	£5,408		**£9,805**

Diabetes - Decrease over two years the number of hospital admissions in people aged over 18 years at Barnsley Hospital with a diagnosis of Diabetes or Specifically Related Conditions by 10% each year															
Combined	**Target**	4	11	9	5	8	10	12	14	6	11	8	11	108	**108**
	2018/19	13	8	6	1	11	6	5	8	10	15	20	12	115	
	Actual Reduction/Increase	9	-3	-3	-4	3	-4	-7	-6	4	4	12	1	7	
	Variance to Target	261%	-27%	-33%	-78%	33%	-41%	-57%	-41%	59%	39%	147%	10%	7%	
	Actual Cost Reduction/Increase	£12,057	-£6,642	-£10,812	-£6,533	-£15,451	-£10,757	-£14,026	-£9,350	£4,149	£474	£10,223	-£208		**-£46,876**

Diabetes - Transfer current outpatient activity into Primary Care / Community settings															
Reduction in Outpatient Activity 10% each year - Firsts	**Target**	98	86	104	86	126	102	81	105	81	79	99	98	1,145	**1,145**
	2018/19	107	99	97	81	75	74	73	77	78	91	94	89	1,035	
	Actual Reduction/Increase	9	14	-7	-5	-51	-28	-8	-28	-3	12	-5	-9	-110	
	Variance to Target	9%	16%	-6%	-6%	-40%	-27%	-10%	-27%	-4%	15%	-5%	-9%	-10%	
	Actual Cost Reduction/Increase	£799	£1,845	-£2,335	-£1,188	-£11,082	-£3,533	£1,748	-£1,988	£1,236	£3,836	£845	£2,113		**-£7,704**

Diabetes - Transfer current outpatient activity into Primary Care / Community settings															
Reduction in Outpatient Activity 10% each year - Follow Ups	**Target**	404	448	542	409	482	371	438	427	398	392	323	365	4,999	**4,999**
	2018/19	396	371	441	363	328	271	478	318	304	396	308	321	4,295	
	Actual Reduction/Increase	-8	-77	-101	-46	-154	-100	40	-109	-94	4	-15	-44	-704	
	Variance to Target	-2%	-17%	-19%	-11%	-32%	-27%	9%	-25%	-24%	1%	-5%	-12%	-14%	
	Actual Cost Reduction/Increase	-£6,250	-£12,817	-£16,052	-£6,905	-£18,577	-£4,225	£5,489	-£3,982	-£4,628	£5,040	£2,852	-£290		**-£60,344**

PEARS		Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Total YTD	Total 2018/19
Contract Change															
PEARS (c/fwd from 2017/18)	**Baseline**	161	161	161	161	161	161	0	0	0	0	0	0	966	**966**
	2018/19	2	1	0	0	1	0	N/A	N/A	N/A	N/A	N/A	N/A	4	
	Expected Reduction	-97	-97	-97	-97	-97	-97	0	0	0	0	0	0		**-580**
	Actual Reduction/Increase	-159	-160	-161	-161	-160	-161	N/A	N/A	N/A	N/A	N/A	N/A	-962	
	Variance to Baseline	-99%	-99%	-100%	-100%	-99%	-100%	0%	0%	0%	0%	0%	0%	-100%	
	Variance to Baseline	-£7,950	-£8,000	-£8,050	-£8,050	-£8,000	-£8,050	N/A	N/A	N/A	N/A	N/A	N/A		**-£48,100**

NHS
Barnsley
Clinical Commissioning Group

Minutes of the Meeting of the NHS Barnsley Clinical Commissioning Group FINANCE & PERFORMANCE COMMITTEE held on Thursday 2 May 2019 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
Roxanna Naylor	- Chief Finance Officer
Dr Adebowale Adekunle	- Elected Member Governing Body
Jamie Wike	- Director of Strategic Planning & Performance
Nigel Bell	- Lay Member Governance
Dr Andrew Mills	- Membership Council Member
Dr Jamie MacInnes	- Elected Member Governing Body

IN ATTENDANCE:

Leanne Whitehead	- Executive Personal Assistant
Rory Browne (items 8 &10)	- Head of Procurement

APOLOGIES:

Patrick Otway	- Head of Commissioning (MH, Children, Specialised)
Lesley Smith	- Chief Officer

Agenda Item		Action & Deadline
FPC19/70	**QUORACY**	
	The meeting was declared quorate.	
FPC19/71	**DECLARATIONS OF INTEREST, SPONSORSHIP, HOSPITALITY AND GIFTS RELEVENT TO THE AGENDA**	
	The Committee noted the declarations of interest report. The Chair and Dr J Harban raised an interest in item 8 of the agenda Approval and Update on Procurements.	
FPC19/72	**MINUTES OF THE PREVIOUS MEETING HELD ON 4 APRIL 2019** – Approved with slight word change on page 4.	**LW**
FPC19/73	**MATTERS ARISING REPORT**	
	FPC19/59 IPR The Chair reported that if the Terms of Reference for the proposed Joint Commissioning arrangements wasn't finalised and the first	

Adopted

	meeting was not yet arranged, therefore he would pick up obesity separately in a different forum. **Agreed Actions:** • **Agreed to remove FCP19/26 – 'Review non elective admissions and potential opportunities for 2019/20 QIPP plans' would now be picked up via the QIPP Delivery Group.** **The Committee received and noted the report.**	**LW**
FPC19/74	**UPDATE ON RECENT PUBLISHED AND EXPECTED GUIDANCE** – No update to report.	
FPC19/75	**UPDATE ON CONTRACTING CYCLE**	
	The Chief Finance Officer updated members on the contracting cycle noting that all contracts have been agreed and documentation had been distributed, so would now be monitoring throughout the year. It was reported that further work had been undertaken by the CCG following the ASU rehabilitation workshops in relation to patient pathway, flows and activity numbers. It was noted that the CCG had worked closely with Lisa Wilkins to ensure staffing levels in the bottom up costings to meet safer staffing requirements and the GP lead would also be asked for input. These costings have been provided to both BHNFT and SWYPFT and a response is expected by 17 May. It was noted that there were no local CQUINS and were now all national ones. The other issue raised from the report was Thames Ambulance Service (TASL). It was reported that there were ongoing issues with the service and the CQC were currently reviewing the provider, the situation would continue to be monitored and actions taken where appropriate. Updates will be provided to the Finance and Performance committee when available. **Agreed Actions:** • **Chief Finance Officer to include details of CQUINS in update report once guidance has been received and CQUINS agreed.** • **Await CQC Update on TASL and pick up at next meeting.** **The Committee were asked to note the contents of the report including:** • **the update on 2019/20 contract negotiations and contract signature** • **the update on 2018/19 contract monitoring.** • **update on Thames Ambulance Service remedial action**	**RN** **RN**

Agreed

	plan	
FPC19/76	**APPROVAL AND OR UPDATE ON PROCUREMENTS**	
	The Head of Procurement attended the meeting to update on procurements. It was reported that there were 3 procurements which had now concluded: 1. Barnsley Primary Care Home Visiting Services 2. Primary Care Vasectomy Service Non Scalpel AQP 3. Community Carpel Tunnel Services including Nerve Conduction Study AQP It was reported that Barnsley Healthcare Federation were awarded the contract for the Barnsley Primary Care Home Visiting Services. The other 2 procurements were being planned to re-advertise in due course. **The Committee received and noted the report.**	
FPC19/77	**PROCUREMENT POLICY**	
	The Head of Procurement presented the updated procurement policy to members and also an extract for inclusion around Brexit. The policy would then be recommended to Governing Body for sign off and uploading to the CCG internet page with all other policies. **Agreed Actions:** • **Circulate track change version to members to see what has changed then recommend to Governing Body** • **Agreed inclusion of Brexit paragraph.** **Members agreed to respond via email their approval of the policy following the receipt of the track changed version.**	
FPC19/78	**BUDGET APPROVAL/FINANCIAL PLAN REPORT**	
	The Chief Finance Officer presented the report to the Committee, it was noted that the Committee had had a previous presentation on the Financial Plan in February and the paper sets out the final position. It was reported that all standards and financial duties were achieved in line with planning guidance requirements. The efficiency target of £13.1m to be delivered in year was set out in the paper. It was reported that there had been a £1.1m growth in co-commissioning following adjustments to allocations for indemnity insurances which were to be funded centrally. Activity Plans and Performance expectations were shared and it was noted that each measure would be included for 19/20 in the Integrated	

Adopted

	Performance Report. **Agreed Actions:** • **To ensure the Finance and Performance Committee and Governing body are sighted on any potential available resource by September to ensure appropriate planning can be undertaken.** The Head of Strategic Planning and Performance updated members on the performance measures and plans against these. **The Committee were asked to note report including:** • **The requirements of NHS England national planning guidance in the financial plan.** • **The investments included within the plan in line with approvals at Governing Body and Management Team.** • **The £13.1m efficiency requirement to ensure financial duties and targets are achieved.** • **Recommend to Governing Body the approval of the 2019/20 budgets.** • **Note the requirement for the development of 2020/21 efficiency plans.** • **Note the summary of the activity and performance plans against which the CCG will monitor performance and be monitored against during 2019/20.**	**RN**
FPC19/79	**INTEGRATED PERFORMANCE REPORT**	
	<u>Finance</u> The Chief Finance Officer presented the finance section of the report to Committee highlighting that the accounts had been closed down and balanced, subject to audit, which were with the CCG at the moment and noted that to date no queries had been received. The Committee congratulated the Finance Team on achieving year end position and closing the accounts. It was noted that there were some concerns over the demand management activity, however these were being investigated further and the final year end position was not yet known. The impact against the 2019/20 QIPP target would also be assessed as part of this review. **Agreed Actions:** • **Update Finance and Performance committee on the year end position and any mitigating actions that may be required if 2019/20 QIPP targets are updated as a result of the deep dive.** <u>Performance</u> The Director of Strategic Planning and Performance updated members on the performance section of the report, the report	**RN/JW**

Adopted

	included February data with year-end data due for the next meeting. Performance continues to be generally strong for Barnsley patients with key standards in relation to A&E, Cancer (2 week wait and 62 day), Referral to treatment, diagnostics, mental health and CHC all being achieved for the latest performance period. Key performance indicator issues which are highlighted within the exception report are: • The number of people waiting longer than 52 weeks for treatment • The number trolley waits in A&E - from decision to admit to admissions over 12 hours - BHNFT • The number of people waiting longer than 31days to be seen following referral (Cancer) • The number of people waiting longer than 31 days for subsequent treatment where this is radiotherapy It was reported that YAS had hit targets for CAT 1 and 2 in March and that recent investments made seem to be making a change. **The Committee were asked to note the report including:** • **2018/19 performance to date** • **Delivery of all financial duties (subject to final audit)** • **The delivery of the CCG's efficiency programme and further work required.**	
FPC19/80	**QIPP PROGRAMME REPORTING**	
	The Director of Strategic Planning and Performance presented an update on the QIPP Programme to the Committee. It was reported that as of the 31 March the £11.5m target will be delivered, however month 12 data was not yet available to confirm the position. **The Committee were asked to:** • **Note the content of the dashboard and position against key performance indicators as at month 11.** • **Note the current position against the £11.5m target.** • **Agree the content of the dashboard for presentation to Governing Body.**	
FPC19/81	**ASSURANCE FRAMEWORK**	
	The Director of Strategic Planning and Performance presented the Assurance Framework to the Committee. **Agreed actions:** • **Check timing for updates to this committee as queried if were being updated in time for Governing Body**	**JW**

Adopted

	meetings only. **The Committee were asked:** • **Review the risks on the 2018/19 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.**	
FPC19/82	**RISK REGISTER**	
	The Director of Strategic Planning and Performance presented the Risk Register to the Committee. **Agreed Actions:** • **Check timing for updates to this committee as queried if were being updated in time for Governing Body meetings only.** **The Committee were asked to:** • **Review the Finance and Performance Committee Risk Register extract 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**
FPC19/83	**MINUTES OF THE BHNFT CONTRACT EXECUTIVE BOARD** – no minutes available	
FPC19/84	**MINUTES OF THE SWYPFT CONTRACT EXECUTIVE BOARD** – no minutes available	
FPC19/85	**MINUTES OF THE CHILDRENS EXECUTIVE COMMISSIONING GROUP HELD ON 25.2.19**	
	An in-depth discussion was had around CAMHS as the Committee felt the minutes were light touch on this service. It was reported that the IST Team were reviewing the CAMHS service at the	

Adopted

	moment and that the Chief Finance Officer and Dr J MacInnes had attended a meeting that week and identified a number of issues in terms for both commissioners and providers for this service. The contracting team were also looking at the contractual arrangements for the contract as BMBC are an associate to the CCG contract for this service. It was noted that Patrick Otway was the lead from the CCG but potentially wouldn't have capacity to deal with the actions required from the review. The Committee agreed to escalate these issues to Governing Body as assurance on the service had been given in the past on various occasions regarding the CAMHS service. This discussion also focused on other services commissioned and it was agreed a full review of specifications should be undertaken. **Agreed Actions:** • **Chief Officer, Chief Finance Officer and Patrick Otway to meet re CAMHS and capacity.** • **Discussions to be had re CCG taking lead on CAMHS as commissioner rather than BMBC.** • **Contracting Team to pull together a list of all specs and check all appropriate documents are in place.** • **Escalate to Governing Body and have a session dedicated to CAMHS with Governing Body.** **The Committee received and noted the minutes.**	**LS/RN/ PO** **RN** **RN** **ALL**
FPC19/86	**MINUTES OF THE ADULTS JOINT COMMISSIONING GROUP –** No minutes available	
FPC19/87	**MANAGEMENT TEAM DECISIONS WITH FINANCIAL IMPLICATIONS**	
	The Director of Strategic Planning and Performance presented the report the Committee. The Finance & Performance Committee is asked to note that the following decisions to commit expenditure were taken by Management Team during April 2019: • Agreed to commission an interim Lynch Syndrome pathology screening service solution (£28,946) • Approved proposal for a teledermatology pilot (£44,640 to be funded from s75 prevention monies) **The Committee received and noted the report.**	
FPC19/88	**ANY OTHER BUSINESS -** No items were raised under this heading.	
FPC19/89	**AREAS FOR ESCALATION TO GOVERNING BODY**	
	• CAMHS • Procurement Policy • Budget Approval/Financial Report	
FPC19/90	**REFLECTION ON HOW THE MEETINGS BUSINESS WAS**	

Adopted

	CONDUCTED - The meeting went well and ran to time.	
FPC19/91	**DATE AND TIME OF NEXT MEETING**	
	Thursday 6 June 2019 at 10.30 am in the Boardroom at Hillder House, 49 – 51 Gawber Road, Barnsley, S75 2PY.	

Adopted

NHS
Barnsley
Clinical Commissioning Group

Minutes of the Meeting of the Barnsley Clinical Commissioning Group AUDIT COMMITTEE held on Thursday 16 May 2019 at 9.30 am in Meeting Room 1, Hillder House, 49/51 Gawber Road, Barnsley S75 2PY

PRESENT:

Nigel Bell	Audit Committee Chair – Lay Member for Governance
Dr Adebowale Adekunle	Elected Member Governing Body
Chris Millington	Lay Member for Patient and Public Engagement and Primary Care Commissioning

IN ATTENDANCE:

Adrian Bailey	Head of Finance
Claire Croft	Counter Fraud Specialist
Leanne Hawkes	Deputy Director 360 Assurance
Rashpal Khangura	KPMG Director
Kay Morgan	Governance and Assurance Manager
Roxanna Naylor	Chief Finance Officer
Richard Walker	Head of Governance and Assurance

APOLOGIES

Kay Meats	Client Manager, 360 Assurance
Lesley Smith	Chief Officer
Salma Younis	KMPG

It was noted that the Chief Officer had sent her apologies for the meeting. The Committee Chair advised that he would invite the Chief Officer to attend a future meeting of the Audit Committee.

