NHS
Barnsley
Clinical Commissioning Group

A meeting of the NHS Barnsley Clinical Commissioning Group Governing Body will be held on Thursday 8 July 2021 at 9.30 am via Microsoft Teams

Click here to join the meeting

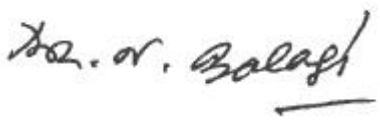
AGENDA
(Public)

Item	Session	GB Requested to	Enclosure Lead	Time
1	House Keeping	Information	Nick Balac	9.30 am
2	Apologies	Note		9.30 am
3	Quoracy	Note		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 21/07/05** Nick Balac	9.45 am 5 mins
6	Patient and Public Involvement Activity Report	Assurance	**GB/Pu 21/07/06** Kirsty Waknell	9.50 am 10 mins
7	Questions from the Public	Information	**Verbal** Kirsty Waknell	10.00 am 5 mins
8	Minutes of the meeting held on: 13 May 2021 (public session) 10 June 2021 (Extraordinary)	Approval	**GB/Pu 21/07/08** Nick Balac	10.05 am 5 mins
9	Matters Arising Report	Note	**GB/Pu 21/07/09** Nick Balac	10.10 am 5 mins
	Strategy			
10	Chief Officer's Report	Information	**GB/Pu 21/07/10** Chris Edwards	10.15 am 10 mins
11	Covid-19 response & Recovery Reset Update	Information & Assurance	**GB/Pu 21/07/11** Jeremy Budd	10.25 am 10 mins

12	Integrated Care at Barnsley Place Assurance Report		Information & Assurance	**GB/Pu 21/07/12** Jeremy Budd	10.35 am 10 mins
13	Assurance Report Maternity Update		Information & Assurance	**GB/Pu 21/07/13** Patrick Otway	10.45 am 10 mins
14	Assurance Report - Locked Rehab		Information & Assurance	**GB/Pu 21/07/14** Jayne Sivakumar Jo Harrison	10.55 am 10 mins
15	PDA Schemes		Information & Assurance	**GB/Pu 21/07/15** Madhavi Guntamukkala	11.05 am 10 mins
16	Commissioning for Outcomes Policy		Approve	**GB/Pu 21/07/16** Madhavi Guntamukkala David Lautman	11.15 am 10 mins
	Quality and Governance				
17	Quality Highlights Report		Assurance	**GB/Pu 21/07/17** Jayne Sivakumar	11.25 am 10 mins
18	Risk & Governance Exception Report		Assurance	**GB/Pu 21/07/18** Richard Walker	11.35 am 10 mins
	Finance and Performance				
19	Integrated Performance Report		Assurance and Information	**GB/Pu 21/07/19** Roxanna Naylor Jamie Wike	11.45 am 15 mins
	Committee Reports and Minutes				
20	20.1	Unadopted Minutes of the Audit Committee held on 10 June 2021	Assurance	**GB/Pu 21/07/20.1** Nigel Bell	12.00 noon 5 mins
	20.2	Minutes of the Finance and Performance Committee held on: • 6 May 2021 • 3 June 2021 - cancelled	Assurance	**GB/Pu 21/07/20.2** Nick Balac	
	20.3	Assurance Report Primary Care Commissioning on 27 May 2021 including adopted minutes 25 March 2021	Assurance	**GB/Pu 21/07/20.3** Chris Millington	
	20.4	Minutes of the Quality and Patient Safety Committee held on 15 April 2021	Assurance	**GB/Pu 21/07/20.4** Jayne Sivakumar	
	20.5	Assurance Report from the Equality and Engagement Committee held on 20 May 2021 including adopted minutes dated 20 May 2021	Assurance	**GB/Pu 21/07/20.5** Chris Millington	

	General			
21	Reports Circulated in Advance for Noting: From the SYB ICS Health Executive Group held on 11 May 2021 • SYB ICS CEO Report (marked Enc B) From the SYB ICS Health Executive Group held on 8 June 2021 • SYB ICS CEO Report (Enc B)	Information & Assurance	Nick Balac	12.05 pm 5 mins
22	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	12.10 pm
23	**Date and Time of the Next Meeting:** Thursday 9 September 2021 at 09.30 am Via Microsoft Teams			12.10 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

8 July 2021

Declarations of Interests, Gifts, Hospitality and Sponsorship Report

PART 1A – SUMMARY REPORT

1.	**THIS PAPER IS FOR**						
	Decision		*Approval*		*Assurance*	X	*Information*	
2.	**PURPOSE**						
	To foresee any potential conflicts of interests relevant to the agenda.						
3.	**REPORT OF**						

	Name	Designation
Executive / Clinical Lead	Richard Walker	Head of Governance & Assurance
Author	Paige Dawson	Governance, Risk & Assurance Facilitator

4. SUMMARY OF PREVIOUS GOVERNANCE

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

Group / Committee	Date	Outcome
N/A		

5. 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 A to this report details all Governing Body Members' current declared interests to update and to enable the Chair and Members to foresee any potential conflicts of interests relevant to the agenda. In some circumstances it could be reasonably considered that a conflict exists even when there is no actual conflict. Members should also declare if they have received any Gifts, Hospitality or Sponsorship.	
6.	**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.	
7.	**APPENDICES / LINKS TO FURTHER INFORMATION**	
	• Appendix A – Governing Body Members Declaration of Interest Report	

Agenda time allocation for report:	5 minutes

PART 1B – SUPPORTING INFORMATION & ASSURANCE

1. Links to Corporate Priorities, GBAF and Risk Register

This report provides assurance against the following corporate priorities on the Governing Body Assurance Framework

1.1 Urgent & Emergency Care		6.1 Efficiency Plans	
2.1 Primary Care		7.1 Transforming Care for people with LD	
3.1 Cancer		8.1 Maternity	
4.1 Mental Health		9.1 Digital and Technology	
5.1 Integrated Care @ System		10.1 Compliance with statutory duties	✓
5.2 Integrated Care @ Place			

The report also provides assurance against the following red or amber risks on the Corporate Risk Register:	*N/A*

2. Links to statutory duties

This report has been prepared with regard to the following CCG statutory duties set out in Chapter A2 of the NHS Act

Management of conflicts of interest (s14O)	✓	Duties as to reducing inequalities (s14T)	
Duty to promote the NHS Constitution (s14P)		Duty to promote the involvement of each patient (s14U)	
Duty to exercise its functions effectively, efficiently and economically (s14Q)		Duty as to patient choice (s14V)	
Duty as to improvement in quality of services (s14R)		Duty as to promoting integration (s14Z1)	
Duty in relation to quality of primary medical services (s14S)		Public involvement and consultation (s14Z2)	

3. Governance Considerations Checklist *(these will be especially relevant where a proposal or policy is brought for decision or approval)*

3.1 Clinical Leadership

Have GB GPs and / or other appropriate clinicians provided input and leadership?	***NA***

3.2 Management of Conflicts of Interest (s14O)

Have any potential conflicts of interest been identified and managed appropriately, having taken advice from the Head of Governance & Assurance and / or the Conflicts of Interest Guardian if appropriate?	***Y***

3.3 Discharging functions effectively, efficiently, & economically (s14Q)

Have any financial implications been considered & discussed with the Finance Team?	***NA***
Where relevant has authority to commit expenditure been sought from Management Team (<£100k) or Governing Body (>£100k)?	***NA***

3.4 Improving quality (s14R, s14S)

Has a Quality Impact Assessment (QIA) been completed if relevant?	***NA***
Have any issues or risks identified been appropriately addressed having taken advice from the Chief Nurse (or Deputy) if appropriate?	***NA***

3.5	**Reducing inequalities (s14T)**	
	Has an Equality Impact Assessment (EIA) been completed if relevant?	***NA***
	Have any issues or risks identified been appropriately addressed having taken advice from Equality Diversity & Inclusion Lead if appropriate?	***NA***
3.6	**Public Involvement & Consultation (s14Z2)**	
	Has a s14Z2: Patient and Public Participation Form been completed if relevant?	***NA***
	Have any issues or risks identified been appropriately addressed having taken advice from the Head of Comms & Engagement if appropriate?	***NA***
3.7	**Data Protection and Data Security**	
	Has a Data Protection Impact Assessment (DPIA) been completed if relevant?	***NA***
	Have any issues or risks identified been appropriately addressed having taken advice from the SIRO, IG Lead and / or DPO if appropriate?	***NA***
3.8	**Procurement considerations**	
	Have any issues or risks identified been appropriately addressed having taken advice from the procurement Shared Service if appropriate?	***NA***
	Has a Single Tender Waiver form been completed if appropriate?	***NA***
	Has a Primary Care Procurement Checklist been completed where GPs, networks or Federations may be a bidder for a procurement opportunity?	***NA***
3.9	**Human Resources**	
	Have any significant HR implications been identified and managed appropriately, having taken advice from the HR Lead if appropriate?	***NA***
3.10	**Environmental Sustainability**	
	Have any significant (positive or negative) impacts on the environment or the CCG's carbon footprint been identified?	***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).
		• Clinical Lead Primary Care South Yorkshire and Bassetlaw ICS (Commissioning).
Nigel Bell	Lay Member - Governance	• Lay Member representing South Yorkshire & Bassetlaw organisations on the Integrated Assurance Committee of South Yorkshire & Bassetlaw Integrated Care System
Chris Edwards	Chief Officer	• Family member employed by Chesterfield Royal • Family member employed by Attain • Accountable Officer for Rotherham CCG

Name	Current position (s) held in the CCG	Declared Interest
		• Maternity Lead at ICS
Madhavi Guntamukkala	Medical Director	• Senior GP in a Barnsley Practice (Apollo Court Medical Practice & The grove Medical Practice) Practices provide services under contract to the CCG • The practice is a member of Barnsley Healthcare Federation which may provide services for Barnsley CCG • Spouse – Dr M Vemula is also partner GP at both practices
John Harban	GP Governing Body Member	• GP Partner at Lundwood Medical Centre and The Kakoty Practice, Barnsley
		• AQP contracts with the Barnsley Clinical Commissioning Group to supply Vasectomy, Carpal Tunnels and Nerve Conduction Studies services
		• Owner/Director Lundwood Surgical Services
		• Wife is Owner/Director of Lundwood Surgical Services
		• 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

Name	Current position (s) held in the CCG	Declared Interest
		• 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
		• Member of the British Medical Association
		• Director of YAAOZ Ltd, with wife
		• Malkarsha Properties Ltd (Director)
		• Partner (share holder) in Primecare LTD – holding the APMs contract for Lakeside Surgery and Goldthorpe
Jamie MacInnes	Governing Body Member	• GP Partner at Dove Valley Practice
		• The practice is a member of Barnsley Healthcare Federation which may provide services for Barnsley CCG

Name	Current position (s) held in the CCG	Declared Interest
		• Shareholder in GSK
		• 3A Honorary Senior Lecturer
		• Wife has a position as a Consultant Breast Surgeon with Leeds Hospital Trust.
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.
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
Jayne Sivakumar	Chief Nurse	• Director of RJS Healthcare Ltd – a healthcare company which receives referrals from healthcare organisations.