UNADOPTED

Ref	Agenda Item	Action	Deadline
AC 19/05/01	**QUORACY -** The meeting was declared quorate		
AC 19/05/02	**DECLARATIONS OF INTEREST, SPONSORSHIP, GIFTS AND HOSPITALITY**		
	The Committee noted the Declaration of Interests Report. The Committee Chair declared a new non-financial professional interest, as a Lay Member representing South Yorkshire & Bassetlaw organisations on the Integrated Assurance Committee of South Yorkshire &		

Ref	Agenda Item	Action	Deadline
	Bassetlaw Integrated Care System. It was noted that the new interest had been added to the CCG's Register of Interests. No other new declarations of interest were received.		
AC 19/05/03	**MINUTES OF THE PREVIOUS MEETING HELD ON 18 APRIL 2019**		
	The Minutes of the meeting held on 18 April 2019 were verified as a correct record of the proceedings subject to amendment of Page 1 second paragraph last sentence to read ' The Internal Audit Plan will be shared with the Chief Officer for her comments'		
AC 19/05/04	**MATTERS ARISING**		
	The Committee noted the Matters Arising Report.		
ITEMS FOR DISCUSSION			
AC 19/05/05	**NHS BARNSLEY CCG ANNUAL REPORT AND ACCOUNTS 2018/19**		
	The Head of Governance and Assurance and Chief Finance Officer introduced the Draft NHS Barnsley CCG Annual Report and Accounts 2018/19 to the Audit Committee. It was noted that the Audit Committee had previously reviewed the Annual Report and Accounts in detail on 18 April 2019. It was clarified that all minor amendments proposed by the Committee had been made and recorded in the change log. As requested by NHSE the annual report had also been updated to include additional detail relating to the outcome from the Conflicts of Interest review and to reflect superficial changes in the NHSE's template report. The Audit Committee noted the assurance provided of all changes made to the Annual Report and Accounts. The ask of the Audit Committee is to recommend to the Governing Body that it approves and adopts the Annual Report and Accounts 2018/19 (subject to any final necessary amendments agreed at the meeting) .		
	5.1 **Draft CCG Annual Report – Performance & Accountability Report**		

UNADOPTED

Ref	Agenda Item		Action	Deadline
		The Audit Committee reviewed and noted the changes made to the Annual Report, Performance and Accountability Reports, including updated data relating to staff sickness absence.		
	5.2	**Final Accounts 2018-19**		
		The Committee received and considered the CCG's Final Accounts 2018/19 and noted the amendments post submission to the auditors as follows: - Page 8 Notes to Financial Statements, inserted Accounting Policy on 'Provisions' paragraph section 1.19.		
	5.3	**Head of Internal Audit Opinion & Annual Report**		
		The Deputy Director 360 Assurance presented the 2018/19 Internal Audit Annual Report and Head of Internal Audit Opinion to the Audit Committee. The Committee noted the overall opinion of 'significant assurance', providing assurance `that a sound framework of governance, risk management and control is in place to meet the organisation's objectives.		
	5.4	**Annual Report Local Counter Fraud Specialist**		
		The Counter Fraud Specialist introduced the 2018/19 Counter Fraud, Bribery and Corruption Annual Report to the Committee. The Committee noted the overall rating of green in the Chief Officer's declaration in respect of the work carried out during 2019/20 and self-assessment against the NHSCFA's Fraud, Bribery and Corruption Standards for Commissioners. Members' attention was drawn to Appendix A of the report 'SRT Process Summary', section 1.4 relating to risk assessments and management of fraud, bribery and corruption risks, which had been rated as amber. This was due to national changes to the standard rating criteria. The Counter Fraud Specialist confirmed that the CCG was not an outlier with regard to this standard. The Committee expressed concern that standards had changed late in the year with no particular advanced notice.		

UNADOPTED

Ref	Agenda Item		Action	Deadline
		In response to a question raised, it was clarified that additional days spent on investigations were justified and had been paid for. ***Agreed action*** ***To feed back the comments of the Audit Committee to the Local Counter Fraud Authority. In respect the timing and notification of changes in standards.***	**CC**	**31.10.19**
	5.5	**Annual Governance Report from External Auditors KPMG (ISA 260)**		
		The KPMG Director presented the External Audit Report 2018/19 to the Audit Committee. The KPMG Director confirmed that it was their intention to issue an unqualified ('clean') opinion on the Annual Report and Accounts following their approval and adoption by the Governing Body on 23 May 2019. The KMPG Director reported that the audit had been supported and complemented by a good standard of documents provided by the Finance Team. The Finance Team were thanked for their responsiveness to the KPMG Audit Team. The KMPG Director commended the Audit Committee for their 'page turner' meeting of the draft Annual Report and Accounts and this was highlighted as good practice. The Audit Committee also expressed their appreciation to all involved with the CCG's Annual Report and Accounts. The Committee noted that information relating to BREXIT within the Annual Governance Report was judged to be sufficient and no further disclosure was required. ***Agreed Action:*** ***To convey the appreciation of the Audit Committee to the Finance Team, Head of Governance and Assurance and the Head of Communications and Engagement for their excellent work on the CCG's Annual Report and Final Accounts 2018/19.***	**NB**	**31.05.19**

UNADOPTED

Ref	Agenda Item		Action	Deadline
	5.6	**Management Representation Letter**		
		The Committee noted the Management Representation Letter.		
	5.7	**Third Party Assurances - Service Auditor Reports**		
		The Committee noted the Third Party Assurances Received 2018/19.		
	The Audit Committee: • **Reviewed the amended Annual Report and Accounts 2018/19** • **Received the final Head of Internal Audit Opinion** • **Receive the final Annual Report of the Local Counter Fraud Specialist** • **Received and considered the ISA260 External Auditor's Report 2018/19** • **Reviewed the Management Representation Letter** • **Received the summary of Third Party Assurances appended to this report** • **On the basis of the above recommended to the Governing Body that it approves and adopts the Annual Report and Accounts 2018/19.**			
AC 19/05/06	**ANY OTHER BUSINESS**			
	6.1	**Audit Committee Training**		
		The KPMG Director offered an opportunity to provide Audit Committee members with a free one hour workshop, 'How to deal with adjustment errors'. The Committee agreed that the workshop would be beneficial. ***Agreed action*** • ***To determine and arrange a date for the workshop either 31 October 2019 or January 2020 and confirm with the KPMG Director.*** • ***Deputy Director 360 Assurance agreed to ascertain if the Client Manager, 360 Assurance would like to attend the workshop.***	**NB/RW/KMo** **LH/KMe**	**31.10.19** **31.10.19**

UNADOPTED

Ref	Agenda Item	Action	Deadline
AC 19/05/07	**DATE AND TIME OF NEXT MEETING**		
	The next meeting of the Audit Committee will be held on Thursday 31 October 2019 at 1.30 am, in Meeting Room 1, Hillder House, 49/51 Gawber Road, Barnsley, S75 2PY.		

UNADOPTED

NHS
Barnsley
Clinical Commissioning Group

Minutes of the NHS Barnsley Clinical Commissioning Group
QUALITY & PATIENT SAFETY COMMITTEE
Thursday 25 April 2019, 13:00pm-15:00pm
Boardroom, Hillder House

PRESENT:

Dr Sudhagar Krishnasamy	-	Associate Medical Director (Acting Chair)
Martine Tune	-	Chief Nurse (Acting)
Chris Millington	-	Lay Governing Body Member for Public and Patient Engagement
Mike Simms	-	Governing Body Secondary Care Doctor
Dr Mark Smith	-	SWYPFT Contracting Lead from the Governing Body
Chris Lawson	-	Head of Medicines Optimisation
Dr Ibrar Ali	-	Membership Council Representative

IN ATTENDANCE:

Terry Hague	-	Primary Care Transformation Manager
Hilary Fitzgerald		Quality Manager
Jill Auty	-	Quality Administration Officer (minutes)
Paige Dawson	-	Risk, Governance and Assurance Facilitator

APOLOGIES:

Julie Frampton	-	Senior Primary Care Commissioning/Contracting Manager
Dr Shahriar Sepehri		Membership Council Representative
Richard Walker	-	Head of Governance and Assurance

Agenda Item	Note	Action	Deadline
Q&PSC 25/04/01	**APOLOGIES & QUORACY**		
	Apologies were noted as above. The meeting was declared quorate.		
Q&PSC 25/04/02	**PATIENT STORY**		
	The Chief Nurse (Acting) apologised for the absence of a patient story at this meeting. The Chief Nurse (Acting) agreed to present a patient story to the next meeting.		

Adopted

Agenda Item	Note	Action	Deadline
	Agreed action: **The Chief Nurse (Acting) agreed to present a patient story to the next meeting.**	**MT**	**June 2019**
Q&PSC 25/04/03	**DECLARATIONS OF INTEREST RELEVANT TO THE AGENDA**		
	No declarations of interest relevant to the agenda were declared.		
Q&PSC 25/04/04	**MINUTES OF THE PREVIOUS MEETING - 21/02/2019**		
	The minutes from the meeting on 21 February 2019 were approved as an accurate record. The Chief Nurse (Acting) reminded the committee members that any comments in relation to the minutes should be emailed to the Quality Administrator prior to the meeting commencing to enable any inaccuracies to then be noted at the meeting.		
Q&PSC 25/04/05	**MATTERS ARISING REPORT**		
	The Acting Committee Chair confirmed that all items were complete apart from the following: **<u>11/10/15</u> – Clinical Quality Board (CQB) meetings** - It was agreed for the Q&PSC Chair to liaise with Nick Balac, BCCG Chair, to discuss attendance of GP membership at the Clinical Quality Boards. <u>13/12/18</u> – It was confirmed that the frequency of CQB meetings going forward will be quarterly subject to approval from the Governing Body. It was agreed that the Chair will take this forward with the BCCG Chair. No update had been received from the Associate Medical Director. The Chief Nurse (Acting) asked Committee members if they had any concerns about the CQB meetings being held quarterly. No concerns were raised. <u>25/04/19</u> – The Acting Chair confirmed the membership for SWYPFT Clinical Quality Board will be Dr Mark Smith and Dr John Harban will represent the BHNFT Clinical Quality Board. It was agreed the Chief Nurse (Acting) would pick this up outside of the meeting take to the May2019 Governing Body Committee		

Adopted

Agenda Item	Note	Action	Deadline
	meeting for approval. **<u>21/02/04</u> –Briefing paper on mental health workstreams** <u>25/04/19</u> –The Chief Nurse (Acting) informed the Committee that the briefing paper on mental health workstreams had not been completed. A discussion will be held with the CCG's Head of Commissioning, Mental Health and Specialised Services about what information is appropriate to present to Q&PSC on mental health workstreams, given that a range of papers about these have already been circulated to the CCG's Governing Body. The Chief Nurse (Acting) will then decide whether separate information on these workstreams needs to come to Q&PSC. **<u>21/02/07</u> – Concerns regarding low rate of A&E Friends and Family at BNHFT CQB.** The Chief Nurse (Acting) that this was discussed at a recent meeting, but highlighted to the Committee that there is ongoing work nationally to establish how best to obtain FFT feedback particularly within an A&E environment. It was agreed to defer this item to the next meeting. **<u>21/02/04</u> – Notify Barnsley Chronicle regarding positive CQC inspections.** <u>25/04/04</u> – The Transformation Manager informed the members that a discussion has taken place with the Communication Team. A process is being put in place to contact the practice and the Chronicle when a positive inspection report is published. It was agreed that this action could be closed. **<u>21/02/14&15</u> – Medicines Management Report -** It was noted that the Head of Medicines Management Optimisation and the Lay Member for Public & Patient Engagement & Chair of Primary Care Commissioning had not met. It was agreed that they would hold a discussion outside of this meeting.	**MT** **MT** **MT**	**May 2019** **June 2019** **June 2019**
QUALITY AND GOVERNANCE			
Q&PSC 25/04/06	**RISK REGISTER & ASSURANCE FRAMEWORK (STANDING ITEM)**		
	The Risk, Governance and Assurance Facilitator presented for assurance the relevant extract from the CCG's Assurance Framework and Risk Register and asked the Committee to review the documents for		

Adopted

Agenda Item	Note	Action	Deadline
	completeness and accuracy and identify any new risks for inclusion on the Risk Register. In relation to the risk relating to D1s the Head of Medicines Optimisation briefed the meeting in detail on the ongoing work to address the concerns around D1s. The final audit report has not been published however provisional data indicates that there has been some improvement. The Head of Optimisation has chased up the report and asked for an action plan to be supplied with it. There followed a lengthy discussion about the new electronic D1 form that the Trust has devised, and where it should be reviewed within the CCG. In relation to medicines information, the new draft form complies fully with the national recommendations for what should be included in a D1. However, the whole form does not comply with the national dataset and therefore contractually the form does not meet recommended standards. It was agreed the new D1 form should be presented at the Clinical Forum first for an initial review before it goes to the Membership Council. The D1 audit report should be presented at Quality and Patient Safety Committee. In relation to the proposed risk relating to Thames Valley Ambulance Service, the Committee agreed and approved the addition of the above to the risk register.		
	Actions agreed: **The new D1 form should be presented at the Clinical Forum first for an initial review before it goes to the Membership Council. The D1 audit report should be presented at Quality and Patient Safety Committee.** **The Head of Optimisation to prepare a briefing paper for Q&PSC on the progress of new D1 form.** **D1s to be added to the next BHNFT CQB agenda.** **The risk relating to Thames Valley Ambulance Service to be added to the risk register.**	**CL** **CL** **JA** **PD**	**June 2019** **June 2019** **June 2019** **June 2019**

Agreed

Agenda Item	Note	Action	Deadline
Q&PSC 25/04/07	**MONTHLY QUALITY METRICS REPORT – (STANDING ITEM)**		
	The Chief Nurse (Acting) presented the Quality Metrics report which for this meeting focused on safeguarding. The following points were highlighted: **<u>Safeguarding</u>** • The Barnsley CCG Safeguarding People Policy has been ratified by the CCG's Governing Body. • There have been changes to the format of the GP Safeguarding forums which are working better as a result. • Safeguarding Children Working Together 2018 Policy identifies that the CCG is equally accountable for safeguarding children as colleagues in Social Services and the Police. • There have been changes to the processes for the Child Death Overview Panel. In addition, there will be a South Yorkshire Panel to increase opportunities for learning by pulling together learning from across a bigger footprint. It was confirmed that learning from child death reviews is disseminated via the CCG's safeguarding leads. The Acting Chair asked if the learning could be shared at BEST. • The Child Sexual Exploitation (CSE) sub group has widened its remit to include all forms of exploitation. • Audits have been completed via the Safeguarding Adults Board on the quality of referrals to the Board. These found that overall the quality of referrals is good, with only minor learning. • 1 risk to the CCG's Safeguarding Adults system in relation to Basic Prevent Awareness training (Level 1) for CCG Staff. Only 78% of staff are complaint versus a target of 90%. Action is being taken to address this. • Compliance with Level 2 Safeguarding Adults training is good at 92%. There followed a discussion about how safeguarding intelligence is received by the CCG. The Chief Nurse (Acting) reassured members that due to the CCG having very close links with other services,		