Name	Current position (s) held in the CCG	Declared Interest
		• Husband is a Consultant Surgeon at the Mid Yorkshire Hospital NHS Foundation Trust.

In attendance:

Richard Walker	Head of Governance and Assurance	• Daughter is employed by Health Education England
Jamie Wike	Chief Operating Officer	• Wife is employed by Barnsley Healthcare Federation as a Primary Care Network Manager
Jeremy Budd	Director of Commissioning	• Director – Your Healthcare CIC (provision of community health services and social care services in SW London) • Director – Barnsley Estates Partnership Limited (LIFT Company for Barnsley) • Director – Barnsley Community Solutions (Tranche 2) Limited (LIFT Company for Barnsley) • Director – Barnsley Community Solutions (Tranche 3) Limited (LIFT Company for Barnsley) • Director Belenus Ltd (Dormant, non-trading)

NHS
Barnsley
Clinical Commissioning Group

Governing Body

8 July 2021

Patient and Public Involvement Activity Report

PART 1A – SUMMARY REPORT

1.	**THIS PAPER IS FOR**						
	Decision		*Approval*		*Assurance*	x	*Information*	
2.	**PURPOSE**						
	This report outlines latest guidance of the patient and public involvement and highlights any activity we have carried out to help inform commissioning decisions and service development.						
3.	**REPORT OF**						

	Name	Designation
Executive	Jeremy Budd	Director of Strategic Commissioning and Partnerships
Author	Kirsty Waknell	Head of Communications and Engagement

4. SUMMARY OF PREVIOUS GOVERNANCE

Group / Committee	Date	Outcome
CCG Engagement and Equality committee	20/5/2021	Noted

5. EXECUTIVE SUMMARY

The CCG patient and public involvement strategy 2021/22 has now been formally adopted by CCG engagement and equality committee.

Working with people and communities forms a central part of the recently published *Integrated Care Systems: design framework*. Guidance is given on the expectations for ICScs and place-based partnerships who will be expected to agree how to listen consistently to, and collectively act on, the experience and aspirations of local people and communities.

6. THE COMMITTEE IS ASKED TO:

- Note the approval of the CCG patient and public involvement strategy 2021/22
- Note the expectations for working with communities and people as outlined in the Integrated Care Systems: Design Framework
- Note the public involvement in CCG meetings in public during 2020/21

Agenda time allocation for report:	5 minutes

PART 1B – SUPPORTING INFORMATION & ASSURANCE

1. Links to Corporate Priorities, GBAF and Risk Register

This report provides assurance against the following corporate priorities on the Governing Body Assurance Framework

1.1 Urgent & Emergency Care		6.1 Efficiency Plans	
2.1 Primary Care		7.1 Transforming Care for people with LD	
3.1 Cancer		8.1 Maternity	
4.1 Mental Health		9.1 Digital and Technology	
5.1 Integrated Care @ System		10.1 Compliance with statutory duties	✓
5.2 Integrated Care @ Place		11.1 Delivery of Enhanced Health in Care Homes	

The report also provides assurance against the following red or amber risks on the Corporate Risk Register:	CCG 13/13b CCG 13/13b CCG 15/06

2. Links to statutory duties

This report has been prepared with regard to the following CCG statutory duties set out in Chapter A2 of the NHS Act

Management of conflicts of interest (s14O)	**See 3.2**	Duties as to reducing inequalities (s14T)	✓
Duty to promote the NHS Constitution (s14P)		Duty to promote the involvement of each patient (s14U)	✓
Duty to exercise its functions effectively, efficiently and economically (s14Q)	**See 3.3**	Duty as to patient choice (s14V)	✓
Duty as to improvement in quality of services (s14R)	✓	Duty as to promoting integration (s14Z1)	✓
Duty in relation to quality of primary medical services (s14S)	✓	Public involvement and consultation (s14Z2)	✓

3. Governance Considerations Checklist *(these will be especially relevant where a proposal or policy is brought for decision or approval)*

3.1 Clinical Leadership

Have GB GPs and / or other appropriate clinicians provided input and leadership?	***Y***

3.2 Management of Conflicts of Interest (s14O)

Have any potential conflicts of interest been identified and managed appropriately, having taken advice from the Head of Governance & Assurance and / or the Conflicts of Interest Guardian if appropriate?	***NA***

3.3 Discharging functions effectively, efficiently, & economically (s14Q)

Have any financial implications been considered & discussed with the Finance Team?	***NA***
Where relevant has authority to commit expenditure been sought from Management Team (<£100k) or Governing Body (>£100k)?	***NA***

3.4	**Improving quality (s14R, s14S)**	
	Has a Quality Impact Assessment (QIA) been completed if relevant?	***NA***
	Have any issues or risks identified been appropriately addressed having taken advice from the Chief Nurse (or Deputy) if appropriate?	***NA***
3.5	**Reducing inequalities (s14T)**	
	Has an Equality Impact Assessment (EIA) been completed if relevant?	***NA***
	Have any issues or risks identified been appropriately addressed having taken advice from Equality Diversity & Inclusion Lead if appropriate?	***NA***
3.6	**Public Involvement & Consultation (s14Z2)**	
	Has a s14Z2: Patient and Public Participation Form been completed if relevant?	***NA***
	Have any issues or risks identified been appropriately addressed having taken advice from the Head of Comms & Engagement if appropriate?	***No***
3.7	**Data Protection and Data Security**	
	Has a Data Protection Impact Assessment (DPIA) been completed if relevant?	***NA***
	Have any issues or risks identified been appropriately addressed having taken advice from the SIRO, IG Lead and / or DPO if appropriate?	***NA***
3.8	**Procurement considerations**	
	Have any issues or risks identified been appropriately addressed having taken advice from the procurement Shared Service if appropriate?	***NA***
	Has a Single Tender Waiver form been completed if appropriate?	***NA***
	Has a Primary Care Procurement Checklist been completed where GPs, networks or Federations may be a bidder for a procurement opportunity?	***NA***
3.9	**Human Resources**	
	Have any significant HR implications been identified and managed appropriately, having taken advice from the HR Lead if appropriate?	***NA***
3.10	**Environmental Sustainability**	
	Have any significant (positive or negative) impacts on the environment or the CCG's carbon footprint been identified?	***NA***

PART 2 – DETAILED REPORT

INTRODUCTION/ BACKGROUND INFORMATION	
1	**Barnsley CCG Patient and Public Involvement Strategy 2021 2022** The CCG patient and public involvement strategy outlines how we are committed to engaging, involving and consulting with a wide range of audiences to develop plans and priorities as well as improve services. The strategy takes into account the statutory requirements of a CCG in relation to patient and public involvement. The strategy was outlined in the previous report to Governing Body and has now been approved and adopted by the CCG engagement and equality committee in May 2021. The refreshed strategy is now available on the CCG website.
2	**Working with people and communities** The recently published Integrated Care Systems: design framework outlines that parties in an ICS, including those of the ICS Partnership, the NHS ICS body and place-based partnerships will be expected to agree how to listen consistently to, and collectively act on, the experience and aspirations of local people and communities. This includes supporting people to sustain and improve their health and wellbeing, as well as involving people and communities in developing plans and priorities, and continually improving services. As part of the ICS-wide arrangements, each ICS NHS body is expected to build a range of engagement approaches into their activities at every level and to prioritise engaging with groups affected by inequalities. The framework suggests that the solutions to reducing inequalities will often be found by engaging with communities through relational and strengths based approaches drawing on the experience of local authority, voluntary community and social enterprise sector (VCSE), and other partners with experience and expertise in this regard. This is expected to be supported by a legal duty for ICS NHS bodies to make arrangements to involve patients, unpaid carers and the public in planning and commissioning arrangements, and by the continuation of the existing NHS trust and foundation trust duties in relation to patient and public involvement, including the role of foundation trusts governors. Working with a range of partners such as Healthwatch, the VCSE sector and experts by experience, the ICS NHS body should assess and where necessary strengthen public, patient and carers' voice at place and system levels. Places are an important component, as they typically cover the area and services with which most residents identify. NHS England and NHS Improvement is working with ICSs, Healthwatch England and others to identify and disseminate some of the most effective place-based approaches, for example through place-level citizens' panel

	work. Arrangements in a system or place should not just provide a mechanism for commentary on services but should be a source of genuine co-production and a key tool for supporting accountability and transparency of the system. Where decision-making affects communities, groups or specific services, these arrangements (including any formal consultation) should fully engage those affected, including populations, patients and carers across health and social care. Each ICS NHS body should use principles previously published as a basis for developing a system-wide strategy for engaging with people and communities, building on the existing relationships, good practice and networks across system partners. Work is already taking place in Barnsley to align locally designed guiding principles to develop the Barnsley approach to working with people and communities. As part of this strategy, the body should work with its partners across the ICS to develop arrangements for: • ensuring the ICS Partnership and place-based partnerships have representation from local people and communities in priority setting and decision-making forums • gathering intelligence about the experience and aspirations of people who use care and support, together with clear approaches to using these insights to inform decision making and quality governance. More detailed information will be made available to systems in guidance on membership and governance of ICS NHS bodies and in the implementation support for how ICSs work with people and communities.
3	**Covid-19 vaccine community engagement** Barnsley Council, as part of ongoing partnership work, has been running a series of series of sessions to encourage people to become vaccine supporters. These have included local businesses and employers, the care sector, council staff in a range of roles and also GP practice patient groups. This is part of the community engagement work which has seen neighbourhood engagement officers and community champions having conversations with local residents about, and supporting them to, get their Covid-19 vaccine.
4	**Involvement in CCG meetings in public** Barnsley CCG welcomes questions from the public at the governing body meetings held in public once every other month. Details of future meetings, together with agendas and minutes from previous ones are available on the CCG website. This is where it is promoted the route for any questions people may want to ask. These meetings are also promoted on social media, highlighting how people can get involved. The governing body meetings are held in public rather than being public meetings: this

means that the public are very welcome to attend but cannot take part in the business of the meeting. There is however the opportunity to ask a question to the chair of the meeting.

Before the pandemic these meetings were held in person in a range of locations across the borough. One of the reasons was to make it easier for people in different areas of the borough who wished to observe the meeting, or ask a question, to attend.

Attendance at these meetings varied but in the main a consistent group of an average of three or four people attended on a regular basis, wherever the meeting was held. Questions were asked at each meeting, some in response to the items raised in discussion, some pre-prepared relating to some items on the agenda and sometimes not.

It was agreed at the governing body in May 2021 to reflect on the involvement of members of the public in the current meeting format.

Since the requirement to meet virtually over the past year where questions are required to be submitted ahead of the meeting, the number of questions submitted from members of the public has dropped off.

Meetings are now recorded live and published in the public domain after the meeting. This differs to some other neighbouring NHS and local authority organisations whereby the meetings are virtual but broadcast live, with questions submitted beforehand.

The CCG meeting videos are uploaded to our website and the average number of views over the previous six meetings was 36 per meeting. If the number of views was the same number of people, this would be considerably higher than the usual attendance at an in-person meeting. People also have the opportunity to skip to areas of interest in the video and ‘attend’ at a time suitable for them.

Prior to and throughout the pandemic, the meeting highlights and decisions are shared in real time on the CCG’s Twitter account. Any questions arising on Twitter are answered where possible on twitter and don’t form part of the formal question section of the meeting. Here is the overview of interaction and engagement on the CCG Twitter account during governing body meetings. To give some context the current number of followers overall on the Barnsley CCG Twitter account is 13.5k.

Over the six virtual meetings in 2020/21 engagement on governing body days has remained fairly static:

- Average number of tweets per meeting = 25 per meeting
- Average number of times followers interact with a tweet (from clicking on it to sharing it to replying) = 241
- The % engagement rate of the total impressions = 1.7% This rate is a good engagement rate on Twitter and shows interaction on governing body days are higher than other days.

This overview is aimed to be helpful when considering interaction and engagement in future meetings in public.

NHS
Barnsley
Clinical Commissioning Group

Minutes of the meeting of the Barnsley Clinical Commissioning Group Governing Body (PUBLIC SESSION) held on Thursday 13 May 2021, 9.30 am via Microsoft Teams

MEMBERS PRESENT

Dr Nick Balac	Chairman
Dr Adebowale Adekunle	Member
Nigel Bell	Lay Member for Governance
Chris Edwards	Chief Officer
Madhavi Guntamukkala	Medical Director & Member
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
Jayne Sivakumar	Chief Nurse
Dr Mark Smith	Member

IN ATTENDANCE

Jeremy Budd	Director of Strategic Commissioning and Partnerships
David Lautman	Lead Commissioning and Transformation Manager (for minute references GB/Pu GB/Pu 21/05/14 only)
Chris Lawson	Head of Medicines Optimisation (for minute reference GB/Pu GB/Pu 21/05/15 only)
Kay Morgan	Governance and Assurance Manager (Minutes)
Patrick Otway	Head of Commissioning (Mental Health, Children's, and Maternity) (for minute references GB/Pu GB/Pu 21/05/16 only)
Kirsty Waknell	Head of Communications and Engagement
Richard Walker	Head of Governance and Assurance
Jamie Wike	Chief Operating Officer

APOLOGIES

Dr John Harban	Member
Dr Hussain Kadarsha	Member

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

Agenda Item		Action	Deadline
GB/Pu 21/05/01	**HOUSEKEEPING**		
	Members noted the etiquette for meetings held via Microsoft Teams.		

Agenda Item		Action	Deadline
GB/Pu 21/05/02	**QUORACY**		
	The meeting was declared quorate.		
GB/Pu 21/05/03	**PATIENT STORY**		
	The Chief Nurse introduced the Patient Story, highlighting that the story is particularly pertinent during national 'Dying Matters Week'. The Patient Story was a woman's reflection on her close friend's end of life care, (with an expressed wish to die at home) and the care provided. The Governing Body noted that the Patient Story demonstrates the importance of advanced care planning and communication throughout end of life care. A patient's preference for end of life care is recorded on clinical systems and this information available to health care professionals involved in the patients care. The Medical Director advised Governing Body that a new end of life care programme is in place for residents in care homes. This focuses on a proactive rather than reactive approach to end of life planning / care and most patients have advance care plans in place. The Lay Member for Patient and Public Engagement & Primary Care Commissioning referred to a personal experience regarding a close relative on end of life care. In the absence of relevant information / support he had no option but to dial 999. It is also important for the ambulance service to be aware and have access to the advanced wishes of patients on end of life care.		
	The Chairman concluded the discussion, advising that the wishes of patients must be respected but, in some instances, a patient's condition can deteriorate rapidly and prevent end of life planning. There is a need for early advanced planning, but this should be revisited as things such as carer support change.		
	The Governing Body noted the Patient Story.		
GB/Pu 21/05/04	**DECLARATIONS OF INTEREST, SPONSORSHIP, HOSPITALITY AND GIFTS RELEVANT TO THE AGENDA**		
	The Governing Body considered the Declarations of		

Agenda Item		Action	Deadline
	Interests Report. The Chairman advised that all Governing Body GP Members have a direct financial interest in agenda item 17 'PDA 2021/22 The Medicines Optimisation Scheme'. GP members are contracted through the PDA to deliver the schemes. However, GP members will be allowed to participate in discussion from a qualitative perspective – approval of the financial aspects is delegated to the Primary Care Commissioning Committee. No other new declarations were received.		
GB/Pu 21/05/05	**PATIENT AND PUBLIC INVOLVEMENT ACTIVITY REPORT**		
	The Head of Communications and Engagement introduced the Patient and Public Involvement Activity Report to the Governing Body. Members were informed that the CCG's Patient and Public Involvement Strategy is currently being reviewed, with a refreshed version due to be submitted for approval to the CCG Engagement and Equality Committee later in May 2021.		
	The Lay Member for Patient and Public Engagement & Primary Care Commissioning advised that the Patient Council had been instrumental in developing the original underpinning principles of the strategy, demonstrating the strong patient voice in engagement work, with particular emphasis on the following two principles: • I'm a part time patient but a full time person • Don't use jargon – be clear about what you are asking and why		
	The Governing Body noted the progress of local involvement activity		
GB/Pu 21/05/06	**QUESTIONS FROM THE PUBLIC**		
	It was reported that the CCG had not received any questions from Members of the public. The Chairman advised that there had been very little engagement from Members of the Public with the Governing Body during the Covid-19 Pandemic and queried what could be done to facilitate greater engagement and questions from the public.		

Agenda Item		Action	Deadline
	The Head of Communications and Engagement commented that other CCGs and the ICS were experiencing the same issue. However, the number of people viewing the recorded Governing Body meetings had increased as this offered improved access. The meetings of Governing Body are also live tweeted throughout the meeting and responses received. ***Agreed action*** ***The Head of Communications and Engagement agreed to consider options to facilitate greater engagement of the public in Governing Body meetings held in public session and provide an update (as part of the Patient and Public Involvement Activity Report) to the next meeting of the Governing Body.***	**KW**	08.07.21
GB/Pu 21/05/07	**MINUTES OF THE MEETING HELD ON 11 MARCH 2021**		
	The minutes of the Governing Body meeting held on 11 March 2021 were verified as a correct record of the proceedings.		
GB/Pu 21/05/08	**MATTERS ARISING REPORT**		
	The Governing Body considered the Matters Arising Report and the following updates were noted: **Minute reference GB 19/11.03 Patient Story – Young Commissioners, OASIS – How the voice of the young commissioner can be involved in commissioning of services.** The Governing Body determined that it is important for the 'voice of the young commissioner' to feature in the work of the Health and Wellbeing Board and Mental Health Partnership particularly moving into the new commissioning landscape and structures. The Chairman agreed to raise this at the next meeting of the Health and Wellbeing Board. It was suggested that the Barnsley Youth Orchestra / Choir could provide a potential forum to engage with young people. **Minute reference GB/Pu 21/01/13 Integrated Care at Barnsley Place – Restoration and Recovery Plan** The Director of Strategic Commissioning and Partnerships reported that a refresh of the Barnsley Restoration and		

Agenda Item		Action	Deadline
	Recovery Plan is in progress. The plan will be submitted to a future Governing Body Development Session. **Minute reference GB/Pu GB/Pu 21/01/15 Suicide Prevention and Bereavement Support Update** It was confirmed that information regarding available suicide prevention and bereavement support services had been sent to practices on 23 February 2021, posted on the BEST website and discussed in PCN meetings. Some GP members indicated that they are not seen the information within their Practice. The Lay Member for Patient and Public Engagement & Primary Care Commissioning requested assurance that information re Suicide Prevention and Bereavement Support Services is appropriate and readily available to all practice staff as required ***Agreed action*** ***To provide assurance that information re Suicide Prevention and Bereavement Support Services is relevant and available to practice staff***	**PO MS**	
STRATEGY			
GB/Pu 21/05/09	**CHIEF OFFICER'S REPORT**		
	The Chief Officer presented his report which provided the Governing Body with with information in respect of: • The NHS 2021/22 priorities and operational planning guidance • A letter from NHS England and NHS Improvement re NHS response to COVID-19: Transition to NHS level 3 incident • A letter from Sir Andrew Cash, System Leader South Yorkshire & Bassetlaw Integrated Care System Re Health & Care Compact, Health and Care Partnership and Place Development Matrix • The Barnsley Director of Public Health Annual Report: '*A day in the life of*'		
	The following comments were noted in respect of the Health and Care Compact, Health and Care Partnership Terms of Reference and Place Development Matrix: • **Health and Care Compact** The values and principles of the compact are balanced		

Agenda Item		Action	Deadline
	and sensible. • **Health and Care Partnership Terms of Reference** The Health and Care Partnership is complicated with a large rich and diverse membership of 50/60 members and this will be a challenge for the leadership of and enacting the objectives of the partnership. • **Place Development Matrix** The Barnsley Place Design Team are undertaking a gap analysis against the development matrix. The Lay Member for Patient and Public Engagement & Primary Care Commissioning advised that consideration should be given to presenting the Health and Care Compact, Health and Care Partnership Terms of Reference and Place Development Matrix to members of the public. The Chairman highlighted that the priorities and planning guidance figures for additional roles, new GPs and more GP appointments by April 2024 appeared ambitious but not out of step with previous aspirational targets.		
	In response to a request from the Lay Member for Patient and Public Engagement & Primary Care Commissioning the Chairman provided an explanation of the acronym 'PCN'. A Primary Care Network (PCN) is where Practices have come together to deliver additional primary care services, reducing health inequalities and improved outcomes and for the people of Barnsley. In Barnsley 6 locality / geographic neighbourhood networks link into one Barnsley Primary Care Network. The PCN is supported by additional roles to enable its work and is co-terminus with other services such as the Community Nursing Service.		
	The Governing Body noted the report and the progress made on the ICS development work across all the work streams, and provided comment on the: • **Health and Care Compact** • **Health and Care Partnership Terms of Reference** • **Place Development Matrix**		
GB/Pu 21/05/10	**COVID-19 RESPONSE AND PHASE 3 RECOVERY UPDATE**		
	The Chief Operating Officer provided the Governing Body with an update in relation to the current situation and the CCG's response to the Coronavirus Disease (COVID19) pandemic. The update also set out the expectations of the		