Adopted

Agenda Item	Note	Action	Deadline
	intelligence sharing is well developed. Members were invited to attend safeguarding meetings if they wished so that they could find out first-hand the good work that is being carried out. **<u>Serious Incidents</u>** The low level of serious incidents reported on StEIS by SWYPFT was raised. The Committee discussed potential reasons for this, and whether the revised reporting criteria for Grade 3 pressure ulcers was one of the reasons. It was also agreed that it would be useful to know if another of SWYPFT's commissioners had also experienced a similar drop in StEIS reported serious incidents. The Committee was assured in relation to this section of the report The Primary Care Transformation Manager then presented the Primary Care section of the Quality Metrics report. It was highlighted that: • Four practices have received ratings of "Good" across all domains in recent CQC visits and these reports have now been published. The members were advised that the CQC have recently introduced an Annual Review process which takes place via telephone followed by a follow-up face to face visit if the practice has not been inspected in the last 5 years. Feedback from a practice that has recently taken part in the new Annual Review process has been positive with the practice acknowledging a feeling of support. The Lay member for Public & Patient Engagement & Chair of Primary Care Commissioning Committee asked for reassurance that Dodworth Medical Practice would be ready for re-inspection. The members were informed that a member of the Primary Care team had been working closely with the practice to ensure that the action plan is being completed and the practice feel ready for re-inspection. The committee were given assurance on this concern. • Special Allocation System – A concern had been raised about the Scheme that was in relation to one specific patient. This person		

Agreed

Agenda Item	Note	Action	Deadline
	involved had now met with the provider of the scheme and a set of behavioural standards has been agreed. • e-Declaration – All practices have submitted reports and analysis of the data is ongoing. **YAS Update** The Chief Nurse (Acting) advised there was no further update on YAS.		
	Actions agreed: • **The Quality Administrator to ensure the Acting Chair's contact details are listed correctly on the Safeguarding Adults mailing list** • **Dialogue to take place with Huddersfield CCG to establish if a drop in StEIS reporting has also been identified.** • **The Quality Manager to compare the numbers of Grade 3 Pressure Ulcers reported on StEIS in 2018/19 compared with the previous 2 years.**	**JA** **HF** **HF**	**May 2019** **June 2019** **June 2019**
Q&PSC 25/04/08	**PREVENT POLICY**		
	The Chief Nurse (Acting) presented the revised policy for approval. The Policy has been updated to comply with the requirements of the Barnsley CCG Policy on Policies and updated national guidance. The Committee approved the Policy and was informed that it does not need to be presented at the Governing Body for ratification, due to the minor nature of the changes.		
Q&PSC 25/04/09	**SY&B QUALITY SURVEILLANCE GROUP – UPDATE – 20/03/19**		
	The Chief Nurse (Acting) gave a verbal update from the SY&B Quality Surveillance Group meeting held on 20 March2019, highlighting the following discussions at the meeting: • Restrictive practice and what this entails, as part of a programme of work that NHSE are leading so that there is a clearer understanding		

Adopted

Agenda Item	Note	Action	Deadline
	of what restrictive practices are. • Quality of practice around all elements of health care acquired infections. • 12 Hour Trolley Breach – 1 breach occurred in in Barnsley in March 2019 that related to a patient who required ventilation but there were no beds available in Intensive Care Unit. Therefore it was deemed clinically appropriate to keep the patient in resus.		
Q&PSC 25/04/10	**QUALITY IMPACT ASSESSMENT (QIA) FOR THE UPDATE TO THE SYB COMMISSIONING FOR OUTCOMES POLICY**		
	By way of background, the Lead Commissioning and Transformation Manager informed Q&PSC that commissioners across South Yorkshire have updated the SYB Commissioning for Outcomes Policy to incorporate the national statutory guidance on evidence based interventions. The Policy came into force on 1 April 2019, having been presented to the CCG's Governing Body on 14 March 2019. As a consequence of this, the Quality Impact Assessment has been updated. Members were asked to provide some additional input on the document and to contribute to the assessment particularly around a clinician's ability to communicate the Policy by supportive and sensitive dialogue. The biggest risk to the Policy is the perceived patient experience of the Policy, and therefore, clinicians play a large part in mitigating this risk. There followed a detailed discussion about the document. The Practice Member Representative Contracting Lead from the Governing Body gave the view that the patient experience is influenced by the conversation the clinician has with the patient around the policy guidelines at the outset of diagnosis rather than a referral which is then rejected. It was also noted that the Quality Manager has been working with members of the CCG and the Trust to improve letters sent to patients who have not been referred correctly under the Policy. These are expected to be completed by the end of May 2019. The members were also advised that the CCG website will also be updated with the new guidelines		

Approved

Agenda Item	Note	Action	Deadline
	for patients to read. The committee asked the Lead Commissioning and Transformation Manager to present a brief paper at Membership Council before the QIA is formally signed off.		
	Action agreed: **The Lead Commissioning and Transformation Manager to present a brief paper at Membership Council before the QIA is formally signed off.**	**DL**	**June 2019**
Q&PSC 25/04/11	**Q&PSC WORKPLAN/AGENDA TIMETABLE 2019/20**		
	The Quality Manager presented the Q&PSC Workplan/Agenda Timetable for 2019/20 for approval. A number of changes have been made to the existing workplan as highlighted below: • Clinical Staffing moved from Regular reporting to Adhoc • Inclusion of Healthcare Safety Investigation Branch Updates/Reports, Prevention of Future Deaths and Intelligence Sharing Meeting • Removal of Action Notes from Health of Children in Care and Care Group and Out of Hours Contract Meeting as these are reviewed in other committee meetings The committee approved the updated Q&PSC Workplan/Agenda Timetable for 2019/20 subject to the following changes: • The Primary Care Transformation Manager to confirm that the Out of Hours Contract Meeting is picked up at the Primary Care Commissioning Committee meetings. • The wording for National Institute of Clinical Excellence (NICE) Technology Appraisals, clinical guidelines and Quality Standards compliance to include (Excluding Medicines).		

Approved

Agenda Item	Note	Action	Deadline
	Agreed actions: **The Primary Care Transformation Manager to confirm that the Out of Hours Contract Meeting is picked up at the Primary Care Commissioning Committee meetings.** **Change to wording – National Institute of Clinical Excellence (NICE) Technology Appraisals, clinical guidelines and Quality Standards compliance (Excluding Medicines)**	**TH** **HF**	**June 2019** **June 2019**
Q&PSC 25/04/12	**QUALITY ASSURANCE VISIT – NEURO REHABILITATION UNIT**		
	The Chief Nurse (Acting) gave a verbal update about the outcome of a recent quality assurance visit to the Neuro-Rehabilitation Unit. Members were informed that this was a very positive visit with the full report to follow shortly. The key points for the CCG to maintain a watching brief on are as follows: • Low number of incidents reported • Staffing mix was diluted • Rehabilitation services have been extended to 7 days a week, but there has been no increase in staff, which has created some challenges. • The Unit is using SystmOne, but some training needs were identified as staff are not using all the functionality of the system. The positives from the visit were: • Very clean wards and additional staff on wards for the visit. • Positive feedback from staff, patients and relatives, with a patient commenting “Glad to be there”. • The Unit’s outcome measures are better than the National Average.		
COMMITTEE REPORTS AND MINUTES GENERAL			
Q&PSC 25/04/13	**MINUTES OF THE 6 FEBRUARY 2019 AREA PRESCRIBING COMMITTEE**		
	Q&PSC received the minutes for information. The Head of Medicines Optimisation highlighted two items to the committee: • Lithium Shared Care Monitoring Audit provided assurance that shared care agreements are in		

Agreed

Agenda Item	Note	Action	Deadline
	place and monitoring was being undertaken. More work needs to be done on out of area patients. • Out of stock issues continue.		
Q&PSC 25/04/14	**MINUTES OF THE 07 FEBRUARY 2019 AND 06 MARCH 2019 PRIMARY CARE QUALITY & COST EFFECTIVE PRESCRIBING GROUP MEETING**		
	Q&PSC received the minutes for information. No queries were raised by the committee members.		
Q&PSC 25/04/15	**CLINICAL QUALITY BOARDS:** • **Adopted SWYPFT minutes – 28 Nov 2018** • **Adopted BHNFT CQB – 06 Dec 2018**		
	Q&PSC received the minutes for information. No queries were raised by the committee members.		
GENERAL			
Q&PSC 25/04/16	**Any Other Business**		
	The Head of Medicines Optimisation advised that through the Area Prescribing Committee it has been raised that there has been an increase in the number of incidents relating to monitored dosage systems. A Task and Finish group has been set up to monitor and investigate ways of working to improve this.		
Q&PSC 25/04/17	**AREAS FOR ESCALATION TO THE GOVERNING BODY AND ITEMS TO BE COVERED IN HIGHLIGHT REPORT**		
	It was agreed the quality highlights to Governing Body should include: • Performance of Thames Ambulance Service Ltd - Red • PREVENT Training Compliance - Amber • Positive CQC inspection reports for Hollygreen Practice, Ashville Medical Practice, Kingswell Surgery and Victoria Medical Centre – Green • Updated PREVENT Policy – Green • Outcome of Safeguarding Audit – Green • Safeguarding Training Compliance - Green	**HF**	**April2019**

Agreed

Agenda Item	Note	Action	Deadline
Q&PSC 25/04/18	**REFLECTION ON HOW WELL THE MEETING'S BUSINESS HAS BEEN CONDUCTED:** • **CONDUCT OF MEETING** • **ANY AREAS FOR ADDITIONAL ASSURANCE** • **ANY TRAINING NEEDS IDENTIFIED**		
	There were no items to raise		
Q&PSC 25/04/19	**DATE AND TIME OF NEXT MEETING** Thursday 20 June 2019 at 1pm in the Boardroom, Hillder House, 49-51 Gawber Road, Barnsley, S75 2PY		

Adopted

NHS
Barnsley
Clinical Commissioning Group

Minutes of the meeting of the Membership Council held on Tuesday 21 May 2019 at 7.00 pm at Hillder House, 49/51, Gawber Road, Barnsley, S75 2PY

PRESENT

Dr Nick Balac	Chair & Practice Representative (St Georges Medical Practice)
Dr Adebowale Adekunle	Practice Representative (Wombwell Chapelfield Medical Centre
Dr Amjed Ali	Practice Representative (Woodland Drive Medical Centre)
Dr John Harban	Practice Representative (Lundwood Medical Centre and The Kakoty Practice)
Dr M Hussain Kadarsha	Practice Representative (Hollygreen Practice)
Dr Jamie MacInnes	Practice Representative (Dove Valley Practice)
Dr Sepehri	Practice Representative (Hillbrow Surgery Mapplewell)
Dr Mark Smith	Practice Representative (Victoria Medical Centre PMS Practice)
Dr Stuart Vas	Practice Representative (Penistone Group Practice)

IN ATTENDANCE

Chris Millington	Lay Member for Patient and Public Engagement & Primary Care Commissioning
Kay Morgan	Governance & Assurance Manager
Lesley Smith	Chief Officer
Richard Walker	Head of Governance and Assurance

APOLOGIES

Dr Eddy Czepulkowski	Practice Representative (High Street Royston)
Dr Mehrban Ghani	Practice Representative: The Rose Tree PMS Practice BHF Brierley Medical Centre BHF Goldthorpe Surgery BHF Apollo Court BHF Highgate Surgery BHF Lundwood Practice
Dr Gareth Kay	Practice Representative (Huddersfield Road)
Dr Sudhagar Krishnasamy	Practice Representative (Royston Group Surgery)
Dr J Maters	Pratice Representative Grimethorpe Surgery
Dr Andy Mills	Practice Representative (Ashville Medical Centre)
Mike Simms	Governing Body Secondary Care Clinician
Dr Heather Smith	Practice Representative (Dr Mellor and Partners PMS Practice)

UNADOPTED

NHS
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Clinical Commissioning Group

Agenda Item	Note	Action	Deadline
MC 19/05/01	**QUORACY**		
	The meeting was not quorate.		
MC 19/05/02	**DECLARATION OF INTERESTS INCLUDING SPONSORSHIP & HOSPITALITY**		
	The Membership Council noted the Declarations of Interests Report. No new declarations were received.		
MC 19/05/03	**MINUTES OF THE MEETING HELD ON 19 MARCH 2018**		
	The minutes of the Membership Council meeting held on 19 March 2019 were verified as a correct record of the proceedings.		
MC 19/05/04	**MATTERS ARISING**		
	The Membership Council considered the Matters Arising Report and the following main points were noted. **Minute reference MC 18/11/06 & 19/01/04 – Shared Care (specialist) Drug Management Services.** Membership Council were informed that a letter had been sent from the Head of Medicines Optimisation to all Practices to request comments about the scope for a review of the Primary Care Shared Care (Specialist Drugs) Service Members were informed that an update on the following two actions will be reported to the next meeting of the Membership Council on 17 September 2019: • **Minute reference MC 18/05/07 - Gender Dysphoria Prescribing** • **Minute reference MC 18/11/07 - 2019/20 PDA, (Triptorelin & Testosterone)** .		
MC 19/05/05	**PRIMARY CARE NETWORK(S) UPDATE**		
	The Chairman provided Membership Council with an update on Primary Care Networks (PCNs). To the best of his knowledge, all Practices and 6 Localities had signed up to option 1, a supra network hosted by the Barnsley		

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Agenda Item	Note	Action	Deadline
	Healthcare Federation underpinned by six locality networks. The preferred option had been submitted to the ICS on 15 May 2019, and will be considered by the Primary Care Commissioning Committee on 30 May 2019, following which the required paperwork will be submitted to NHS England. Membership Council noted that feedback is currently awaited from the ICS and further national PCN guidance is expected. Members were informed that negotiations are currently ongoing around the local nominated clinical directors and the supra network's Accountable Clinical Director.		
	Discussion took place and in response to questions raised it was clarified that: • The Accountable Clinical Director will be part of the ICS Partnership Board. The ICS and PCNs will work closely together. • Legal advice around the formation and establishment of PCNs will be sought as and when required. • The Barnsley PCNs will be groups of 30 to 50,000 with enabling support from the CCG. • Each locality PCN will hold its constituent Practices to account for delivery. • Defence Unions will advise on indemnity in respect of PCNs and GPs looking after patients from other Practices.		
	The Membership Council noted the update on Primary Care Networks (PCNs).		
MC 19/05/06	**TELE DERMATOLOGY PILOT**		
	Dr Adekunle (Clinical Lead for Dermatology) introduced a report to Membership Council regarding a Primary Care Teledermatology Pathway Pilot. Membership Council considered the pilot and provided the following suggestions and comments.		
	Dr Harban queried the costs of the equipment and suggested that one set of the required equipment be available in each network. In response to questions raised it was clarified that the equipment consisted of two devices, one dermascope connected to a desk top (with software)		

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Agenda Item	Note	Action	Deadline
	and a modified iPhone with derma scope attached and appropriate app. The app will encrypt a digital image and send to an external database (image deleted once sent) which Practices can access. It was highlighted that Practices will need information re installation of equipment and training in how to use the equipment. Training to use the equipment can be provided to either a GP, Practice Nurse of Healthcare Assistant. In response to a question raised Dr Adekunle advised that the equipment will probably not be available at branch surgeries It was noted that the response from Dermatologist to the referrer will be via a desk top computer and this will need to be saved.		
	Dr Vas and Dr Sepheri expressed an interest in joining the pilot. Dr Vas suggested that it may be sensible for one Practice to trial the equipment in the first instance before rolling out to other Practices.		
	The Chairman concluded discussion indicating that the pilot will inform a permanent solution for Tele Dermatology. Membership Council had provided rich and important feedback to consider in terms of the pilot.		
	The Membership Council noted the report. The Chairman and Dr Adekunle agreed to review the proposal for the tele Dermatology Pilot taking account the comments received from Membership Council.		
MC 19/05/07	**NHS BARNSLEY CCG ANNUAL 360 STAKEHOLDER SURVEY**		
	The Head of Governance and Assurance provided the Membership Council with the results of the 360 Stakeholder Survey 2018-19. The results of the survey had been shared with contributors and included on the CCG's website. Membership Council noted the positive survey results for the CCG. It was noted that a composite 360 Stakeholder Survey Report had been produced for South Yorkshire and Bassetlaw. Rotherham CCG had been highlighted as a leading edge CCG and also		

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NHS Barnsley Clinical Commissioning Group

Agenda Item	Note	Action	Deadline
	acclaimed as a national exemplar CCG.		
	The Membership Council noted the 360 Stakeholder Survey Report.		
MC 19/05/08	**FUTURE SEXUAL HEALTH SERVICES 1920/21**		
	The Chairman introduced a report to the Membership Council regarding Sexual Health Services in Barnsley. It was noted that the Local Authority are proposing to undertake a competitive procurement process for sexual health services during 2019 and wished to ensure that Barnsley CCG, its Practices and NHSE inform and shape the offer to patients to collectively maximise positive sexual health and contraception outcomes. Members were advised that Dr Mark Smith and Dr Jamie MacInnes will represent the CCG regarding the procurement of sexual health services.		
	Membership Council provided the following comments in respect of the procurement. • The provider of the Sexual Health Services should deliver professional training and development for Primary Care. • Sexual health services must be accessible across Barnsley with local accessibility and availability of evening appointments.		
	The Governing Body noted the Report. **Agreed Action:** **To include the procurement of Sexual Health Services in the Membership Council Briefing and invite comments from member Practices.**	**KM**	**17.09.19**
MC 19/05/09	**ANY OTHER BUSINESS**		
	09.1 Terms of Office Dr Adebowle Adekunle		
	It was noted that Dr Adekunle had an interest in this item and he did not participate in the discussion. The Head of Governance and Assurance informed the Membership Council that Dr Adekunle's initial term of office was due to expire on 17 July 2019. The		

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Agenda Item	Note		Action	Deadline
		terms of office for a number of other Governing Body GP members ends on 31 March 2020. It would be sensible therefore to align the terms of office for GP Governing Body members to 31 March 2020 and hold one election to be concluded before April 2020. The Membership Council were therefore asked to extend Dr Adekunle's term of office until 31 March 2020. All members present at the meeting agreed to the proposal and for this decision to be ratified at the next meeting of the Membership Council on 17 July 2019.		
	09.2	**DNAR - End of Life**		
		Dr Harban referred to DNARs for patients on end of life care and queried why community and Macmillan Nurses will not sign the DNAR but request a GP to do so. Another example was provided of where a community nurse did not want to directly admit patients but rather requested a GP to admit the patient. The Chairman advised that these kinds of issues and service anomalies were the first pieces of work for the new PCNs to tackle and enable efficient working across the system.		
MC 19/05/10	**MEMBERSHIP COUNCIL BRIEFING**			
	It was agreed that the following items would be included in the Membership Council Briefing: • Primary Care Networks • To invite comments of the Procurement of Sexual Health Services.			
MC 19/05/11	**REFLECTION OF HOW WELL THE MEETING'S BUSINESS HAD BEEN CONDUCTED**			
	The business of the meeting had been well conducted.			
MC 19/05/12	**DATE AND TIME OF NEXT MEETING**			

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Agenda Item	Note	Action	Deadline
	The next meeting of the Membership Council will be held on Tuesday 16 July 2019 at 7.00 pm in the Boardroom Hillder House, 49/51 Gawber Road, Barnsley S75 2PY.		

UNADOPTED

NHS
Barnsley
Clinical Commissioning Group

GOVERNING BODY PUBLIC

11 July 2019

PRIMARY CARE COMMISSIONING COMMITTEE HIGHLIGHTS REPORT

PART 1A – SUMMARY REPORT

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

	Name	*Designation*
Lay member Lead	C Millington	Lay Member
Author	J Frampton	Senior Primary Care Commissioning Manager

3. EXECUTIVE SUMMARY

This report provides the July Governing Body with the agreed highlights from the public Primary Care Commissioning Committee held on 30th May 2019.

It was agreed at the meeting that the following would be highlighted:

- CQC reports for the following practices
  - Ashville Practice – Good across all domains
  - Goldthorpe Medical Practice – Good across all domains
  - Victoria Medical Centre – Good overall with requires improvement in 1 domain which the primary care team are supporting

Letters have been sent to the practices to congratulate all staff and to thank them for the continued efforts to provide high quality services for their patients.

The Working Win Health Employment Trial update was presented by colleagues from BMBC and the trial team to PCCC members.

- The Working Win initiative was presented to PCCC members in response to a request from the Chief Officer.
- Barnsley has signed up to this trial and GPs are referring people to this service.
- Working Win had embedded well in Barnsley with colleagues working closely with clinical partners at SWYPFT Mental Health Access Team, BMBC, GP Practices, the Voluntary and Community sectors.

	• Across SYB more than 3,250 people have signed up to the trial with 531 people achieving employment. In Barnsley the numbers are 410 people signed up of which 62 have achieved employment. • The evaluation of the trial requires a minimum of 6,000 participants across SYB. This means a further 2,800 participants across SYB would need to be recruited of which 737 participants were required from Barnsley before referrals closed at the end of October 2019. There are a number of actions identified by the PCCC members which are underway to promote the uptake of this service.
4.	**APPENDICES**
	Appendix 1 – Adopted Minutes of the Primary Care Commissioning Committee held on 28 March 2019.
4.	**THE GOVERNING BODY / COMMITTEE IS ASKED TO:**
	Note the highlights identified

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
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*

NHS Barnsley Clinical Commissioning Group

Minutes of the PUBLIC Primary Care Commissioning Committee meeting held on Thursday, 28 March 2019 at 2.30pm in the Boardroom Hillder House, 49–51 Gawber Road S75 2PY

MEMBERS PRESENT:

Chris Millington (*Chair*)	Lay Member for Patient & Public Engagement and Primary Care Commissioning
Nigel Bell	Lay Member for Governance
Mike Simms	Secondary Care Clinician
Lesley Smith	Chief Officer
Richard Walker	Head of Assurance & Governance

GP CLINICAL ADVISORS

Dr Sudhagar Krishnasamy	Associate Medical Director
Dr Mark Smith	Governing Body Member

IN ATTENDANCE:

Julie Frampton	Senior Primary Care Commissioning Manager
Angela Musgrave	Executive Personal Assistant
Ruth Simms	Assistant Finance Manager
Julia Burrows	Director of Public Health, BMBC
Victoria Lindon	Assistant Head of Primary Care Co-Commissioning, NHSE

APOLOGIES:

Jackie Holdich	Head of Delivery, Integrated Primary & Out of Hospital Care
Roxanna Naylor	Chief Finance Officer
Sarah Tyler	Lay Member for Accountable Care
Dr Nick Balac	CCG Chairman
Lee Eddell	Commissioning Manager, NHSE

MEMBERS OF THE PUBLIC:

Agenda Item	Note	Action	Deadline
PCCC 19/03/01	**APOLOGIES**		
	The Chair welcomed members to the meeting and apologies were noted as above.		
PCCC 19/03/02	**QUORACY**		
	The meeting was declared quorate.		
PCCC 19/03/03	**DECLARATIONS OF INTEREST RELEVANT TO THE AGENDA**		
	There were no declarations of interest relevant to the agenda.		

ADOPTED

PCCC 19/03/04	**MINUTES OF THE LAST MEETING**		
	The minutes of the meeting held on 31 January 2019 were verified as a correct record of proceedings.		
PCCC 19/03/05	**MATTERS ARISING REPORT**		
	The Committee noted the matters arising report. All actions were complete.		
STRATEGY, PLANNING, NEEDS ASSESSMENT AND CO-ORDINATION OF PRIMARY CARE			
PCCC 19/03/06	**PRIMARY CARE NETWORKS UPDATE** The Chief Officer provided members with a verbal update regarding the work taking place with GP practices in line with the new GP Contract and the establishment of Primary Care Networks (PCN). On the 13 of February 2019 Barnsley GP practices attended a workshop with wider system partners across the Borough where, in collective discussions, consideration was given to have one supra-network across Barnsley, underpinned by 6 locality teams. Following a request from attendees at the workshop to explore this suggestion further, better understand what this might look like and understand the benefits it might offer, the CCG had since shared a paper with practices on how this might work, to help inform their local discussions. Attendees also considered what the new network contract offered (investment in new roles), what the deliverables would be (national service specifications), as well as the risks and opportunities. It was noted that to be eligible for a Network Contract, a PCN would need to submit a completed registration form to the CCG by no later than 15 May 2019. Over the next 5 years significant additional funding would flow through the network DES, half of which would be for new and additional roles to support practices address workload issues. The additional workforce would support the delivery of seven service specifications that were clinical areas for improvement rather than entirely new areas of work which the PCN would be accountable for.		

ADOPTED

	The Associate Medical Director informed the meeting that following an Extraordinary LMC meeting held on 27 March to discuss potential PCN configurations with GP practices, a Network agreement was negotiated which would be shared with practices by Friday, 29 March. It was also noted that GP practices felt more comfortable working within the original six localities with an over-arching supra-network and, that both partner organisations and GP practices did not want to disturb the good working relationships already established through the locality model. A number of issues which would require further discussions had been raised at the LMC meeting on 27 March including how practices would agree to work with each other to divide responsibilities, resources and accountability particularly with extended hours. A further concern was how to ensure preservation of the existing workforce. In response to a question from the Director of Public Health regarding how the funding would be drawn down and shared across the six localities, the Chief Officer advised that the CCG would forward a copy of the paper that had been developed and shared with practices which explained the complexities and gave context.	**LS**	**Complete**
PCCC 19/03/07	**IT UPDATE** The Senior Primary Care Commissioning Manager introduced the IT Update Report which provided members with an update on work currently in progress within the various IT projects. Appended to the update report was a project plan which included monthly updates and highlighted issues which would require resolving within the PCCC meeting or for escalating where necessary. Monthly IT Operational Steering Group meetings had been established with the responsibility for delivering a number of GPIT projects. Any issues or risks identified would be escalated and brought to the CCGs Management Team for resolution and to the PCCC for assurance.		

ADOPTED

	GP WIFI The meeting noted that although infrastructure problems had been experienced in some buildings which had pushed the programme of work back, 60% of GP practices now had WIFI installed. **Windows 10 Update** Huddersfield Road Surgery had been one of a number of practices across Yorkshire and the Humber to be an early adopter for Windows 10 and the lessons learnt from all of the installations had been used to develop a comprehensive list of issues readily available around connecting systems within Barnsley. Practices had been informed that software would not be installed unless there was a service agreement in place. To support the reinstallation of ECG machines, Barnsley CCG would be purchasing licenses for all practices. Practices had also been asked to ensure that all registers such as asbestos and business continuity were up to date. **HSCN** Notification had been received from NHS digital that 8 GP practices required moving from their existing N3 connection to HSCN. 4 practices would need to transfer by 22 July and the remaining 4 practices by 22 August 2019. One other practice was having significant problems with their N3 connection and connectivity. The CCG had asked for this practice to be prioritised. Following this notification a costed solution paper outlining what was required for the HSCN design and equipment needed to enable a tight deadline to be achieved would be considered at Management Team. **MOBILE WORKING** Following issues experienced in sourcing sim cards and VPNs that were Windows 10 compliant to ensure suitability for the Windows 10 laptops a provider had now been identified. Unfortunately the currently problem was that eMBED had advised that due to resource issues it could be May or June before imaging of the laptops could be completed. This issue had been raised as a concern and the CCG had asked that funding from the ETTF scheme should come directly to the CCG to fund the services of an alternative technical engineer to complete the imaging.		

ADOPTED

	E-CONSULTATION Procurement of an eConsultation system was now complete and a preferred provider had been agreed. A Project Manager had been appointed to work across SYB to support the work and ensure the process was completed to time. The Lay Member for Governance thanked Julie for providing a very useful IT Update which pulled everything together and kept members appraised of progress across the various programmes of IT schemes taking place. The Assistant Head of Primary Care Co-Commissioning, NHSE suggested that it may be helpful to include the national NHS App Roll Out within the IT Programme of Work for Primary Care. **Action:** NHS App Roll Out to be included in the IT Programme of Work for Primary Care.	**JF**	**Complete**
QUALITY AND FINANCE			
PCCC 19/03/08	**FINANCE UPDATE** The Assistant Finance Manager presented the Finance Update on the financial position for delegated Primary Care Commissioning budgets as at 31 January 2019 (month 10). The forecast position as at month 10 was an underspend of £831k, the majority of which related to the underutilisation of accruals. £135k related to indemnity payments which would be funded centrally by NHSE for 2018/19. **The Committee** noted the contents of the Finance report and the update from the Assistant Finance Manager.		
PCCC 19/03/09	**CQC UPDATES** The Senior Primary Care Commissioning Manager introduced the CQC Report which provided members with an update on the current CQC position in relation to primary care contracts. The following practices had received a rating of 'Good' across all domains. • Hollygreen Practice • Kingswell Surgery		

ADOPTED

	The CCG had written to both practices to congratulate all staff and thanked them for their continued efforts to provide high quality services. The CQC had completed inspections at the practices named below. Details of the outcome would be shared when published and assurance would be brought to the next Committee meeting in May. • Ashville Medical Practice • Caxton House • The Rose Tree Practice (White Rose Medical Centre) • Victoria Medical Centre <u>Changes to CQC Regulatory Primary Care Medical Services</u> From April 2019 the CQC are to introduce a new system of provider information collections and annual regulatory reviews for good and outstanding services. The CQC attended the Practice Managers' meeting on 5 March and provided Managers with an update on the CQC changes which had been well received. It was noted that Practices not having had an inspection since 2014-15 would be contacted by the CQC imminently and would require a telephone interview as well as an inspection. **The Committee** noted the 'Good' CQC ratings and the change in the CQC Regulatory Primary Care Medical Services process**.** It was suggested that the letters sent to Practices congratulating staff and thanking them for their continued efforts to provide high quality services should also be signed by the Chair of the PCCC. **Action:** The signature of the PCCC Chair to be included on letters sent from the CCG to all Practices receiving a 'Good' CQC rating. **Action:** The 'good' rating from the CQC inspections of Hollygreen Practice and Kingswell surgery to be included in the highlight report to be on the May Public Governing Body agenda.	**JF** **JF**	**Complete** **Complete**

ADOPTED

CONTRACT MANAGEMENT			
PCCC 19/03/10	**PUBLIC CONTRACTUAL ISSUES REPORT**		
	The Senior Primary Care Commissioning Manager introduced the Contractual Issues Report which provided members with an update on the current contractual issues in relation to primary care contracts. **e-Declaration Update** All 33 Barnsley GP practices had submitted their responses within the deadline. **Procurement Updates** Home Visiting At the Extraordinary meeting of the PCCC held on 14 February the Home Visiting Service Procurement Award report had been received and unanimously agreed. The outcome of the procurement process had been to award the contract to Barnsley Healthcare Federation. Any Qualified Provider Contracts Procurement for the Any Qualified Provider Contracts for Community Carpal Tunnel services including Nerve Conduction and Vasectomy Non Scalpel service was now complete. Once a preferred provider(s) had been agreed this would be brought to a future meeting for approval of contracts to be awarded. **In Year APMS, GMS and PMS Contract Variations** Lakeside Surgery APMS Contract Variation Members were informed that Barnsley CCG had received an application to add the Alliance Primary Care Limited company as a new partner to the Lakeside Surgery APMS contract from 1 April 2019. The Committee were also informed that the current partners (Dr Guntamukkala and Dr Vemula) would submit an application to be removed from the contract once the process of varying on the new contract holders was complete. This request would come to a future PCCC meeting for approval.		

ADOPTED

PMS Contract Changes

The Dove Valley Practice PMS Contract Variation
Barnsley CCG had received an application to remove Dr Catherine Liley, GP partner from the Dove Valley Practice contract due to her resignation on 1 April 2019.

Dr Matthew Dowling would be joining the partnership.

Hill Brow Surgery PMS Contract Variation
Barnsley CCG had received an application to remove Dr Monica Duggal from the Hill Brow Surgery contract due to her retirement on 31 March 2019.

Royston High Street Practice – GMS Contract
Members noted the application request received to vary the GMS contract for Royston High Street practice due to a 24 hour retirement for Dr Edward Czepulkowski.