Agenda Item		Action	Deadline
	2021/22 Planning Guidance in relation to the recovery of services and delivery of the priorities for the NHS. The Governing Body noted that the current Covid-19 case rate in Barnsley is at 40 cases per 100,000 and positively moving in the right direction. The new variants are of concern but are not heavily present in Barnsley and surrounding areas.		
	In response to a question raised about the Covid vaccination programme, the Chief Operating Officer clarified that it is intended to offer a booster Covid vaccination in Autumn 2021. The model for the booster vaccination is not yet known, the cohorts to be vaccinated or the whole population and if the booster will be wrapped together with the flu vaccination. The Chairman commented that Autumn is a busy time for Practices and planning will be required to avoid further large scale disruption in Primary Care.		
	The Governing Body noted the update provided in this paper including the priorities for the NHS and the progress in implementing the vaccination programme		
GB/Pu 21/05/11	**ASSURANCE REPORT – URGENT AND EMERGENCY CARE UPDATE**		
	The Chief Operating Officer provided the Governing Body with an update on Urgent and Emergency Care including assurance of actions being taken and developments underway to mitigate risks and improve urgent care services for Barnsley patients. The Governing Body was informed that the A&E Department remains extremely busy. There have been occasions with 380 patients attending and with 50% waiting 4 hours or more but this is not all of the time.		
	The Governing Body noted the update on the current position and plans for Urgent and Emergency Care.		
GB/Pu 21/05/12	**ASSURANCE REPORT – PRIMARY CARE**		
	The Governing Body received and noted an Assurance Report in respect of Primary Care.		
	The Governing Body noted the information in the report that will provide assurance regarding the		

Agenda Item		Action	Deadline
	delivery of the priorities in Primary Care. ***Agreed Action*** ***The Head of Primary Care to attend and present future Primary Care Assurance Reports to the Governing Body meetings.***	**JW**	
GB/Pu 21/05/13	**ASSURANCE REPORT – DIGITAL AND IT UPDATE**		
	The Director of Strategic Commissioning and Partnerships introduced his report providing the Governing Body with an update on the IT/Digital projects and schemes currently being delivered across the CCG area. The Governing Body noted that a summary digital shared care record for each patient will be available by September 2021 and available at the point of care to health care professionals across a health community where care is provided.		
	The Governing Body noted the report for information.		
GB/Pu 21/05/14	**LOCAL PLASTIC AND RECONSTRUCTIVE SURGERY SERVICE**		
	The Chief Operating Officer presented a report seeking Governing Body approval for a Local Plastics and Reconstructive Surgery Service Specification and to provide an update on service mobilisation.		
	It was noted that the first phase of the service had commenced on 1 February 2021. The local plastics and reconstructive surgery service supports the overall ethos of 'care closer to home'. The Chairman commented that set within the changing commissioning landscape, the new service had been a provider led initiative, and this highlights the potential of future integrated partnership structures to closer understand the needs of local people.		
	The Governing Body noted the service update and approved the Plastics and Reconstructive Surgery Specification		
GB/Pu 21/05/15	**PDA 2021/22 THE MEDICINES OPTIMISATION SCHEME UPDATE**		
	The Chairman reiterated that all Governing Body GP Members will have an interest in the PDA Medicines Optimisation Scheme as their Practices will receive funding		

Agenda Item		Action	Deadline
	to deliver the scheme but from a patient safety and improving outcomes perspective GP members will participate in discussion of the qualitative aspects of the scheme.		
	The Medical Director and Head of Medicines Optimisation presented the final draft of the Practice Delivery Agreement for 2021/22 Medicines Optimisation Section for Governing Body Members approval. The Medical Director commented that the Medicines Optimisation Scheme is evidence based, helps to reduce prescribing risks, and supports reviews of medication. It is hoped to integrate this work across other providers so all prescribers will work to same aims and objectives. It was noted that the remaining section(s) of the PDA will be brought for Governing Body approval in July 2021.		
	The Chairman concluded the discussion, commenting that the scheme will save lives and improve the quality of prescribing. On behalf of the Governing Body he further extended his appreciation to all involved in developing the scheme.		
	The Governing Body noted the 2021/22 Draft Medicines Optimisation section of the Practice Delivery Agreement.		
GB/Pu 21/05/16	**ASSURANCE REPORT – MENTAL HEALTH UPDATE**		
	The Head of Commissioning (Mental Health, Children's, and Maternity) provided the Governing Body with an update on the mental health services being delivered within the borough and the achievement, or otherwise, of nationally recommended targets. The report covered: • Delivery of four guiding principles / priorities set out for mental health in the NHS Long Term Plan, • Specialist Perinatal Mental Health, • Adult Common Mental Health Illnesses (IAPT) • Adult Severe Mental Illnesses (SMI) • Community Care IPS (Individual Placement Support) Community Mental Health Transformation • Crisis Alternative • Mental Health Liaison and Crisis Care • Children and Young People's Mental Health		

Agenda Item		Action	Deadline
	Discussion took place. It was highlighted that the Finance and Performance Committee had queried access to services other than to CAMHS for Children and young people who may have needs akin to adults to ensure the needs of children and young people are met. In response to questions raised the Head of Commissioning (Mental Health, Children's, and Maternity): • Agreed to look into the issues of GP rereferrals to CAMHS and MHST being bounced back to GPs. Dr Mark Smith reported that MHST is a trail blazer Team and as such a number of practitioners within the team are currently enhancing their skills and there is reduced capacity in the team. Capacity is expected to be restored shortly and a much better service provided. • Clarified that that eating disorders are included in the CAMHS pathway. A task and finish group has been established to review services for eating disorders. A 'deep dive' report re services for eating disorders will be presented to the Mental Health Partnership Board. It was noted that the CCG commissions 'Chilypep' to engage with young people. The Children and Young People Steering Group links into the Mental Health Partnership Board.		
	The Governing Body noted the report. ***Agreed Actions*** ***To pick up on issues highlighted at Finance & Performance Committee re accessibility to services (other than CAMHS) for children and young people suffering stress and feedback to Finance and Performance Committee*** ***To pick up on GP referrals to CAHMS and report back to the Governing Body***	**PO** **PO**	**08.07.21** **08.07.21**
QUALITY AND GOVERNANCE			
GB/Pu 21/05/17	**QUALITY HIGHLIGHTS REPORT**		
	The Chief Nurse introduced the Quality Highlights report with six rated quality issues to the Governing Body,		

Agenda Item		Action	Deadline
	• Green – Safeguarding Update • Green – Patient Experience Qtr. 3 Report • Green – SYB QUIT PGD • Amber – SWYPFT Waiting Lists • Amber – Minimising Harm • Red – Adult SALT Service		
	The Governing Body noted the Quality Highlights Report for information and assurance.		
GB/Pu 21/05/18	**RISK AND GOVERNANCE EXCEPTION REPORT**		
	The Head of Governance and Assurance introduced the Risk and Governance Exception Report to the Governing Body including the Governing Body Assurance Framework, Corporate Risk Register, Data Security & Protection Toolkit Update, Quarter 4 Workforce Report, Annual Report & Accounts 2020/21, Committee Annual Assurance Reports 2020/21, Committee Effectiveness Survey and Data Quality Policy. The Chairman referred to the risks relating to Continuing Health Care and advised that a comprehensive report re CHC/Complex cases will be considered by the Governing Body in private session following the meeting in public session.		
	The Governing Body: • **Reviewed the Assurance Framework and Risk Register** • **Determined that all risks are being appropriately Managed** • **Did not identify any potential new risks or risks for removal** • **Noted the DSP Toolkit update** • **Noted the Quarter 4 Workforce Report 2020/21** • **Noted the Committee Annual Assurance Reports 2020/21** • **Noted the findings of the Committee Effectiveness survey** • **Noted the updated Data Quality Policy.**		
GB/Pu 21/05/19	**URGENT DECISIONS**		

Agenda Item		Action	Deadline
	The Head of Governance and Assurance requested the Governing Body to ratify three urgent decisions taken since its last meeting in March 2021 in respect of the: • DSCRO Contract • Mental Health Investment Standard (MHIS) independent verification process • West Yorkshire And Barnsley ATU (Assessment and Treatment Unit) Reconfiguration.		
	The Governing Body ratified • **The urgent decision to extend the DSCRO SLA with NECS to 31 March 2024** • **The urgent decision to enable the Accountable Officer to sign the MHIS statement and Letter of Representation, and** • **The urgent decision to support the proposed reconfiguration of the West Yorkshire and Barnsley ATU.**		
FINANCE AND PERFORMANCE			
GB/Pu 21/05/20	**INTEGRATED PERFORMANCE REPORT**		
	Performance The Chief Operating Officer provided the Governing Body with an overview of the key exceptions to performance indicators up to month 12 (March 2021). The Governing Body noted that the information provided continued to show the adverse impact of Covid-19 upon delivery of some constitutional standards including referral to treatment times, waiting times for diagnostic waits, A&E waits, and performance on some cancer pathways. It was noted that referral to treatment times are on an improvement trajectory though still the highest since April 2020.		
	Finance The Chief Finance Officer provided the key headline messages from the month 12 (31 March 2021) Finance Report. All financial duties and planning guidance requirements have been delivered (subject to audit) with a surplus outturn position of £195k.		

Agenda Item		Action	Deadline
	The Governing Body was informed that the closure meeting with the external auditors will be held 20 May 2020 however no issues had been raised as yet. The Governing Body expressed appreciation to the Finance Team for their hard work in achieving financial balance and producing the final accounts during a difficult year.		
	The Governing Body noted the contents of the report including: • **Performance to date 2020/21** • **Finance update to Month 12**		
GB/Pu 21/05/21	**2021/22 FINANCIAL PLAN – APRIL TO SEPTEMBER 2021 (H1)**		
	The Chief Finance Officer introduced her report to the Governing Body providing the final details on the CCGs financial plan for April to September of 2021/22 (H1). The Governing Body noted the overview of the financial framework, the financial plan assumptions, CCG and system allocation, efficiency plans and the financial plan (April to September 2021 H1). The Finance and Performance Committee had consisered the detailed budgets and are recommending that these budgets are adopted for the period April to September 2021.		
	The Governing Body noted the contents of the report and approved the budgets for the period April – September 2021, noting the level of unidentified efficiency and provide any mitigating actions in order to achieve financial balance and business rule requirements.		
COMMITTEE REPORTS AND MINUTES			
GB/Pu 21/05/22	**COMMITTEE REPORTS AND MINUTES**		
	The Governing Body received and noted the following Committee minutes & assurance reports: • Minutes of the Membership Council held on 21 April 2021		

Agenda Item		Action	Deadline
	• Unadopted Minutes of the Audit Committee held on 18 March 2021 The Lay Member for Governance highlighted to the Governing Body that the Audit Committee had considered the CCG Draft 2020/21 Annual Report and Accounts, the Counter Fraud Plan 2021/22, CCG Committee Assurance Reports, and the Value for Money Audit Plan 2021/21. • Minutes of the Finance and Performance Committee held on 4 March 2021 and 1 April 2021. • Assurance Report from the Primary Care Commissioning Committee held on 25 March 2021. It was noted that the Primary Care Commissioning Committee had considered two main items: ○ The results of the GP Survey providing assurance that the Barnsley CCG Practices are on a par with both national and South Yorkshire & Bassetlaw Practices. ○ The outcome of a 360 assurance review indicating that the CCG's delegated primary care functions had been appropriately discharged. • Adopted Minutes of the Quality and Patient Safety Committee held on 18 February 2021.		
GB/Pu 21/05/23	**REPORTS CIRCULATED IN ADVANCE FOR NOTING**		
	The Governing Body noted the reports circulated in advance of the meeting: From the SY&B ICS Health Executive Group held on 9 March 2021 • SYB ICS CEO Report (Enc B) From the SY&B ICS Health Executive Group held on 13 April 2021 • SYB ICS CEO Report (Enc B) .		
GB/Pu 21/05/24	**REFLECTION ON HOW WELL THE MEETING'S BUSINESS HAS BEEN CONDUCTED**		

Agenda Item		Action	Deadline
	The Governing Body agreed that the all papers were presented in a timely manner and the quality of papers received was good.		
	The Chairman thanked Barnsley people for viewing the meeting. **The Governing Body agreed to close the public session of the meeting and proceed to the private part of the agenda. The recording of the meeting was ceased.**		
GB/Pu 21/05/25	**DATE AND TIME OF THE NEXT MEETING**		
	Thursday 8 July 2021 at 09.30 am via Microsoft Teams		

NHS
Barnsley
Clinical Commissioning Group

Minutes of the meeting of the Barnsley Clinical Commissioning Group Governing Body (Extra Ordinary) held on Thursday 10 June 2021, 10.30 am via Microsoft Teams

MEMBERS PRESENT

Dr Nick Balac	Chairman
Dr Adebowale Adekunle	Member
Nigel Bell	Lay Member for Governance
Chris Edwards	Chief Officer
Madhavi Guntamukkala	Medical Director & Member
Dr John Harban	Member
Dr Hussain Kadarsha	Member
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
Jayne Sivakumar	Chief Nurse
Dr Mark Smith	Member

IN ATTENDANCE

Adrian Bailey	Head of Finance: Statutory Accounts and Financial Reporting
Jeremy Budd	Director of Strategic Commissioning and Partnerships
Rashpal Khangura	Director KPMG
Kay Meats	Client Manager 360 Assurance
Kay Morgan	Governance and Assurance Manager (Minutes)
Richard Walker	Head of Governance and Assurance
Jamie Wike	Chief Operating Officer

APOLOGIES

No Apologies

The Chairman opened the meeting. It was noted that the CCG's audited Annual Report and Accounts 2020/21 were reviewed by Audit Committee immediately prior to the Governing Body extra ordinary meeting. The Audit Committee are recommending the CCG's Annual Report and Accounts 2019/20 to the Governing Body for approval and adoption.

Agenda Item		Action	Deadline
GB/Pu 21/06/01	**HOUSEKEEPING**		
	Members noted the etiquette for meetings held via Microsoft Teams.		

Agenda Item		Action	Deadline
GB/Pu 21/06/02	**QUORACY**		
	The meeting was declared quorate.		
GB/Pu 21/06/03	**DECLARATIONS OF INTEREST, SPONSORSHIP, HOSPITALITY AND GIFTS RELEVANT TO THE AGENDA**		
	The Governing Body considered the Declarations of Interests Report. No other new declarations were received.		
GB/Pu 21/06/04	**NHS BARNSLEY CCG ANNUAL REPORT AND ACCOUNTS**		
	The Chief Finance Officer personally thanked the Head of Finance: Statutory Accounts and Financial Reporting, Head of Governance and Assurance and Head of Comms and Engagement for their hard work and contributions in pulling together the CCG's Annual Report and Accounts as presented to the Governing Body. The Audit Committee had also echoed their appreciation to all involved in the production of the Annual Report and Accounts.		
	The Head of Governance and Assurance presented the CCG's Annual Report and Accounts to the Governing Body for adoption. The draft Annual Report and Accounts and been considered in detail by the Audit Committee on 22 April 2021 following which a small number of changes were made prior to submission to NHSE/I and the external auditors. Following the conclusion of the external audit the revised Annual Report and Accounts has again been considered in detail by the Audit Committee on 10 June 2021, and following this meeting Audit Committee is recommending the adoption of the Annual Reports and Accounts 2020/21 to the Governing Body. The NHSE review of the draft annual report determined that it substantially met all the requirements and raised just a small number of minor suggestions all of which had been incorporated in the final version. The external audit also generated a small number of changes. 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 10 June 2021.		

Agenda Item			Action	Deadline
		The Head of Internal Audit Opinion provided significant assurance over the CCG's systems of the CCGs internal control. The Head of Governance and Assurance brought to the attention of the Governing Body, three further changes to the Annual Report since the agenda papers were issued: • Remuneration Report - added narrative re Chief Officers remuneration pro rata to an annualised full-time equivalent (as the highest paid member of CCG staff) • Amended a reference to the '20/21 NHS rating' to '19/20' • Performance Report - At the request of the CCG Chair, extended narrative regarding the work of the PCN delivering the Covid vaccination programme supported by the Barnsley Healthcare Federation. In addition to papers provided for the meeting, the CCG Committee Annual Assurance Reports were received by the Governing Body in May 2021, providing assurance that the Committees of the Governing Body have discharged the responsibilities delegated to them in their Terms of Reference and have managed the key risks within theirs remit. The Governing Body considered the following range of governance papers in support of the Annual Report & Accounts.		
	04.1	**Annual Report - Performance / Accountability Report & Final Accounts**		
		The Governing Body noted the Annual Report – (Performance / Accountability Reports) & Final Accounts		
	04.2	**Annual Governance Report from External Auditors KPMG (ISA 260)**		
		The KPMG Director presented the ISA 260 Report to the Governing Body. 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 10 June 20212.		

Agenda Item			Action	Deadline
		The KPMG Director drew members attention to • The Audit risks on page 7 of the ISA 260 re ○ Expenditure Recognition - Fraud risk related to misstatement of expenditure ○ Management override of controls - Fraud risk related to unpredictable way management override of controls may occur The findings of the audit did not identify any issues to report. • Annual Report and Governance Statement (page 10) The contents of the Annual Report (including the Accountability Report, Directors' Report, Performance Report and Annual Governance Statement (AGS) were reviewed and the relevant parts of the Remuneration Report audited and all comply with the NHS Group Accounting Manual (GAM) issued by Department of Health and Social Care. Clarification was requested and included in the Remuneration Report relating to the highest paid director in terms of disclosure to the public. • Value for Money (Page11) The Audit identified a significant risk (rated as amber) relating to financial sustainability given the uncertainty regarding the financial regime into 2021/22. However, it was explained that that every CCG currently carries this risk. The KPMG Director formally thanked to the Chief Finance Officer, Head of Finance: Statutory Accounts and Financial Reporting and the wider team for the excellent support provided with the audit, which was complemented by a good standard of documents and positive responses to queries raised.		

Agenda Item			Action	Deadline
		The Audit Committee Chair added that having read many sets of annual reports and final accounts in his career, the CCGs final Accounts and Annual report are excellent and a credit to everyone involved.		
	04.3	**Head of Internal Audit Opinion & Annual Report**		
		The Client Manager 360 Assurance presented the 2020/21 Internal Audit Head of Internal Audit Opinion and Annual Report to the Governing Body. The Committee noted the overall opinion of 'significant assurance.' The Client Manager 360 Assurance thanked CCG staff for their assistant throughout the year, in difficult circumstances and working remotely. The Audit Committee Chair referred to the review of Children's Continuing Care and the 'weak' assurance opinion provided. The Audit Committee were concerned with the 'weak' assurance opinion and requested that a task and finish group be established to consider findings / recommendations of the review and provide a report and action plan to the Audit Committee. The Audit Committee wish to maintain a close focus and monitor progress with the action plan. The Governing Body will be provided with an update in due course.		
	04.4	**Annual Report Local Counter Fraud Specialist**		
		The Client Manager 360 Assurance presented the Annual Report of the Local Counter Fraud Specialist to the Governing Body. She explained that from April 2021 all NHS organisations are required to undertake assessment against the new *Government Functional Standard 013: Counter Fraud* ("the Functional Standard"). The CCGs has a positive overall rating of 'green' against the standards. There are a small number of actions and work required to move the 'amber' and 'red' rated areas to 'green' throughout year.		