The Primary Care Commissioning Committee:-

1. Noted the process being undertaken in respect of the General Practices e-Declaration for assurance

2. Procurement Updates
   i) Noted the information regarding the Home Visiting service procurement
   ii) Noted the information regarding the AQP procurement

3. In year APMS, GMS and PMS Contract Variations
   i) Approved the Lakeside Surgery APMS Contract Variation
   ii) Approved the Dove Valley PMS Contract Variation
   iii) Approved the Hill Brow Surgery Contract Variation
   iv) Noted the information regarding Royston High Street GMS Contract for assurance

ADOPTED

GOVERNANCE, RISK AND ASSURANCE			
PCCC 19/03/11	**RISK AND GOVERNANCE REPORT**		
	The Head of Governance and Assurance provided an overview of the Risk and Governance Report confirming that no new risks had been identified since the previous meeting which needed to be brought to the attention of the Committee from either the Assurance Framework or the Risk Register. **Assurance Framework 2018/19** Appendix 1 of the report provided the Committee with an extract from the GBAF of the one risk for which the Committee were the assurance provider. The risk had been scored as 'Amber' High Risk and related to Risk Ref 2.1 - the delivery of Primary Care priorities if identified threat(s) were not successfully managed and mitigated. **Risk Register** There were currently six risks on the Corporate Risk Register for which the Committee were responsible for managing. **Mandated NHSE Audit of Primary Medical Services** Although NHS England (NHSE) had delegated primary care commissioning functions to CCGs, it still retained the overall accountability for ensuring the functions were being discharged effectively. NHSE had therefore introduced a mandatory Internal Audit Framework for all CCGs which required the independent completion of assessments. Four domains would be covered on a cyclical basis, over the next three to four years - Commissioning & procurement of services; Contract oversight and management functions; Primary Care Finance; and Governance. The focus for 2018/19 had been on governance arrangements. Internal Audit had issued the final report for Barnsley CCG which provided NHSE with 'significant assurance' over the CCG's arrangements and included only two low risk recommendations.		

ADOPTED

	The Primary Care Commissioning Committee:- • Reviewed the risk on the Assurance Framework for which the Primary Care Commissioning Committee was responsible • Reviewed the Risk Register attached and: o Confirmed all risks identified were appropriately described and scored o Confirmed there were no other risks which needed to be included on the Risk Register • Noted the 360 Assurance's Primary Medical Care and Contracting – Review of Governance Arrangements		
PCCC 19/03/12	**ANNUAL ASSURANCE REPORT 2018/19** The Head of Governance & Assurance introduced the Committee Annual Assurance Report for 2018/19. Members were informed that it was a requirement of all CCG Committees to provide a Committee Annual Assurance report at the end of each year to offer assurance to the Accountable Officer and Governing Body that the Committee had carried out the responsibilities delegated to them as detailed in their terms of reference. The report demonstrated how, throughout 2018/19, the PCCC had continued to function as an effective Committee undertaking the responsibilities for commissioning primary medical services. It was noted that there was one error on the report which related to the designation of the author which should read: Report of: Chris Millington, Lay Member for Patient and Public Engagement & Primary Care Commissioning. **The Committee:** Noted and approved the contents of the Annual Primary Care Commissioning Committee Assurance Report for 2018/19 subject to the amendment of the author's designation.	**RW**	**Complete**

ADOPTED

PCCC 19/03/13	**PUBLIC PRIMARY CARE COMMISSIONING COMMITTEE WORK PLAN UPDATE 2019/20** The Head of Governance & Assurance introduced the Public PCCC Work Plan and Agenda Timetable for 2019/20 to ensure business was carried out in a planned, structured way and to provide assurance that its functions would be discharged as per the terms of reference. **The Committee**: Reviewed and approved the updated Public PCCC Work Plan and Agenda Timetable for 2019/20 with the following amendments. • Removal of the PDA Outcomes on page 1 • ETTF Update to be populated • Self-assessment of Committee's effectiveness – report expected at July 19 meeting **Action:** Work Plan/agenda to be amended to reflect the points above.	**AM**	**Complete**
OTHER			
PCCC 19/03/14	**REFLECTION OF CONDUCT OF THE MEETING** The Committee agreed that the meeting had been conducted appropriately.		
PCCC 19/03/15	**QUESTIONS FROM MEMBERS OF THE PUBLIC RELEVANT TO THE AGENDA** There were no members of the public present at the meeting.		
PCCC 19/03/16	**ANY OTHER BUSINESS** <u>Working Win</u> Following a query from the Chief Officer regarding what impact the Working Win Health Employment Trial had had on days lost through ill health in Barnsley, the Director of Public Health acknowledged that work was ongoing within the Council to acquire further clarity around the scheme which was managed by South Yorkshire Housing Association. The Director of Public Health agreed that it would be helpful to have a presentation or deep dive session at the CCG to include people from the Council and South Yorkshire Housing Association to better understand the impact the scheme was having.		

ADOPTED

	It was also agreed that it would be helpful to have an update on Working Win to include GP referrals at the PCCC in May 2019. **Action:** Working Win Health Employment Trial update to be on the PCCC agenda in May 2019.	**JF/JB**	**Complete**
PCCC 19/03/17	**ITEMS FOR ESCALATING TO THE GOVERNING BODY ASSURANCE REPORT** • The 'good' rating from the CQC inspections of Hollygreen Practice and Kingswell surgery • GP IT Project Update	**AM** **AM**	**Complete** **Complete**
PCCC 19/03/19	**DATE AND TIME OF THE NEXT SCHEDULED MEETING**		
	Thursday, 30 May 2019 at 2.30pm to 3.30pm in the Boardroom, Hillder House, Barnsley		

ADOPTED

MEETING:	Health and Wellbeing Board
DATE:	Tuesday, 4 June 2019
TIME:	4.00 pm
VENUE:	Reception Room, Barnsley Town Hall

MINUTES

Present

Councillor Sir Stephen Houghton CBE, Leader of the Council (Chair)
Councillor Margaret Bruff, Cabinet Spokesperson - Childrens
Councillor Jenny Platts, Cabinet Spokesperson - Adults and Communities
Wendy Lowder, Executive Director Communities
Julia Burrows, Director Public Health
Adrian England, HealthWatch Barnsley
Lesley Smith, Chief Officer, NHS Barnsley Clinical Commissioning Group
Andy Snell (BHNFT)
James Barker, Director of Business Development
Sue Wing (SYWFT)
Alicia Morcroft (BMBC)
David Armitage (BMBC)
Rebecca Clarke (BMBC)
Stuart Rogers (BMBC)
Julie Tolhurst (BMBC)

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1 Declarations of Pecuniary and Non-Pecuniary Interests

There were no declarations of pecuniary or non-pecuniary interest.

2 Minutes of the Board Meeting held on 9th April, 2019 (HWB.04.06.2019/2)

The meeting considered the minutes of the previous meeting held on 9th April, 2019.

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

3 Minutes from the Children and Young People's Trust Executive Group held on 31st January, 2019 (HWB.04.06.2019/3)

The meeting considered the minutes from the Children and Young People's Trust Executive Group held on 31st January, 2019.

RESOLVED that the minutes be received.

4 Public Questions (HWB.04.06.2019/4)

The meeting noted that no public questions had been received for consideration at today's meeting.

5 Health and Wellbeing Board Membership: engagement review of wider providers (HWB.04.06.2019/5)

A joint report of the Chief Executive, Berneslai Homes, and BMBC Executive Director, People setting out proposals as to how the Health and Wellbeing Board would engage with wider providers, stakeholders and partners and in particular the Provider Forum and the Barnsley Schools Alliance. This followed a discussion at the last meeting of the Board around membership. Following consultation and further evaluation on the most effective means of maintaining and building on the effective dialogue already established with stakeholders, it had been concluded that the Board be requested to support the proposal that the Chair of the Provider Forum remain a member of the Health and Wellbeing Board.

RESOLVED that the Health and Wellbeing Board support the proposal that the Chair of the Provider Forum remain a member of the Board.

6 Health and Wellbeing Strategy: Review & Development Proposal (HWB.04.06.2019/6)

The Board considered a report which provided an overview, suggested approach and timescales in reviewing the current Health and Wellbeing Board Strategy 2016-2020 and the proposals in relation to the development of the next Health and Wellbeing Board Strategy for the period 2020-2023.

The Board considered its statutory role aligned to the findings set out in the Joint Strategic Needs Assessment (JSNA). Members in particular welcomed the community voice input and planned community conversations which would assist in the development of improvement to integrated care systems. Wider stakeholder engagement would commence in late October/early November and the outcomes would help inform the draft Strategy ready for formal consultation which would take place in early 2020.

RESOLVED:-

(i) that the Board support the proposed approach to review the current Health and Wellbeing Board Strategy (2016-2020) and welcome the findings to be presented to the Health and Wellbeing Board in July 2019; and

(ii) that the Board supports the proposed approach for the development of the next Health and Wellbeing Board Strategy (2020-2023) and agreed that the next Development Session would be used to discuss a proposed strategic approach.

7 Implementing the Physical Activity Plan (HWB.04.06.2019/7)

The Board were given a presentation and considered a report which provided an opportunity to discuss the Active in Barnsley partnership approach and implementing the Physical Activity Plan and more generally improve physical activity levels in Barnsley. It was noted that physical activity had been one of the Board's public health strategic priorities for the past three years, delivered through the Sport and Active Lifestyle Strategy. The Board noted the low levels of physical activity amongst

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adults in Barnsley and that the town ranked fifth highest for levels of inactivity compared with similar statistical neighbours.

RESOLVED:-

(i) that the Health and Wellbeing Board noted the Physical Activity Plan 2018-2021; and

(ii) supported the proposals to improve figures in relation to physical activity amongst adults and young children.

8 Sexual Health Needs Assessment (HWB.04.06.2019/8)

The Board received a presentation and considered a report highlighting recommendations from the Sexual Health Needs Assessment and Service Review, the challenges it provided and the future direction of the service.

The Board noted in particular that whilst improvements had been made in some areas greater emphasis was required in others most notably under 18's contraception.

RESOLVED that the Health and Wellbeing Board:-

(i) recognised the investment in a mandated sexual health offer that required a partnership approach and resource prioritisation based on evidence needs and intervention effectiveness;

(ii) support evidence based interventions and amplify sexual health "truths" in relation to local investment (for example this was not solely a young people issue, just under 60% of people attending Level 3 service are aged 25 or over); and

(iii) recognised amplify that choices would need to be made in 2019 in order to inform a new contract in 2020.

9 Health Protection Board Update Report (HWB.04.06.2019/9)

The Board considered an update report from the Barnsley Health Protection Board setting out its activity over the last year as a means of providing reassurance that the health of the residents of Barnsley was being protected in a pro-active and effective way.

The Board considered in particular areas of success in relation to infection prevention and control and TB. It also noted those areas where further action was required, most notably flu vaccination for over 65s and acknowledged at risk groups and HIV. The Health and Wellbeing Board welcomed the HPB's continued programme of work and receipt of the minutes of their meetings.

RESOLVED that the work of the Health Protection Board over the last year be noted and those areas requiring further action and the interventions recommended be supported.

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Chair

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South Yorkshire and Bassetlaw Integrated Care System

Collaborative Partnership Board

Minutes of the meeting of

8 March 2019

The Boardroom, NHS Sheffield CCG
722 Prince of Wales Road, Sheffield, S9 4EU

Decision Summary

Minute reference	Item	Action
06/19	**Integrated Care System (ICS) Workforce Update**	That a response to a national letter received on workforce would be sent on behalf of the system as well as a joint letter on behalf of the North ICS' which would be coordinated by the South Yorkshire and Bassetlaw Integrated Care System (SYB ICS).
07/19	**Taking forward development of South Yorkshire and Bassetlaw strategic plan**	That KM would share the NHS Improvement correspondence to ensure a dual process was not taking place regarding misalignment of plans and that JC would then address this situation to resolve.
08/19	**Establishment of hosted network across the South Yorkshire and Bassetlaw Integrated Care System.**	That AN would consider questions for discussion in advance of a Hospital Services Review Clinical Workshop.

South Yorkshire and Bassetlaw Integrated Care System

Collaborative Partnership Board

Minutes of the meeting of

8 March 2019

The Boardroom, NHS Sheffield CCG
722 Prince of Wales Road, Sheffield, S9 4EU

Name	Organisation	Designation	Present	Apologies	Deputy for
Sir Andrew Cash CHAIR	South Yorkshire and Bassetlaw ICS	Chief Executive, SYB ICS	√		
Adrian England	Healthwatch Barnsley	Chair	√		
Ainsley Macdonnell	Nottinghamshire County Council	Service Director	√		Anthony May
Alison Knowles	Locality Director North of England,	NHS England		√	
Alan Davis	South West Yorkshire Partnership NHS FT	Director of Human Resources	√		Kathryn Singh
Andrew Hilton	Sheffield GP Federation	GP		√	
Anne Gibbs	Sheffield Teaching Hospitals NHS FT	Director of Strategy		√	
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 and Director of Strategy and Transformation	√		Louise Barnett
David Pearson	Nottingham County Council	Deputy Chief Executive		√	
Des Breen	South Yorkshire and Bassetlaw ICS	Medical Director	√		
Diana Terris	Barnsley Metropolitan Borough Council	Chief Executive		√	
Greg Fell	Sheffield City Council	Director of Public Health		√	
Frances Cunning	Yorkshire & the Humber Public Health England Centre	Deputy Director – Health and Wellbeing		√	
Helen Stevens	South Yorkshire and Bassetlaw ICS	Associate Director of Communications and Engagement		√	
Idris Griffiths	NHS Bassetlaw Clinical Commissioning Group	Accountable Officer		√	
Jackie Mills	NHS Sheffield Clinical Commissioning Group	Deputy Director of Finance	√		Maddy Ruff
Jackie Pederson	NHS Doncaster Clinical Commissioning Group	Accountable Officer	√		
Jeremy Cook	South Yorkshire and Bassetlaw ICS	Director of Finance	√		

John Mothersole	Sheffield City Council	Chief Executive		√	
John Somers	Sheffield Children's NHS Foundation Trust	Chief Executive		√	
Jo Miller	Doncaster Metropolitan Borough Council	Chief Executive		√	
Julia Burrows	Barnsley Metropolitan Borough Council	Director of Public Health	√		
Kathryn Singh	Rotherham, Doncaster and South Humber NHS FT	Chief Executive		√	
Kathy Scott	Yorkshire and Humber Academic Health and Science Network	Deputy Chief Executive	√		Richard Stubbs
Kirsten Major	Sheffield Teaching Hospitals NHS FT	Chief Executive	√		
Kevan Taylor	Sheffield Health and Social Care NHS FT	Chief Executive	√		
Lesley Smith	NHS Barnsley Clinical Commissioning Group	SYB ICS Deputy System Lead, Chief Officer NHS Barnsley CCG	√		
Lisa Kell	South Yorkshire and Bassetlaw ICS	Director of Commissioning Reform		√	
Louise Barnett	The Rotherham NHS FT	Chief Executive		√	
Maddy Ruff	NHS Sheffield Clinical Commissioning Group	Accountable Officer		√	
Matthew Groom	NHS England Specialised Commissioning	Assistant Director	√		
Mike Curtis	Health Education England	Local Director		√	
Neil Priestley	Sheffield Teaching Hospitals NHS FT	Director of Finance		√	
Neil Taylor	Bassetlaw District Council	Chief Executive		√	
Paul Moffat	Doncaster Children's Services Trust	Director of Performance, Quality and Innovation		√	
Patrick Birch	Doncaster Metropolitan Borough Council	Strategic Lead for Adult Transformation	√		Jo Miller
Paul Smeeton	Nottinghamshire Healthcare NHS Foundation Trust	Executive Director	√		Ruth Hawkins
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	Yorkshire and Humber Academic Health Science Network	Chief Executive		√	
Rob Webster	South West Yorkshire Partnership NHS FT	Chief Executive		√	
Rod Barnes	Yorkshire Ambulance Service NHS Trust	Chief Executive	√		
Rupert Suckling	Doncaster Metropolitan Borough Council	Director of Public Health		√	
Ruth Hawkins	Nottinghamshire	Chief Executive		√	

	Healthcare NHS FT				
Sharon Kemp	Rotherham Metropolitan Borough Council	Chief Executive		√	
Simon Morritt	Chesterfield Royal Hospital NHS FT	Chief Executive		√	
Steve Shore	Healthwatch Doncaster	Chair		√	
Teresa Roche	Rotherham Metropolitan Borough Council	Director of Public Health	√		Sharon Kemp
Tim Moorhead	NHS Sheffield Clinical Commissioning Group	Clinical Chair		√	
Tony Campbell	Chesterfield Royal Hospital NHS FT	Chief Operating Officer		√	
Wendy Allott	NHS Rotherham Clinical Commissioning Group	Chief Finance Officer	√		Chris Edwards
Will Cleary-Gray	South Yorkshire and Bassetlaw ICS	Chief Operating Officer	√		
Yvonne Elliott	Primary Care Sheffield	Deputy Chief Executive Officer	√		

Minute reference	Item	Action
01/19	**Welcome and introductions** The Chair welcomed members to the meeting, noting congratulations to Kirsten Major on her appointment as Chief Executive at Sheffield Teaching Hospitals NHS Foundation Trust.	
02/19	**Apologies for absence** The Chair noted the apologies for absence.	
03/19	**Minutes of the previous meeting held 19th October 2018** The minutes of the previous meeting were agreed as a true record and would be posted on the website after this meeting. **www.healthandcaretogethersyb.co.uk**	
04/19	**Matters arising** **Mental Health workstream progress update (Item 105/18 refers)** The Board was updated on a positive Mental Health and Learning Disabilities (MHLD) workstream meeting, noting a planned joint Primary Care (PC) and MHLD workshop.	
05/19	**National Update** **CEO ICS Report** The Collaborative Partnership Board noted the contents of the report. The Board noted the NHS Long Term Plan (LTP) had been released identifying a new service model that would join primary and community services, with a concentration on: - Out of hospital care and reducing pressure on emergency hospital services - Delivering person centered care - Focus on digital care - Focus on population health	

The Board noted the release of the Primary Care Strategy and changes to the GP contract, noting 36 proposed neighbourhoods across the South Yorkshire and Bassetlaw (SYB) system.

Discussions would take place further in a planned North meeting on workforce.

The Board noted NHS England (NHSE) and NHS Improvement (NHSI) had implemented one Chief Executive for both organisations as well as discussions around the potential creation of integrated care trusts and establishing joint committees.

The response to the NHS LTP would be submitted from the SYB ICS by Autumn 2019.

The Board was updated on a meeting with SYB ICS and Local Authority (LA) colleagues regarding the wider determinants of health, agreeing at that session to work in detail together on several areas including complex lives. Doncaster had agreed to share detail from work taking place already to apply at system level. Discussions took place around loneliness and how social prescribing and investing in voluntary and community sectors affected this. Physical activity and the active travel agenda were discussed, as well as digital population and employment. The priorities would be worked up in detail and discussed further at system level as part of the response to the LTP. This workshop was established to discuss where health and care comes together. A set of key priorities across health and care would begin to form the basis of the agenda for future Board meetings.

The Board noted changes to ICS governance:

- From 01 April 2019 for 12 months, the NHS organisations would move into a different meeting structure, with Chief Executives and Accountable Officers of every organsation, plus regulatory organisations coming together monthly. Once a quarter a full day session would take place with wider partners. Quarterly, an Oversight Board would take place and NHS E/I would join the SYB ICS for this. The Board would continue to meet, noting the membership of the group would likely be addressed and changed accordingly to reflect the wider care agenda
- The Board noted work taking place around the commissioning review in the light of primary care functions, how local commissioning and integrated commissioning with Local Authorities and how commissioning may work at a system level
- The Board noted changes to structures within NHS E/I

Feedback from Place

Barnsley

LS updated the Board on legislation around integrated care trusts and that a strategic outline case had been set out a year prior, undergoing a procurement process. The group noted that this had been placed on hold in October 2018. At this point work took place around localities, with workshops taking place with primary care exploring moving from 6 neighbourhoods to 3. Work was taking place with practices around Primary Care Networks (PCN).

Work was also taking place around establishing a joint commissioning board.

A section 75 Prevention agreement had been established.

BJ highlighted discussions in Doncaster around the Primary Care Networks (PCNs) that suggested their approach was going to amalgamate the investment for clinical leadership to create more substantive city-wide roles. It was noted that, as far as possible, common principles would be required for the ICS to best respond to the new contract across the region.

	A comment was made that work would be required to support and guide Primary Care staff through changes. It was also noted that different models of Networks could be a risk. LS confirmed that practices were engaged in the process of developing the Networks. **Bassetlaw** It was noted that 3 PCN's were established at varying stages of development. These were multi agency Networks with clinical focus. Place plans had been launched of which 3 primary care homes were integral. Workstreams were established, focusing on wider determinants of health. A social prescribing offer was established. **Doncaster** The Board noted PCN developments were underway. A well represented debate had taken place around this. The Board noted that the GP Federation had put an offer out to practices to host the 4 PCNs, and discussions would take place at practice level to allow the model to develop. The Board debated sharing the common principles across the 5 places. A discussion would take place at the ICS Primary Care Steering Group. The Board noted interviews taking place of 5 GPs as a leadership cohort to get involved with system leaders. It was anticipated that the GP leaders would work with the GP Federation. It was agreed this would be useful. The Board noted the joint strategy from 01 April with the Local Authority including joint delivery plans across health and social care, focusing on integration and delivery of LTP priorities. A monitoring process would be embedded as a whole system A Place plan refresh was underway, addressing delegated authority for a joint commissioning function. A review was taking place on governance arrangements of the Integrated Care Partnership. On the back of the joint commissioning strategy, a joint commissioning function was being explored for living well and aging well. Contracts were on track, with ambitions to get the system into the best place for delivery. **Sheffield** The Board noted that an independent chair would be appointed for the Accountable Care Partnership Board. Developments around integrated commissioning were taking place across the system. Shaping Sheffield Plan engagement workshops had been taking place. Work was taking place for stronger integrated care around patients at risk of admission and to develop single point of access for all health and care. An ongoing issue around integrated care for young people in transition regarding	

	mental health was noted and an agreement reached for a single commissioning process for the whole age range. This had been agreed through a Board commitment from Sheffield Health and Social Care NHS Foundation Trust and Sheffield Children's NHS Foundation Trust and was supported by the whole system. The Board noted an issue raised around a sharp increase in reported knife crime in Sheffield. KM updated the Board on work being done around this as a city. A discussion took place around scaling up these discussions at system level. A comment was made that there were wider issues to explore around the complex lives work as part of this. **<u>Rotherham</u>** The Board noted a locality structure within Rotherham, and that partnerships with the Local Authorioty and localities were formed to explore how these converted to Primary Care Networks. A Place Board was established with governance structures and a partnership work programme was underway. The Board was asked to note system level performance on the key health constitutional targets and issues around cancer waiting times and that plans were in place to address this.	
06/19	**ICS workforce update** The Board was presented with an update on workforce and activity around the review initiated to assess the current position, and clarify what needed to be delivered effectively at ICS level over the coming months. Two key messages were noted on leadership, acknowledging that workforce was one of the biggest challenges and that the system should drive the agenda for this. This would require a structure and governance change within the system with the ICS taking on wider responsibilities for key decisions. KT updated the group on correspondence received noting key themes on: - Making the experience of working for health and care rewarding - Leadership culture and the further work required on this - Key challenges around nursing and midwifery recruitment - New roles and different skill mixes needed coordinating - Devolution of existing accountability to ICS' The group was invited to comment. A comment was made on the semantics around title of human resources, (HR) leadership development and organisational development role and it was felt that the scope of work within this was wider than one role. A comment was made around ensuring that links were made to five new, additional roles in the GP contract into any work taking place. A comment was made around the importance of implementing a compassionate and values led system. A comment was made around considering the geography of training and whether as a system, and whether the ICS could consider making the bursaries part of the contract of employment, linking job offers to paying back fees. A comment was made around the importance of governance and investments by the system was crucial and potential to explore coordinated system training in conjunction with HR. The Board noted discussions with Health Education England and the ambulance	

	service, noting four paramedic rotation pilot schemes (rotating into primary care). Discussions were summarised as follows: - It was noted that the NHS and Care sectors must be attractive place to work - The workforce challenges in nursing needed to be resolved - This needed to be developed as a major part of the system plan It was agreed that a response to the national letter received would be sent on behalf of the system and a joint letter on behalf of the North ICS' would also be coordinated by the SYBICS.	**KEVAN TAYOR, ANDREW CASH**
07/19	**Taking forward development of SYB strategic plan** The Board noted that a system operating plan for SYB would be required, which would be a summation of organisation and Place plans. The plan captured the achievements of previous years and set out objectives for 19/20 and the first year of the strategic plan. The Board was asked to note the alignment of plans for this year being worked through which would be submitted. It was highlighted that changes to governance would be detailed in the submission to demonstrate how delivery would be supported. There would be an initial outline draft for the submission for a focused region discussion taking place in May. A task and finish group would be coordinated to develop this plan. Final submission of this plan would take place in October 2019. JC highlighted that Place based discussions were taking place to ensure Plans were aligned and discussions would take place where required. A query was raised around joining together alignment plans and request for alignment from NHS I. KM agreed to share the NHS I correspondence to ensure a dual process was not taking place. JC agreed to address this situation to resolve. The Board noted that 9 April CEO/AO meeting would be utilised to further discussions on the submission.	**KIRSTEN MAJOR, JEREMY COOK**
08/19	**Establishment of hosted network across the SYB ICS** The Board noted developments on establishing the hosted networks to focus on strengthening shared working to support sustainability within the five Hospital Services Review (HSR) specialties with a view to rolling out wider. With regard to a scheduled workshop on 21st March to discuss whether changes were required to clinical models for paediatrics and maternity, a comment was made around question 1 – "can we maintain status quo" which was proposed to be addressed in the workshop. As it had been established that status quo would be not sustainable it was suggested this was amended to "how do we build on what we currently have?" AN agreed to address this in the narrative going forward.	**ALEXANDRA NORRISH**
09/19	**Finance update** The Board was updated on month 9 noting the ICS was ahead of financial plan. An issue was noted around potential changes to the Memorandum of Understanding as a result of improved financial plans submitted in September. This has been queried with NHSI/E. It was noted that two organisations in the ICS were unlikely to meet their financial plan. A comment was made that the rules and potential for unintended consequences need clarifying.	
10/19	**Integrated Care System Highlight Report** The Collaborative Partnership Board received the ICS Highlight Report.	

	The report provided a summary of progress on the SYB ICS workstreams identifying the key risks. This should be shared by all with Boards and Governing bodies.	
11/19	**NHS long term plan engagement update** This item was included for information.	
12/19	**Any Other Business** There was no other business to consider.	
13/19	**Date and Time of Next Meeting** The next meeting will take place at 9.30am to 11.30am on 9 May 2019 in the Boardroom, 722 Prince of Wales Road, Sheffield, S9 4EU.	

Joint Committee of Clinical Commissioning Groups

Public Meeting held 27 February 2019, 3:30 – 4pm, at NHS Sheffield CCG

Action Summary for CCG Boards

104/19	**Previous minutes of the meeting** Amend Item 97/18 Questions from the Public members, question 4 to read: The JCCCG is a formal joint committee of the CCG commissioners within Bassetlaw, Barnsley, Doncaster, Rotherham Sheffield, North Derbyshire and Wakefield	**MM**

Public Minutes of the meeting of the

Joint Committee of the Clinical Commissioning Group Meeting

Public Meeting held 27 February 2019, 4- 5:30pm, at NHS Bassetlaw CCG

Present:
Dr Tim Moorhead, Clinical Chair, NHS Sheffield Clinical Commissioning Group (Chair)
Will Cleary-Gray, Chief Operating Officer, South Yorkshire and Bassetlaw Integrated Care System
Chris Edwards, Accountable Officer, NHS Rotherham Clinical Commissioning Group
Andrew Goodall, Healthwatch Representative
Idris Griffiths, Accountable Officer, NHS Bassetlaw Clinical Commissioning Group
Dr Eric Kelly, Clinical Chair, NHS Bassetlaw Clinical Commissioning Group
Dr Ben Milton, Clinical Chair, NHS North Derbyshire Clinical Commissioning Group
Philip Moss, Lay Member
Jeremy Budd, Director of Accountable Care, NHS Barnsley Clinical Commissioning Group
Alison Knowles, Locality Director – North, NHS England
Hayley Tingle, Chief Finance Officer, NHS Doncaster Clinical Commissioning Group
Jackie Mills, Deputy Director of Finance, NHS Sheffield Clinical Commissioning Group

Apologies:
Lesley Smith, Accountable Officer, NHS Barnsley Clinical Commissioning Group
Maddy Ruff, Accountable Officer, NHS Sheffield Clinical Commissioning Group
Jackie Pederson, Accountable Officer, NHS Doncaster Clinical Commissioning Group
Julia Newton, Director of Finance, NHS Sheffield Clinical Commissioning Group
Dr Nick Balac, Clinical Chair, NHS Barnsley Clinical Commissioning Group
Sir Andrew Cash, Lead, South Yorkshire and Bassetlaw Integrated Care System
Dr Chris Clayton, Chief Executive Officer, NHS Derbyshire Clinical Commissioning Group
Dr Phillip Earnshaw, Clinical Chair, NHS Wakefield Clinical Commissioning Group
Pat Keane, Chief Operating Officer, NHS Wakefield Clinical Commissioning Group (Deputy for Jo Webster, Accountable Officer)
Dr Steven Lloyd, Clinical Chair, NHS Hardwick Clinical Commissioning Group
Jo Webster, Chief Officer, NHS Wakefield Clinical Commissioning Group
Dr David Crichton, Clinical Chair, NHS Doncaster Clinical Commissioning Group
Dr Richard Cullen, Clinical Chair, NHS Rotherham Clinical Commissioning Group
Priscilla McGuire, Lay Member

In attendance:
Mags McDadd, Corporate Committee Clerk, Executive PA/Business Manager, South Yorkshire and Bassetlaw Integrated Care System
Lisa Kell, Director of Commissioning Reform, South Yorkshire and Bassetlaw Integrated Care System
Alexandra Norrish, Programme Director, Hospital Services Programme, South Yorkshire and Bassetlaw Integrated Care System
Helen Stevens, Associate Director of Communications and Engagement, South Yorkshire and Bassetlaw Integrated Care System
Marianna Hargreaves, Transformation Programme Lead, South Yorkshire and Bassetlaw Integrated Care System
James Scott, Programme Lead, South Yorkshire and Bassetlaw Integrated Care System

Members of the Public
Ken Dolan, South Yorkshire and Bassetlaw NHS Action Group (SYBNAG)
Nora Everett, SYBNAG
Doug Wright, Keep Our NHS Public (KONHSP)
Julie Ingram, SYBNAG
Steve Sullivan, Bayer

Councillor Susan Shaw, District Councillor
Peter Deakin
Dianne Caster
Stuart Henley

Minute reference	Item	ACTION
100/19	**Welcome and introductions** The Chair welcomed members and the public to the meeting. The meeting was informed that Steve Lloyd is no longer Clinical Chair of NHS Hardwick CCG.	
101/19	**Apologies** Apologies were received and noted.	
102/19	**Declarations of Interest** There were no declarations of interest.	
103/19	**Questions from the public** Questions were submitted by public members prior to the meeting and all responses were emailed to individuals in advance of the meeting. Nora Everitt advised the meeting that she had not had the opportunity to review the responses to her questions in advance of the meeting and asked that as this is a meeting held in public could public members have the opportunity to hear all questions submitted and subsequent responses. The Chair proceeded to read all the questions received in advance of the meeting and responses, as follows: <u>Questions submitted by Nora Everitt, SYB NAG</u> **Question 1: SYBNAG members note the listed ten areas described at the bottom of P1 of Agenda Paper D as having been identified as 'forming part of a good public engagement approach':** • **Transparency on decision-making: ICS, local partnership/place, organisation level** • **Public information about vision, plan, progress and performance** • **Regular flow of communication updates across channels** • **Proactive and systematic dialogue with public representatives** • **Voluntary sector and Healthwatch involved as key partners and enablers** • **Understand existing information on public and patient experience and aspirations**	