Agenda Item			Action	Deadline
	04.5	**Management Representation Letter**		
		The Governing Body noted and approved the Management Representation letter confirming that the financial statements are true and that they have been prepared in accordance with the accounting policies directed by NHS England.		
	04.6	**Statement as to Disclosures 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.		
	The Governing Body • **Received the audited Annual Report and Accounts 2020/21** • **Received and considered the ISA260 External Auditor's Report 2020/21 and the Draft Annual Audit Letter 2020/21** • **Received the final Head of Internal Audit Opinion 2020/21** • **Received the Annual Report of the Local Counter Fraud Specialist 2020/21** • **Received and approved the Management Representation Letter 2020/21 and authorised the Chief Officer to sign it on the CCG's behalf** • **Confirmed that the Statement as to Disclosure to Auditors is accurate** • **Approved and adopted the Annual Report and Accounts 2020/21 (following recommendation from the Audit Committee)** • **Authorised the Accountable Officer to sign and date the Performance Report, the Accountability Report, the Statement of Accountable Officer's Responsibilities, and the Statement of Financial Position on the CCG's behalf.**			
GB/Pu 21/06/05	**DATE AND TIME OF THE NEXT MEETING**			
	Thursday 8 July 2021 at 09.30 am via Microsoft Teams			

NHS
Barnsley
Clinical Commissioning Group

GOVERNING BODY
(Public session)

8 July 2021
MATTERS ARISING REPORT

The table below provides an update on actions arising from the previous meeting of the Governing Body (public session) held on 13 May 2021

Table 1

Minute Ref	Issue	Action	Outcome/Action
GB/Pu 21/05/06	**QUESTIONS FROM THE PUBLIC** The Head of Communications and Engagement agreed to consider options to facilitate greater engagement of the public in Governing Body meetings held in public session and provide an update (as part of the Patient and Public Involvement Activity Report) to the next meeting of the Governing Body.	KW	**Complete**
GB/Pu 21/05/12	**ASSURANCE REPORT – PRIMARY CARE** The Head of Primary Care to attend and present future Primary Care Assurance Reports to the Governing Body meetings.	JW (JF)	Noted and **Complete**

GB/Pu 21/05/16	**ASSURANCE REPORT – MENTAL HEALTH UPDATE**		
	To pick up on issues highlighted at Finance & Performance Committee re accessibility to services (other than CAMHS) for children and young people suffering stress and feedback to Finance and Performance Committee	PO	There is a significant amount of support for children and young peoples emotional health and wellbeing (including stress) within the borough. This support is provided via Compass (who deliver the Mental Health Support Team in Schools), Public Health Nursing Service (0-19 service), Chilypep and the Children and Young Peoples Social Prescribing Service.
	To pick up on GP referrals to CAHMS and report back to the Governing Body	PO	In terms of GP referrals in to CAMHS, GP's continue to be the highest referral source but are also the source of the greatest number of inappropriate referrals received by CAMHS (around 45-50% of all GP referrals into CAMHS are deemed 'inappropriate' due to the limited level of information that has been provided on the referral in relation to the young person). CAMHS are also working with GP Practices to promote to GP's / Practices the level of information that is required as part of the referral e.g sharing examples of exemplar referral forms.

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
GB 19/11/03	**PATIENT STORY - YOUNG COMMISSIONERS, OASIS** To consider how the voice of the young commissioners can be involved with the work of the CCG, Health and Wellbeing Board and and Mental Health Partnership particularly moving into the new commissioning landscape and structures .	**NB**	**IN PROGRESS** - Under consideration Patient Council Member; considering introductions via her contacts. 13.05.2021 Update The Chairman agreed to raise this at the next meeting of the Health and Wellbeing Board.
GB/Pu 21/01/13	**INTEGRATED CARE AT BARNSLEY PLACE ASSURANCE REPORT** To submit the refreshed Restoration and Recovery Plan (in light of phase 4 letter) to Governing Body on 11 March 2021.	JB	The plan will be submitted to a future Governing Body Development Session.
GB/Pu 21/01/15 & GB/Pu 21/05/08	**SUICIDE PREVENTION AND BEREAVEMENT SUPPORT UPDATE** To develop information for Primary Care detailing available services re Suicide Prevention and Bereavement support services. To provide assurance that information re Suicide Prevention and Bereavement Support Services is relevant and available to practice staff	 PO MS PO MS	Ongoing - PO liaising with Public Health colleagues to see how the MH information can be best shared. Information sent out the practices on 23/2/21. Exploring possibility of putting MH information on single page on BEST site. Public Health colleagues are linking directly with Primary Care staff. With regards to the Suicide Follow up service (that was originally funded as a pilot over winter)

			discussions are ongoing with SWYPFT as to how this service could best continue and a proposal has been received which outlines the need for additional resources and will be considered within the priority areas already identified by the Mental Health Partnership Board. Additional funding for mental health is to be received into the CCG via Mental Health Recovery funds and Service Development Funding.
	To ensure that the Attempted Suicide Follow up Service is part of the SPA (single point of access) Mental Health access model and part of routine contracting for Mental Health Services to deliver the service.	PO MS	Work is progressing to ensure that the attempted suicide follow up service is part of the Single point of access (SPA).
GB/Pu 21/03/13	**ASSURANCE REPORT – OUT OF AREA LOCKED REHABILITATION PROVISION FOR PATIENTS** To receive a further Assurance Report regarding Locked Rehabilitation (OOALR) provision at the 8 July 2021 Governing Body meeting.	JSiv JH	**Complete** - This item is scheduled on the 8 July 2021 Governing Body (public session) Agenda
GB/Pu 21/03/16	**RISK AND GOVERNANCE EXCEPTION REPORT** The Head of Governance and Assurance and Head of Primary Care to review risk 14/10 'Primary Care Clinical Workforce' with a view to rewording the risk descriptor and or inclusion of an additional risk regarding delivery of the Primary Care Network (PCN) Directly Enhanced Service (DES).	RW JF	**In Progress** The Head of Governance and Assurance and Head of Primary Care have had an initial meeting to discuss this risk and the Head of Primary Care will be reviewing the wording in detail with a view to taking proposed amendments to Primary Care Commissioning Committee at its meeting in May 2021.

NHS
Barnsley
Clinical Commissioning Group

GOVERNING BODY
Public Session

8 July 2021

REPORT OF THE CHIEF OFFICER

PART 1A – SUMMARY REPORT

1.	**THIS PAPER IS FOR**						
	Decision	☐	*Approval*	☐	*Assurance*	☐	*Information* ✓
2.	**PURPOSE**						
	This report provides the Governing Body with two NHS documents: • Integrated Care Systems: design framework Version 1, June 2021 • Guidance on the employment commitment Supporting the development and transition towards statutory Integrated Care Systems • Update on the Covid Pandemic Inquiry						
3.	**REPORT OF**						

	Name	**Designation**
Executive / Clinical Lead	Chris Edwards	Chief Officer
Author	Chris Edwards	Chief Officer

4.	**SUMMARY OF PREVIOUS GOVERNANCE**

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

Group / Committee	**Date**	**Outcome**
N/A		

5.	**EXECUTIVE SUMMARY**

Integrated Care Systems: Design Framework

This ICS Design Framework sets out in more detail how NHS organisations should respond to the next phase of system development, including the anticipated establishment of statutory ICS NHS bodies from April 2022. It describes the 'core' arrangements expected to be seen in each system and those local partners expect to determine in their local context.

Its purpose is to provide some 'guide rails' for NHS organisations as they develop

	their plans - reflecting the best ways of serving communities and patients in their specific local context - to give them the best chance of delivering on the four core purposes, in the urgent context of COVID recovery. This document aims to be clear and specific on the consistent requirements for systems and to define the parameters for the tailoring to local circumstances which is key to success. It goes beyond likely minimum statutory requirements and sets out the ambition from NHS England and NHS Improvement on what will be necessary for systems to be successful as they lead our recovery from the pandemic and the wider delivery of the Long Term Plan.
	Guidance on the Employment Commitment Supporting the Development and Transition Towards Statutory Integrated Care Systems The NHS England and NHS Improvement executive paper *Integrating care: next steps to building strong and effective integrated care systems across England* and its accompanying letter to NHS leaders outlined an 'employment commitment' to colleagues directly affected by the proposed legislative change. The purpose of this commitment is to provide those people in organisations directly affected by the proposed legislative changes with employment stability throughout the transition period while minimising uncertainty as much as reasonably possible. The ambition is to provide as much stability of employment as possible while Integrated Care Systems (ICSs) evolve and develop new roles and functions that not only improve health and care but also maximise the skills, experience and expertise of all our NHS people. The employment commitment, therefore, sets the tone for all affected organisations to approach this transition. The document provides guidance in respect of what the employment commitment is, its application in practice and how it affects people.
	COVID Pandemic Inquiry The prime minister says he intends to launch the inquiry in Spring 2022. He told MPs the delay was necessary to avoid putting too much stress on the NHS, advisers and government while there was the risk of a winter surge later this year. The exact aims and remit - known as the terms of reference - will be announced closer to the start of the inquiry next year.
6.	**THE GOVERNING BODY IS ASKED TO:**
	• Note this Report
7.	**APPENDICES / LINKS TO FURTHER INFORMATION**
	• Appendix A - NHS Integrated Care Systems: design framework Version 1, June 2021 • Appendix B - NHS Guidance on the employment commitment Supporting the development and transition towards statutory Integrated Care Systems

Agenda time allocation for report:	*10 minutes*

PART 1B – SUPPORTING INFORMATION & ASSURANCE

1. Links to Corporate Priorities, GBAF and Risk Register

This report provides assurance against the following corporate priorities on the Governing Body Assurance Framework

1.1 Urgent & Emergency Care		6.1 Efficiency Plans	✓
2.1 Primary Care		7.1 Transforming Care for people with LD	
3.1 Cancer		8.1 Maternity	
4.1 Mental Health		9.1 Digital and Technology	
5.1 Integrated Care @ System	✓	10.1 Compliance with statutory duties	✓
5.2 Integrated Care @ Place	✓	11.1 Delivery of Enhanced Health in Care Homes	

The report also provides assurance against the following red or amber risks on the Corporate Risk Register:	*N/A*

2. Links to statutory duties

This report has been prepared with regard to the following CCG statutory duties set out in Chapter A2 of the NHS Act

Management of conflicts of interest (s14O)	**See 3.2**	Duties as to reducing inequalities (s14T)	✓
Duty to promote the NHS Constitution (s14P)		Duty to promote the involvement of each patient (s14U)	
Duty to exercise its functions effectively, efficiently, and economically (s14Q)	✓	Duty as to patient choice (s14V)	
Duty as to improvement in quality of services (s14R)		Duty as to promoting integration (s14Z1)	✓
Duty in relation to quality of primary medical services (s14S)		Public involvement and consultation (s14Z2)	

3. Governance Considerations Checklist *(these will be especially relevant where a proposal or policy is brought for decision or approval)*

3.1 Clinical Leadership

Have GB GPs and / or other appropriate clinicians provided input and leadership?	***NA***

3.2 Management of Conflicts of Interest (s14O)

Have any potential conflicts of interest been identified and managed appropriately, having taken advice from the Head of Governance & Assurance and / or the Conflicts of Interest Guardian if appropriate?	***NA***

3.3 Discharging functions effectively, efficiently, & economically (s14Q)

Have any financial implications been considered & discussed with the Finance Team?	***NA***
Where relevant has authority to commit expenditure been sought from Management Team (<£100k) or Governing Body (>£100k)?	***NA***

3.4	**Improving quality (s14R, s14S)**	
	Has a Quality Impact Assessment (QIA) been completed if relevant?	***NA***
	Have any issues or risks identified been appropriately addressed having taken advice from the Chief Nurse (or Deputy) if appropriate?	***NA***
3.5	**Reducing inequalities (s14T)**	
	Has an Equality Impact Assessment (EIA) been completed if relevant?	***NA***
	Have any issues or risks identified been appropriately addressed having taken advice from Equality Diversity & Inclusion Lead if appropriate?	***NA***
3.6	**Public Involvement & Consultation (s14Z2)**	
	Has a s14Z2: Patient and Public Participation Form been completed if relevant?	***NA***
	Have any issues or risks identified been appropriately addressed having taken advice from the Head of Comms & Engagement if appropriate?	***NA***
3.7	**Data Protection and Data Security**	
	Has a Data Protection Impact Assessment (DPIA) been completed if relevant?	***NA***
	Have any issues or risks identified been appropriately addressed having taken advice from the SIRO, IG Lead and / or DPO if appropriate?	***NA***
3.8	**Procurement considerations**	
	Have any issues or risks identified been appropriately addressed having taken advice from the procurement Shared Service if appropriate?	***NA***
	Has a Single Tender Waiver form been completed if appropriate?	***NA***
	Has a Primary Care Procurement Checklist been completed where GPs, networks or Federations may be a bidder for a procurement opportunity?	***NA***
3.9	**Human Resources**	
	Have any significant HR implications been identified and managed appropriately, having taken advice from the HR Lead if appropriate?	***NA***
3.10	**Environmental Sustainability**	
	Have any significant (positive or negative) impacts on the environment or the CCG's carbon footprint been identified?	***NA***

Classification: Official

Publications approval reference: PAR642

Integrated Care Systems: design framework

Version 1, June 2021

Contents

Introduction and summary

Everyone across the health and care system in England, in the NHS, local authorities and voluntary organisations, has made extraordinary efforts to manage the COVID-19 pandemic and deliver the vaccination programme while continuing to provide essential services.

We still face major operational challenges: tackling backlogs; meeting deferred demand, new care needs, changing public expectations; tackling longstanding health inequalities; enabling respite and recovery for those who have been at the frontline of our response; and re-adjusting to a post-pandemic financial regime. The intensity of the incident may have abated, but we are still managing exceptional pressure and uncertainty, with differential impacts across the country.

As we respond, Integrated Care Systems (ICSs) will play a critical role in aligning action between partners to achieve their shared purpose: to improve outcomes and tackle inequalities, to enhance productivity and make best use of resources and to strengthen local communities.

Throughout the pandemic our people told us time and time again that collaboration allowed faster decisions and better outcomes. Co-operation created resilience. Teamwork across organisations, sectors and professions enabled us to manage the pressures facing the NHS and our partners.

As we re-focus on the ambitions set out in the NHS Long Term Plan, it is imperative we maintain our commitment to collaborative action, along with the agility and pace in decision-making that has characterised our response to the pandemic.

We want to do everything we can to support this nationally and give you the best chance of making effective and enduring change for the people you serve.

This means seizing the opportunities presented by legislative reform to remove barriers to integrated care and create the conditions for local partnerships to thrive. And it means asking NHS leaders, working with partners in local government and beyond, to continue developing Integrated Care Systems during 2021/22, and preparing for new statutory arrangements from next year.

We know this is a significant ask. This document sets out the next steps. It builds on previous publications[1] to capture the headline ambitions for how we will expect NHS leaders and organisations to operate with their partners in ICSs from April 2022. It aims to support you as you continue to deliver against the core purpose of ICSs and put in place the practical steps to prepare for their new arrangements that we expect to be enabled by legislation in this Parliamentary session.

The ambition for ICSs is significant and the challenge for all leaders within systems is an exciting one. Successful systems will align action and maintain momentum during transition, with systems continuing to make progress in improving outcomes and supporting recovery while embedding new arrangements for strategic planning and collective accountability across partners. The collective leadership of ICSs and the organisations they include will bring teams with them on that journey and will command the confidence of NHS and other public sector leaders across their system as they deliver for their communities. The level of ambition and expectation is shared across all ICSs – and there will be consistent expectations set through the oversight framework, financial framework national standards and LTP commitment – with ICSs adjusting their arrangements to be most effective in their local context.

It is important that this next year of developing ICSs and implementing statutory changes, if approved by Parliament and once finalised, builds on progress to date and the great work that has already taken place across the country. Effective transition will see high performing systems taking their existing ways of working and creatively adapting these to the new statutory arrangements. It is an acceleration, in the current direction.

This document begins to describe future ambitions for:

- the **functions of the ICS Partnership** to align the ambitions, purpose and strategies of partners across each system[2]
- the **functions of the ICS NHS body**, including planning to meet population health needs, allocating resources, ensuring that services

[1] Integrating care: next steps to building strong and effective integrated care systems and Integration and innovation: working together to improve health and social care for all NHS Operational Planning and Contracting Guidance

[2] Guidance on the Partnership will be developed by DHSC with local government, NHS and other stakeholders. Expectations described here are based on the proposals set out in the Government's White Paper and initial discussions with local government partners.

are in place to deliver against ambitions, facilitating the transformation of services, co-ordinating and improving people and culture development, and overseeing delivery of improved outcomes for their population

- the **governance and management arrangements** that each ICS NHS body will need to establish to carry out those functions including the flexibility to operate in a way that reflects the local context through place-based partnerships and provider collaboratives
- the opportunity for **partner organisations** to work together as part of ICSs to agree and jointly deliver shared ambitions
- **key elements of good practice** that will be essential to the success of ICSs, including strong clinical and professional leadership, deep and embedded engagement with people and communities, and streamlined arrangements for maintaining accountability and oversight
- the key features of the **financial framework** that will underpin the future ambitions of systems, including the freedom and mechanisms to use resource flexibly to better meet identified needs and to manage financial resources at system level
- the roadmap to **implement new arrangements** for ICS NHS bodies by April 2022 to establish new organisations, appoint leadership teams to new statutory organisations and to ensure that people affected by change are offered a smooth transition that allows them to maintain focus on their critical role in supporting recovery from the pandemic.

Further information or guidance, developed through engagement with systems and stakeholders, will be made available to support detailed planning. Where relevant, this will follow the presentation of proposed legislation to Parliament.

We have heard a clear message from systems that they are looking for specificity about the consistent elements of how we will ask them to operate, alongside a high degree of flexibility to design their ways of working to best reflect local circumstances. This document aims to achieve both: to be clear and specific on the consistent requirements for systems and to define the parameters for the tailoring to local circumstances which is key to success. It goes beyond likely minimum statutory requirements and sets out the ambition from NHS England and NHS

Improvement[3] on what will be necessary for systems to be successful as they lead our recovery from the pandemic and the wider delivery of the Long Term Plan.

The Framework does not attempt to describe the full breadth of future ICS arrangements or role of all constituent partners but focuses on how we expect the NHS to contribute. For non-NHS organisations, we hope this document will provide helpful framing on how the NHS will be approaching the proposed establishment of ICS NHS bodies, and inform broader discussions on the creation of system-wide and place-based partnership arrangements.

From the outset, our ambition for ICSs has been co-developed with system leaders, people who use services and many other stakeholders. We will continue this approach as we develop guidance and implementation support, based on feedback and ongoing learning from what works best.

The Framework is based on the objectives articulated in Integrating Care: next steps, which were reflected in the Government's White Paper.[4] But content referring to new statutory arrangements and duties, and/or which is dependent on the implementation of such arrangements and duties, is subject to legislation and its parliamentary process. Systems may make reasonable preparatory steps in advance of legislation but should not act as though the legislation is in place or inevitable.

[3] In this document we use 'NHS England and NHS Improvement' when referring to the functions and activities of both NHS England and NHS Improvement prior to April 2022, and NHS England only from April 2022 (subject to legislation).

[4] This document uses the terminology of the White Paper (ICS Partnership and ICS NHS Body). The final legal terms to be adopted for the new statutory components of each ICS will be determined by the legislation.

Context

In November 2020 NHS England and NHS Improvement published *Integrating care: Next steps to building strong and effective integrated care systems across England*. It described the core purpose of an ICS being to:

- **improve outcomes** in population health and healthcare
- **tackle inequalities** in outcomes, experience and access
- **enhance productivity** and value for money
- help the NHS support broader **social and economic development**.

It emphasised that the next phase of ICS development should be rooted in underlying principles of subsidiarity and collaboration. It described common features that every system is expected to have and develop, as the foundations for integrating care, with local flexibility in how best to design these to achieve consistent national standards and reduce inequalities, as:

- decisions taken closer to, and in consultation with, the communities they affect are likely to lead to better outcomes
- collaboration between partners, both within a place and at scale, is essential to address health inequalities, sustain joined-up, efficient and effective services and enhance productivity
- local flexibility, enabled by common digital capabilities and coordinated flows of data, will allow systems to identify the best way to improve the health and wellbeing of their populations.

Reflecting insight drawn from local systems, the document outlined the key components to enable ICSs to deliver their core purpose, including:

- **strong place-based partnerships** between the NHS, local councils and voluntary organisations, local residents, people who access service their carers and families, leading the detailed design and delivery of integrated services within specific localities (in many places, long-established local authority boundaries), incorporating a number of neighbourhoods
- **provider collaboratives**, bringing NHS providers together across one or more ICSs, working with clinical networks and alliances and other partners, to secure the benefits of working at scale.

In February 2021 NHS England and NHS Improvement made recommendations to Government to establish ICSs on a statutory basis, with strengthened provisions to ensure that local government could play a full part in ICS decision-making. These proposals were adopted in the Government's White Paper *Integration and Innovation: working together to improve health and social care for all*, and we expect legislation to be presented to Parliament shortly. This document is based on our expectations as to the content of that legislation, describing how new arrangements would look if the proposals were implemented, while recognising that the legislation is subject to Parliament's amendment and approval.

Subject to the passage of legislation, the statutory[5] ICS arrangements will comprise:

- an ICS Partnership, the broad alliance of organisations and representatives concerned with improving the care, health and wellbeing of the population, jointly convened by local authorities and the NHS
- an ICS NHS body, bringing the NHS together locally to improve population health and care.

This ICS Design Framework sets out in more detail how we expect NHS organisations to respond in the next phase of system development, including the anticipated establishment of statutory ICS NHS bodies from April 2022. It describes the 'core' arrangements we will expect to see in each system and those we expect local partners to determine in their local context; depending on their variation in scale, geography, population health need and maturity of system arrangements.

Its purpose is to provide some 'guide rails' for NHS organisations as they develop their plans - reflecting the best ways of serving communities and patients in their specific local context - to give them the best chance of delivering on the four core purposes, in the urgent context of COVID recovery.

[5] ICSs will comprise a much wider set of partnership arrangements supported by this statutory framework.