	• **Redesign services in partnership with citizens and communities** • **Reach out to the unengaged to properly understand communities** • **Focus on patient and community empowerment** • **Strong communication and engagement leadership** **However we wonder why these are not the same ten areas that are listed in the 'Patient and public participation in commissioning health and care: statutory guidance for clinical commissioning groups and NHS England.'The ten areas in the Statutory Guidance, (quoted below) are those used by NHS England as actions to be demonstrated by all CCGs in the assessment of how well they meet their 14Z2 legal duty for public involvement in commissioning plans, proposals and decisions.** **"This guidance sets out 10 key actions for CCGs and NHS England on how to embed involvement in their work. They should:** 1. ***Involve the public in governance*** 2. ***Explain public involvement in commissioning plans/business plan*** 3. ***Demonstrate public involvement in annual reports*** 4. ***Promote and publicise public involvement*** 5. ***Assess, plan and take action to involve*** 6. ***Feed back and evaluate*** 7. ***Implement assurance and improvement systems*** 8. ***Advance equalities and reduce health inequalities*** 9. ***Provide support for effective involvement*** 10. ***Hold providers to account"*** **The CCGs must have 'due regard to the Statutory Guidance and it defines this (on P42) by saying: "Having 'regard' means that the guidance should be considered and taken account of. Where the guidance is not followed, this should be justified and the reasons clearly documented." See https://www.england.nhs.uk/participation/involvementguidance/** **We feel that the SYBICS is collaborating with NHS England to imply that they are meeting their legal obligations for direct public involvement by meeting the ten areas of assessment when it can be proven that they don't. (e.g. not informing Rotherham Healthwatch about the Discovery Day). So we need to inform you that we are seeking legal advice on this.** **Can the JCCCG please provide us with evidence that they do meet each of the ten points in the statutory guidance?** *Response:* *The ten areas for good public engagement, as outlined in the ICSs approach to conversations with the public about the NHS Long Term Plan, are those issued by NHS England for ICSs. SYB ICS is using the areas of focus to ensure its approach follows good practice.*	

They do not replace the statutory duties or guidance previously issued by NHS England for CCGs and NHS England and each statutory organisation within the ICS (including the JCCCG members) continues to meet its legal obligations. Involvement with the public on any proposals for change is documented in the annual reports of all partners and evidence to support the work is available via each CCG or Trust.

Rotherham Healthwatch, along with all the Healthwatches in SYB, was sent an invitation to the Discovery Day on October 4, 2018 and is documented on our email distribution system.

In response, Nora advised the meeting the Rotherham Healthwatch did not receive an invitation and in addition legal action would be sought on the ten points in the statutory guidance.

Question 2: Are the deputies for each CCG Accountable Officer full voting members of the JCCCG?

Response:
Deputies attending the JCCCG are acting on behalf of the accountable officer and can vote on behalf of the AO for the organisation they are representing provided the meeting is quorate. Deputies only vote in the absence of the AO, and as such hold the CCG Board's proxy vote.

Question 3: SYBNAG members are concerned that treatment at Private Hospitals often goes wrong and the NHS has to sort it out. The SYBICS has recently developed significant changes to the NHS hospital in the area covered by the JCCCG based on safety and quality issues.
What steps are being taken to ensure that Private Hospitals work to NHS standards of safety and quality – such as having an Intensive Care Unit in case of adverse reaction to treatment?

Response:
All clinical practice in England whether independent or NHS delivered is governed by the same professional bodies and clinicians are guided by clinical standards, such as those set out by the Royal Colleges, National Institute of Health and Care Excellence (NICE) and the General Medical (or Nursing) Council. All clinical staff work to these, irrespective of who they work for (eg the NHS or a private sector provider). Private and NHS hospitals are also regulated by the Care Quality Commission (CQC).

Regarding intensive care provision in the independent sector, all care is consultant led (the vast majority are NHS consultants), and arrangements to treat patients are well established. Independent hospitals act in similar way to NHS District General Hospitals in the lower levels of ITU support they provide and clinical transfer protocols are in place with larger SYB hospitals to ensure that patients requiring more support are rapidly transferred by ambulance to a larger ITU
All services commissioned by the NHS must meet quality and safety standards and constitutional rights such as choice and access standards which are managed and governed within a standard NHS contact. You can read more about the standard contract here:
https://www.england.nhs.uk/nhs-standard-contract/2017-19-update-may/

	Question 4: There are 113 questions to the JCCCG recorded that have been asked by a member of the public since April 2017. However for 47 of these questions we feel that you did not answer the actual question asked. When this was raised in March 2018 the questioner was told they could take the matter up with the JCCCG Chair. However you do not publicise this opportunity to raise matters not answered with the JCCCG Chair to members of the public as a whole. **We feel that both these facts demonstrate a total disrespect for the public.** **Why do you do this?** Response: *The JCCCG Chair offered to respond to matters where questions were not considered answered. There has been no correspondence or a request to meet the Chair to understand which questions and why they are considered insufficient.* *We will update the website to publicise the process.* **Question 5: The JCCCG agreed that all written questions from the public submitted to their meetings would be responded to in writing to the questioner.** **Why don't you do this?** *Response:* *Individuals who ask written questions receive responses within three working days. To date, all questions have been received by email and all have been responded to by email. The questions and responses are also posted onto the website.* **Question 6: Given the lack of a written response to public questions the actual responses are only made public a few days before the next JCCCG meeting held in public, which again shows that you do not respect public contributions.** **Why is this so?** *Response:* *All questions receive responses by email (in advance of the JCCCG) and the questions and responses are posted on the website after the meeting.* **Question 7: The public questions, concerns and suggestions raised and recorded at the JCCCG meetings are not included in your public feedback mechanisms and reports.** **Why is this so?** *Response:* *All questions and interactions with the public are recorded in the JCCCG minutes and the questions and responses are posted on the website*. Helen Stevens clarified that all public consultation received, including public correspondence and minutes from Public JCCCG meeting are incorporated public feedback and reports. **Question 8: Given the Long Term Plan requirement for**	

	implementation of integrated services: **How does the ICS plan in practice to merge the budgets from Public Health services, Local Authority funded services, VCSE services, and private service provision with other primary care services in order to integrate them?** *Response:* *The work of the ICS is to bring partners together to explore integrated ways of working within the individual organisational budgets. There are no plans to merge budgets at this stage.* Questions received from Doug Wright, Doncaster and Bassetlaw Keep Our NHS Public **Question 1: Agenda item 9, Communication and Engagement, Page 26, 2, shows ten areas forming part of a good public engagement approach.** **Question is why can't members of the public attend various regional and local NHS committee meetings, with public questions/statements at the beginning of the agenda?** **(this should at least include the Integrated Care Systems (ICS) Collaborative Partnership Board meetings and the five local ICS bodies, such as the Doncaster Joint Commissioning Board)** *Response:* *The Collaborative Partnership Board meeting of the SYB ICS partners is not a statutory body, cannot make any decisions and is not required to meet in public. It is a forum for strategic discussion between partners. Each partner within the ICS is accountable to the public through its Board or Governing Body and any South Yorkshire and Bassetlaw ICS discussion that impacts on those organisations, or requires a decision, is discussed at individual Board and Governing Body meetings. The public can attend all Board and Governing Body meetings of the ICS partners where they can ask questions.* *Meetings of the five ICSs (Barnsley, Bassetlaw, Doncaster, Rotherham and Sheffield) have local arrangements for meeting and discussing strategic 'place' matters and your inquiry should be directed to each ICS however, the public can attend all Board and Governing Body meetings of the ICS partners where they can ask questions.* **Question 2: South Yorkshire ICS's budget originally had to be reduced by £571 million before the financial year 2021/22. Can you tell me what is the current budget estimate and detail where in our region these cuts will take place? If not who can tell me?** *Response:* *The £571m was the SYB share of the £30bn savings the NHS had to make by 2020 and referred to the 'gap' between the resources available and the likely demand for health and care services within the timeframe.* *Two subsequent national allocations (£8bn in 2017 in £20bn in 2018) has reduced some of the challenges that we face while also allowing us to invest in key services such as mental health and cancer. However, each of the partner organisations within South Yorkshire and Bassetlaw*	

	Integrated Care System continues to work to efficiency savings. This is in line with all NHS organisations in England which are required to make annual efficiencies together with any local need, as identified by their Board or Governing Body. *The details of the efficiency plans are available in the papers of Board and Governing Body meetings held in public.* Questions from Priscilla McGuire, Lay Member **Question 1: Unfortunately I can't attend the next JCCCG meeting but want to raise a couple of issues that were raised at our February monthly lay member CCG meeting i.e lay members (PPI) from South Yorkshire and Bassetlaw CCGs and from the JCCCG.** **A few members raised concerns about the frequency of JCCCG meetings and also transparency. They questioned why in their view, there were so few meetings last year, queried the cancellation of some meetings and also why meetings are often held in private. Helen and I did our best to assure members that there was no secret agenda or anything being discussed in private meetings that should be shared publicly. We also explained the reasons why some meetings such as the January meeting were cancelled. However, I did promise to raise members' concerns at a JCCCG meeting.** **Not sure what assurance you/JCCCG members can provide but some kind of response that I could take back to the lay members meeting would be helpful.** *Response* *The key reason for standing down previous JCCCG meetings is on the basis of whether there is an item for the JCCCG to consider and a decision to be made based on the agreed priorities for the JCCCG.* *The JCCCG is not an information sharing forum for the wider ICS business The JCCCG is a decision making committee, with some key priorities and a limited scope of delegated authority agreed by SYB Governing Bodies for hyper acute stroke services and children's surgery out of hours only. This is set out in the JCCCG Manual Agreement and the Terms of Reference* Nora added that public members would welcome a public forum whereby questions could be heard allowing sufficient time to answer effectively. Discussion ensued and members noted that more was needed to be done in the quest for additional meetings in public and to also consider a process of more generic questioning rather than focusing on specific issues.	
104/19	**Previous minutes of the meeting** The minutes of the meeting held on 24 October 2019 were accepted as a true and accurate record and are published on the website **www.healthandcaretogethersyb.co.uk)**, with the following amendment. Item 97/18 Questions from the Public members, question 4 to read: The	

	JCCCG is a formal joint committee of the CCG commissioners within Bassetlaw, Barnsley, Doncaster, Rotherham Sheffield, North Derbyshire and Wakefield	
105/19	**Matters Arising** There were no matters arising noted.	
106/19	**Hyper Acute Stroke Services Change** The Chair welcomed Marianna Hargreaves to the meeting to provide an update on the Hyper Acute Stroke Services (HASU). Members were informed that commissioners continue to work together to commission and contract the new model of HASU. The specification was finalised and shared formally with providers at the end of 2018, with a letter signaling the intent to commission and contract the new model. A HASU Implementation Group, Chaired by Richard Jenkins the Chief Executive of Barnsley Hospital NHS Foundation Trust, with representation from all Trusts, the Yorkshire Ambulance Service, Sheffield CCG as lead commissioner and the Stroke Association is now established to oversee the implementation. Implementation dates were considered in the February Implementation Group and are in the process of being agreed and confirmed by all parties. A Clinical Quality Sub Group has been established, chaired by a Lead Stroke Physician focusing on the clinical tasks, including the development of a patient leaflet in collaboration with the Stroke Association. It was also noted that workforce planning is a key area of focus and it is anticipated that HASUs will soon be in a position to recruit additional therapy and nursing staff over the coming months. A Stroke Workforce Role is also due to be advertised as funding had been secured from Health Education England for this. Philip Moss asked whether the model will support access to mechanical thrombectomy? Marianna advised that mechanical thrombectomy is commissioned by NHS England to be delivered by Neuroscience centres. Marianna confirmed that the new SYB HASU model does support improving access to mechanical thrombectomy as HASU in the new model will be well placed to undertake diagnostics, including more sophisticated imagery to identify eligible people that would benefit from it. Members noted the progress to plan for and implement the new South Yorkshire and Bassetlaw model for HASU. The Chair thanked Marianna for her presentation.	
107/19	**Update on the Hospital Services Programme** The Chair welcomed Alexandra Norrish to the meeting and invited her to present an update on the Hospital Services Programme. Members were informed that the Hosts of the Hosted Networks were	

	announced last week, following agreement between the acute providers. The Hosts will facilitate shared working between the Trusts, e.g. around shared clinical standards and joint workforce planning. Work is now underway with Trusts and Commissioners to agree the structure, membership and work programmes of each of the individual networks. Following the cancellation of the December JCCCG meeting, a paper was circulated to CCGs asking Governing Bodies to confirm that some sites would be 'fixed', ie in the event of any changes to clinical models for maternity, paediatrics and gastroenterology, there would be no change to the clinical model on these sites. In addition to the CCG executive leadership discussing this and confirming their agreement in writing, and in the interest of transparency, this was brought to the public meeting of JCCCG. The fixed sites were confirmed: 1. Fixed site for Maternity Services at Sheffield Teaching Hospitals NHS Foundation Trust 2. Fixed site for Paediatrics at Sheffield Children's NHS Foundation Trust 3. No fixed site for overnight Gastrointestinal bleeds On clinical models, Alexandra said that the Hospital Services team had taken account of feedback from Boards, CCGs and the public around concerns about Standalone Midwifery Led Units. She said that there may be two reasons that a SMLU is necessary: because there have been changes to paediatrics which mean that neonatology (and therefore obstetrics) cannot be sustained overnight; or because obstetrics or its dependent services are themselves not safe or sustainable. Alexandra said that the Clinical Working Groups have been working on the first of these, looking at ways to maintain obstetrics on a site in the event that there is no paediatric inpatient service overnight on that site. This requires a different way to support 24/7 neonatology services, rather than through paediatric mid-grade doctors. The Royal College has given their support in other health economies to a model of supporting neonatology through specially trained Advanced Practitioners specialising in neonatology, rather than by using paediatrics mid-grades. The Clinical Working Groups are content with this as a clinical model although there would be challenges around training and recruiting Advanced Neonatal Nurse Practitioners. Philip asked whether the programme was on schedule and Alexandra informed members that although there has been a few weeks slippage, this would be added to the timeframe. She said that a summit for all Accountable Officers and Trust Chief Executive Officers to review the way forward on configuration options had been arranged for 21 March. The Chair thanked Alexandra for her presentation.	
108/19	**Communication and Engagement**	

	The Chair invited Helen Stevens to present her reports. <u>NHS Long Term Plan – Engagement</u> Helen informed members that the Long Term Plan sets out the requirements of ICSs to work together with local partners to develop their local response by producing an ICS five-year strategic plan by the Autumn 2019. The ICS is expected to take the lead in ensuring the co-ordination of communications and engagement activity with staff from all the organisations involved in the local system, including local authorities and other non-NHS partners. An action plan of acitivities across SYB is being developed and will be shared with the ICS Collaborative Partnership Board and System Health Executive Group once finalised and shared with Boards and Governing Bodies for their meetings in public. The Chair asked that clear communication is published as soon as possible.. To support this work, NHS England is investing nationally in local Healthwatch's to provide extra capacity to support additional engagement with the local public, and in particular seldom heard groups, to which partners are expected to deliver. Helen advised that JCCCG members note the contents of the report and to approve the approach and support of their communications and engagement teams to deliver the system wide approach. **ICS Discovery Day – Engagement feedback and action plan** Helen informed members a self-assessment survey was undertaken with representatives from Healthwatch, the community and voluntary sector, local authorities, Clinical Commissioning Group lay members, Foundation Trust governors, members of the South Yorkshire and Bassetlaw Integrated Care System Citizens' Panel, engagement and communications leads and campaign groups from across South Yorkshire and Bassetlaw. The findings from the survey informed discussions at a workshop ('Discovery Day') with more than 80 attendees from the above groups. Feedback from the day was gathered and independently analysed, with subsequent themes used to develop a locally-owned draft plan for public engagement across SYB. This paper outlines the approach, the themes and the resulting draft plan and a draft action plan is currently in circulation widely with community and voluntary sector groups for further comment and thereafter once all comments have been received, the plan will be updated and shared with JCCCG, The Integrated Care System Collaborative Partnership Board and Integrated Care System partners before implementation. The Chair thanked Helen for the informative reports and expressed appreciation to Helen and the Communication and Engagement team for their hard work.	

109/19	**To consider any other business** Ben Milton asked members to note the merger of four Clinical Commissioning Groups in Derbyshire, with the inclusion of Northern Derbyshire and NHS Hardwick and NHS North Derbyshire CCGs from 1 April 2019, and consider the changes and future way of working. The new name will be Derby and Derbyshire CCG. The Chair added that this item would be discussed further at the JCCCG private meeting being held after this meeting.	
110/19	**Date and Time of Next Meeting** The Chair informed the meeting that the next meeting will take place on 24 April 2019, 3.30pm – 4.00pm in The Boardroom, NHS Sheffield CCG, 722 Prince of Wales Road, Sheffield, S9 4EU.	

Joint Committee of Clinical Commissioning Groups

Meeting held IN PUBLIC

22 May 2019, 4.30pm - 5:30pm, at The Boardroom, NHS Sheffield Clinical Commissioning Group

Action Summary

114/19	**Ratification of previous meetings:** The minutes of the public meeting held on 27 February 2019 were accepted as a true and accurate record with one amendment.	**MM**
116/19	**2019/20 Joint Committee Governance arrangements** Consider re-naming the JCCCG to reflect the strengthening of commissioning collaboration and ambition of the committee. Present a report at a future meeting on options.	**JP**
	Draft JCCCG Manual Agreement and JCCCG Terms of Reference (revised) LK agreed to discuss with CCGs whether any data sharing agreements are required for the JCCCG priorities. PMG asked that further emphasis on GDPR is added, LK agreed to amend the manual agreement.	**LK**
	Share the 19/20 JCCCG priorities at the next meeting.	**LK**
	Include attendance at meetings in terms of reference (75% attendance annually for JCCCG members)	**LK**
	A clinical engagement assurance process is to be provided to Governing Bodies and JCCCG to assure that work is clinically led. This will be included in the manual agreement	**LK**
	Quarterly progress report from July 2019	**LK**
	LK agreed to update the JCCCG Terms of Reference and Manual Agreement and 19/20 JCCCG Priorities with the points made today for final review at the June JCCCG meeting and to recommend to GBs for sign off in July (in public)	**LK**

Minutes of the Meeting of
The Joint Committee of Clinical Commissioning Groups
Public Session

Meeting held 22 May 2019, 4.30pm - 5.30pm
at Boardroom 722 Prince of Wales Road Sheffield S9 4EU

Present:
Dr David Crichton, Clinical Chair, NHS Doncaster Clinical Commissioning Group (Chair)
Dr Nick Balac, Clinical Chair, NHS Barnsley Clinical Commissioning Group
Jeremy Budd, Director of Commissioning, NHS Barnsley Clinical Commissioning Group
Dr Eric Kelly, Clinical Chair, NHS Bassetlaw Clinical Commissioning Group
Andrew Goodall, Healthwatch Representative
Philip Moss, Lay Member
Priscilla McGuire, Lay Member
Helen Stevens, Associate Director of Communications and Engagement, South Yorkshire and Bassetlaw Integrated Care System
Chris Edwards, Accountable Officer, NHS Rotherham Clinical Commissioning Group
Dr Richard Cullen, Clinical Chair, NHS Rotherham Clinical Commissioning Group
Jackie Pederson, Accountable Officer, NHS Doncaster Clinical Commissioning Group
Jackie Mills, Deputy Director of Finance, NHS Sheffield Clinical Commissioning Group
Zara Jones, Executive Director of Commissioning Operations, NHS Derby and Derbyshire Clinical Commissioning Group
Idris Griffiths, Accountable Officer, NHS Bassetlaw Clinical Commissioning Group

Apologies:
Dr Tim Moorhead, Clinical Chair, NHS Sheffield Clinical Commissioning Group
Dr Chris Clayton, Chief Executive Officer, NHS Derby and Derbyshire Clinical Commissioning Group
Lesley Smith, Accountable Officer, NHS Barnsley Clinical Commissioning Group
Maddy Ruff, Accountable Officer, NHS Sheffield Clinical Commissioning Group
Julia Newton, Director of Finance, NHS Sheffield Clinical Commissioning Group
Dr Phillip Earnshaw, Clinical Chair, NHS Wakefield Clinical Commissioning Group
Pat Keane, Chief Operating Officer, NHS Wakefield Clinical Commissioning Group (Deputy for Jo Webster, Accountable Officer)
Dr Avi Bhatia, Clinical Chair, NHS Derby and Derbyshire Clinical Commissioning Group
Sir Andrew Cash, Chief Executive, South Yorkshire Bassetlaw Integrated Care System
Matthew Groom, Assistant Director, Specialised Commissioning, NHS England

In attendance
Mags McDadd, Corporate Committee Clerk, Exec PA Business Manager, South Yorkshire and Bassetlaw Integrated Care System
Lisa Kell, Director of Commissioning, South Yorkshire and Bassetlaw Integrated Care System

Public in attendance

Julia Ingram, SYBNAG	Peter Deakin, BSONHS	Ken Dolan, BSONHS
Nora Everitt, SYBNAG	Steve Merriamn, SYBNAG	Steve Sullivan Bayer

Minute reference	Item	ACTION
C110/19	**Welcome and introductions** The Chair welcomed members and attendees to the meeting, introducing himself as the newly appointed Chair up to April 2020.	
C111/19	**Apologies** Apologies were received and noted.	
C112/19	**Declarations of Interest** There were no declarations of interest.	
C113/19	**Questions from the public** Questions were submitted by South Yorkshire and Bassetlaw NHS Action Group prior to the meeting. The JCCCG provided a response: **Q. 1 We wish to make a statement including a request:** The Draft Manual Agreement and JC CCG ToR was only made public on Wednesday 15/5/19 and has 36 pages of text that has some significant legal implications regarding public accountability and involvement. We feel that we cannot individually, or collectively, ask meaningful questions on this document within two working days as this does not allow us sufficient time for intelligent consideration and response. We therefore ask that the JCCCG please accept and consider our formal response to the Manual Agreement, including the JC CCG Terms of Reference. We will send our response to all voting members of the JC CCG to arrive by Monday 3/6/19, a full week before the next meeting of the JC CCG Sub-Group and just over three weeks before the next JCCCG meeting. We wish however to say that we are pleased to see the Manual Agreement in the public domain as this was not the case with the original one, and we feel this can show, and has now shown, that the JCCCG recognises public accountability. **Response:** Thank you for your statement. We would like to clarify that the first Manual Agreement of the JCCCG was shared at individual CCG Governing Bodies in their meetings in public in 2017. **Q. 2 Questions on the JCCCG Sub Group Terms of Reference document** **a) Why can the public not attend the JC CCG Sub Group, observe the meeting and receive agenda packs of the papers and reports discussed, as we do for Trust and CCG meetings?** **Response:** The JCSG supports and coordinates the work of the 19/20 JC CCG priorities agreed by the commissioners it will also reduce the amount of operational detail that is currently being undertaken at the JC CCG. The JCSG will not make any decisions on behalf of the JC CCG and the TOR have been included in the papers of the May Public JC CCG. Given the operational nature of this meeting, non-decision making and the JC CCG now meeting in public each month it is not necessary for the JCSG to meet in public.	

b) Will the JC CCG Sub Group minutes and the reports to, and by, the Sub Group be in the public domain?

Response:
The JCSG minutes will be included in the Private JC CCG papers for information

c) re. Paragraph 1
Is there an omission in the second sentence which refers to the JC CCG and not to the new JC CCG Sub Group?

Response:
No. the sentence refers to the role of the JC CCG that is supported by the JCSG

d) re. Paragraph 2 – 4th Bullet Point
Will the Sub Group not liaise with the Chair of the JC CCG in planning and managing the agenda and co-ordination of the JC CCG papers as this is normal meeting facilitation etiquette, or was such an omission an oversight?

Response:
The Chair of the JCSG is involved in planning of the JCSG agenda and papers and agrees the final version. The same process applies with the JC CCG where the Clinical Chair of the JC CCG is involved and agrees the final version of papers and agenda before being sent out within the agreed timeframes

e) re. Paragraph 2 – 5th Bullet Point
Is it the case, as this implies, that workstream leads and programme directors will no longer report to the JC CCG meeting, only the Sub Group, which will deny the JC CCG members the opportunity to ask the officers direct questions and clarifications?

Response:
The JC CCG is established as a decision making committee of the CCGs, it is not an operational meeting (which it had become more of). The intention with the public JC CCG meeting is to split the business of the agenda into parts:

- Part 1 - any decisions to be taken (which would be a relatively short section) and
- Part 2 - a progress update of the 19/20 JCCCG Priorities
- Part 3 - a strategic service focus part where the JC CCG would receive information regarding a specific area on the JCCCG priorities with lead clinicians and programme directors attending for their item.

The JCSG will be required to assure the JC CCG of the work it is doing and reporting to the JC CCG. The JC CCG will also provide reports to the CCG Governing Bodies throughout the year.

f) re. Paragraph 2 – 7th Bullet Point
This gives little confidence and can you reassure us that the ICS officers are aware of the three CCG legal duties for public accountability other than 14Z2? These are, namely:

- **14Z11 (a)**
- **14Z13 (2) and (8)(a) & (b); and**
- **14Z15(2) and (6)(b)**

Response:
See below.

	g) re. Paragraph 4 **We ask the ICS officers and JC CCG members to note the following CCG legal duties relating to public accountability and to note there are implications for these in the changes currently being made in CCG commissioning arrangements and commissioning plans across SY and Bassetlaw.** **Response:** The JCCCG does not have its own list of duties set out in statute like a CCG or NHS England does, it only exercises those functions a CCG member specifically delegates to it. Therefore the legal duties are for CCGs, they do not apply to the role of the JC CCG – see manual agreement and JC CCG Terms of Reference. It is for each CCG to fulfil their obligations to involve the public in accordance with s.14Z2 of the NHS Act with regard to determining commissioning intentions on a general basis. The JCCCG would only lead on involvement, which may include public consultation, if the constituent CCG members specifically asked it to do so. h) **re. Paragraph 10** **i) It appears that the JC CCG will not be meeting in public every month for part of their meeting, as was suggested on the ICS website. Are the JC CCG meetings in public going back to every other month now?** **Response:** The JC CCG will meet monthly from May 19 and part of each agenda at all meetings will be in public **ii) Why was the Sub Group not mentioned at the meeting on 3/5/19, when we were invited to build a new working relationship that felt less adversarial? But at that point the Sub Group was already meeting and we don't understand why we were not informed of the intention to set one up to manage the JC CCG business.** **Response:** The discussion at the meeting on the 3/5/19 was responding to questions from the public representatives and most of the questions did not specifically relate to the remit of the JC CCG. As a consequence, we ran out of time to discuss it further. The JC CCG is keen to build a positive and constructive relationship with public representatives and our commitment to meeting in public and sharing the TOR and manual agreement in public are all steps we have taken to demonstrate our transparent approach wherever it is appropriate to do so. Following discussing the Chair re-iterated that the purpose of Joint Committee Sub Group is to support the working of the JCCCG at a strategic level and not a decision making forum.	
C114/19	**Ratification of previous meetings:** The minutes of the public meeting held on 27 February 2019 were accepted as a true and accurate record with one amendment. ICS Discovery Day – PMG asked to include JCCCG lay members as representatives.	**MM**
C115/19	**Matters arising** There were no matters arising.	
C116/19	**2019/20 Joint Committee Governance arrangements** <u>Joint Committee Sub Group (JCSG) Terms of Reference (ToR)</u> LK presented the revised JCSG ToR to the group to consider the agree the following	

	changes as the final version: 1. Section 7 – Report to Governing Bodies: change "monthly" to "quarterly" 2. Remove asterisks in the table as all future JCCCG meetings are to be held in public 3. Include a reporting timetable in section 7 4. Include venue details of JCCCG meetings (where available) The group considered rotating the JCCCG meetings to each CCG site and noted that availability and room sizes restrict monthly rotation. Public members were asked for their views and noted that Sheffield CCG was a suitable location for public transport, accessibility and parking. The group considered the duration of JCCCG public and JCCCG private meetings and agreed the majority of the JCCCGs meeting to be held in public. JP asked members to consider renaming the JCCCG to reflect the strengthening of commissioner collaboration and ambition of the committee to work together more as a system. JP was asked to bring back an options paper to a future meeting. Members confirmed approval of the JCSG terms of reference subject to the proposed changes discussed. <u>Draft JCCCG Manual Agreement and JCCCG Terms of Reference (revised)</u> LK informed members that the manual agreement sets out how local health systems will work together to commission health services to the public with some specific responsibilities delegated to it from the five SYB Clinical Commissioning Groups. The group was asked to consider the draft vs3 JC CCG manual agreement and consider and approve the changes proposed, including: 1. Definition and Membership of the JCCCG 2. Conflicts of Interest - The ICS JCCCG will operate an up-to-date Register of Interest, each member is responsible to declare any conflicts of interest at the beginning of each JCCCG meeting. 3. The role of the Joint Committee Sub Group 4. Delegation of CCGs to JCCCGs - Governing Bodies are considering specific delegation requirements for JCCCG 5. Pending support at June JCCCG meeting, the JCCCG Manual Agreement and JCCCG Terms of Reference to be shared with Governing Bodies in July (public) for sign off. LK agreed to discuss with CCGs whether data sharing agreements that governs the processing of personal data in accordance with the law is required in the manual agreement. PMG asked that further emphasis on GDPR is added, LS agreed to amend the manual agreement. LK agreed to share with the JCCCG 19/20 priorities at the next JCCCG meeting. EK noted that it would be helpful to include members' expected attendance at JCCCG meetings and deputies to attend in exceptional circumstance only. Members agreed to minimum 75% attendance annually for all JCCCG members with the exception of Associates members whereby delegated deputies will be acceptable. Members raised concerns that clinical engagement and involvement is required from the outset of JCCCG projects and programs. It was noted that work is underway to	**JP** **LK** **LK** **LK** **LK**

	establish a robust clinical engagement process that will provide assurance to GBs and JCCCG that work is clinically lead. Members noted and agreed the proposed recommendations and timescales. LK agreed to update the JCCCG Terms of Reference, Manual Agreement and Priorities and bring back to the JCCCG in June meeting in public to recommend to July GBs.	**LK**
C117/19	**Any other business** The Chair informed members that the timeframe for receiving questions from the public is extended to 12.00pm on the Monday prior to the meeting date. PM asked if a progress report could be available, specific for the public audience. LK agreed to action quarterly starting from July, end of quarter 1 The group was informed that the ambition for the new ICS Collaborative Partnership Board under the new ICS interim governance arrangements is for the meetings to be held in public. Further detail from the SYB ICS is awaited on this.	**LK**
C118/19	**Date and Time of Next Meeting** The Chair informed the meeting that the next meeting will take place on 26 June 2019, 3.30 – 5.00, NHS Doncaster CCG, The Boardroom, Sovereign House, Heavens Walk, Doncaster, DN4 5DJ.	