The ICS Partnership

Each ICS will have a Partnership at system level established by the NHS and local government as equal partners. The Partnership will operate as a forum[6] to bring partners – local government, NHS and others – together across the ICS area to align purpose and ambitions with plans to integrate care and improve health and wellbeing outcomes for their population.

The Partnership will facilitate joint action to improve health and care services and to influence the wider determinants of health and broader social and economic development. This joined-up, inclusive working is central to ensuring that ICS partners are targeting their collective action and resources at the areas which will have the greatest impact on outcomes and inequalities as we recover from the pandemic.

We expect the ICS Partnership will have a specific responsibility to develop an 'integrated care strategy' for its whole population using best available evidence and data, covering health and social care (both children's and adult's social care), and addressing the wider determinants of health and wellbeing. This should be built bottom-up from local assessments of needs and assets identified at place level, based on Joint Strategic Needs Assessments. We expect these plans to be focused on improving health and care outcomes, reducing inequalities and addressing the consequences of the pandemic for communities. We expect each Partnership to champion inclusion and transparency and to challenge all partners to demonstrate progress in reducing inequalities and improving outcomes. It should support place- and neighbourhood-level engagement, ensuring the system is connected to the needs of every community it includes.

The Government has indicated that it does not intend to bring forward detailed or prescriptive legislation on how these Partnerships should operate. Rather the intention is to set a high-level legislative framework within which systems can develop the partnership arrangements that work best for them, based on the core principles of equal partnership across health and Local Government, subsidiarity, collaboration and flexibility.

[6] The ICS Partnership will be a committee, rather than a corporate body.

To support this process, formal guidance on ICS Partnerships will be developed jointly by the Department of Health and Social Care (DHSC), NHS England and NHS Improvement, and the Local Government Association (LGA), and consulted on ahead of implementation, including on the role and accountabilities of the chair of the Integrated Care Partnership. This document gives an overview of the type of information that we expect to be included in that guidance.

Establishment and membership

The Partnership will be established locally and jointly by the relevant local authorities and the ICS NHS body, evolving from existing arrangements and with mutual agreement on its terms of reference, membership, ways of operating and administration. Appropriate arrangements will vary considerably, depending on the size and scale of each system.

Members must include local authorities that are responsible for social care services in the ICS area, as well as the local NHS (represented at least by the ICS NHS body). Beyond this, members may be from health and wellbeing boards, other statutory organisations, voluntary, community and social enterprise (VCSE) sector partners, social care providers and organisations with a relevant wider interest, such as employers, housing and education providers and the criminal justice system. They should draw on experience and expertise from across the wide range of partners working to improve health and care in their communities, including ensuring that the views and needs of patients, carers and the social care sector are built into their ways of working. The membership may change as the priorities of the partnership evolve.

To facilitate broad membership and stakeholder participation, Partnerships may use a range of sub-groups, networks and other methods to convene parties to agree and deliver the priorities set out in the shared strategy.

Leadership and accountability

The ICS NHS body and local authorities will need to jointly select a Partnership chair and define their role, term of office and accountabilities.

Some systems will prefer the Partnership and ICS NHS body to have separate chairs. This may, for instance, provide greater scope for democratic representation. Others may select the appointed NHS ICS body chair as the chair for both the NHS

Board and the Partnership to help ensure co-ordination. This will be a matter for local determination.

We expect public health experts to play a significant role in these partnerships, specifically including local authority directors of public health and their teams who can support, inform and guide approaches to population health management and improvement.

Partnerships will need clear and transparent mechanisms for ensuring strategies are developed with people with lived experience of health and care services and communities, for example including patients, service users, unpaid carers and traditionally under-represented groups. These mechanisms should draw on best engagement practice; for example, by using citizens' panels and co-production approaches, including insights from place and neighbourhood engagement. Partnerships should build on the expertise, relationships and engagement forums that already exist across local areas, building priorities from the bottom up, to ensure the priorities in the strategy resonate with people across the ICS.

As a key forum for convening and influencing and engaging the public, the Partnership will need to be transparent with formal sessions held in public. Its work must be communicated to stakeholders in clear and inclusive language.

Partnership principles

The ICS Partnership will play a key role in nurturing the culture and behaviours of a system. We invite systems to consider these 10 principles:

1. Come together under a distributed leadership model and commit to working together equally.
2. Use a collective model of decision-making that seeks to find consensus between system partners and make decisions based on unanimity as the norm, including working though difficult issues where appropriate.
3. Operate a collective model of accountability, where partners hold each other mutually accountable for their shared and individual organisational contributions to shared objectives.
4. Agree arrangements for transparency and local accountability, including meeting in public with minutes and papers available online.

5. Focus on improving outcomes for people, including improved health and wellbeing, supporting people to live more independent lives, and reduced health inequalities.
6. Champion co-production and inclusiveness throughout the ICS.
7. Support the triple aim (better health for everyone, better care for all and efficient use of NHS resources), the legal duties on statutory bodies to co-operate and the principle of subsidiarity (that decision-making should happen at the most local appropriate level).
8. Ensure place-based partnership arrangements are respected and supported, and have appropriate resource, capacity and autonomy to address community priorities, in line with the principle of subsidiarity.
9. Draw on the experience and expertise of professional, clinical, political and community leaders and promote strong clinical and professional system leadership.
10. Create a learning system, sharing evidence and insight across and beyond the ICS, crossing organisational and professional boundaries.

The ICS NHS body

ICS NHS bodies will be established as new organisations that bind partner organisations together in a new way with common purpose. They will lead integration within the NHS, bringing together all those involved in planning and providing NHS services to take a collaborative approach to agreeing and delivering ambitions for the health of their population. They will ensure that dynamic joint working arrangements, as demonstrated through the response to COVID-19, become the norm. They will establish shared strategic priorities within the NHS and provide seamless connections to wider partnership arrangements at a system level to tackle population health challenges and enhance services at the interface of health and social care.

Functions of the ICS NHS body

The ICS NHS body will be a statutory organisation responsible for specific functions that enable it to deliver against the four core purposes:

- **Developing a plan** to meet the health needs of the population within their area, having regard to the Partnership's strategy. This will include ensuring NHS services and performance are restored following the pandemic, in line with national operational planning requirements, and Long Term Plan commitments are met.
- **Allocating resources** to deliver the plan across the system, including determining what resources should be available to meet the needs of the population in each place and setting principles for how they should be allocated across services and providers (both revenue and capital). This will require striking the right balance between enabling local decision-making to meet specific needs and securing the benefits of standardisation and scale across larger footprints, especially for more specialist or acute services.
- **Establishing joint working arrangements** with partners that embed collaboration as the basis for delivery of joint priorities within the plan. The ICS NHS body may choose to commission jointly with local authorities, including the use of powers to make partnership arrangements under section 75 of the 2006 Act and supported through the integrated care strategy, across the whole system; this may happen at place where that is the relevant local authority footprint.

- **Establishing governance arrangements** to support collective accountability between partner organisations for whole-system delivery and performance, underpinned by the statutory and contractual accountabilities of individual organisations, to ensure the plan is implemented effectively within a system financial envelope set by NHS England and NHS Improvement.
- **Arranging for the provision of health services** in line with the allocated resources across the ICS through a range of activities including:

– Putting contracts and agreements in place to secure delivery of its plan by providers. These may be contracts and agreements with individual providers or lead providers within a place-based partnership or provider collaborative. They will reflect the resource allocations, priorities and specifications developed across the whole system and at place level. We expect contracts and agreements to be strategic, long-term and based on outcomes, with providers responsible for designing services and interventions to meet agreed system objectives.

– Convening and supporting providers (working both at scale and at place) to lead[7] major service transformation programmes to achieve agreed outcomes, including through joining-up health, care and wider support. In addition to ensuring that plans and contracts are designed to enable this, the ICS NHS body will facilitate partners in the health and care system to work together, combining their expertise and resources to deliver improvements, fostering and deploying research and innovations.

– Working with local authority and VCSE partners to put in place personalised care for people, including assessment and provision of continuing healthcare and funded nursing care, and agreeing personal health budgets and direct payments for care. This may be delegated to individual place partnerships and delivered through integrated teams working in neighbourhoods or across local places, further supporting the integration of planning and provision with adult social care and VCSE organisations.

- **Leading system implementation of the People Plan** by aligning partners across each ICS to develop and support the ‘one workforce’, including through closer collaboration across the health and care

[7] It is expected that the ICS NHS body will be able to delegate functions to statutory providers to enable this.

sector, and with local government, the voluntary and community sector and volunteers (See ‘People and culture’ section below).

- **Leading system-wide action on data and digital**: ICS NHS bodies will work with partners across the NHS and with local authorities to put in place smart digital and data foundations to connect health and care services and ultimately transform care to put the citizen at the centre of their care (see ‘Data and digital’ section below);
- Using joined-up data and digital capabilities to **understand local priorities, track delivery of plans, monitor and address variation and drive continuous improvemen**t in performance and outcomes.
- Working alongside councils to **invest in local community organisations and infrastructure** and, through joint working between health, social care and other partners including police, education, housing, safeguarding partnerships, employment and welfare services, **ensuring that the NHS plays a full part in social and economic development and environmental sustainability**.
- **Driving joint work on estates, procurement, supply chain and commercial strategies** to maximise value for money across the system and support these wider goals of development and sustainability
- **Planning for, responding to and leading recovery from incidents** (EPRR), to ensure NHS and partner organisations are joined up at times of greatest need, including taking on incident coordination responsibilities as delegated by NHS England and NHS Improvement.
- **Functions NHS England and NHS Improvement will be delegating** including commissioning of primary care and appropriate specialised services.

We expect that all clinical commissioning group (CCG) functions and duties will transfer to an ICS NHS body when they are established, along with all CCG assets and liabilities including their commissioning responsibilities and contracts.

Relevant statutory duties of CCGs regarding safeguarding, children in care and special educational needs and disabilities (SEND) will apply to ICS NHS bodies. We will clarify in guidance how these statutory duties will transition to ICS NHS bodies. ICSs should support joint working around responsibilities such as safeguarding through new and existing partnership arrangements; and health and

care strategies and governance should account for the needs of children and young people.

The board of the ICS NHS body will be responsible for ensuring that the body meets its statutory duties. We expect these duties will include supporting achievement of the triple aim, improving quality of services, reducing inequalities, ensuring public involvement, obtaining clinical and public health advice, promoting innovation and research, and other duties that may be defined in law.

We are reviewing our own operating model - including how our functions and activities will be carried out in future and how associated resources will be deployed -in the context of the expected creation of statutory ICS NHS bodies. We are committed to ensuring that the principle of subsidiarity is applied in considering our own functions, that resources are devolved accordingly, and that the creation of ICS NHS bodies does not lead to duplication or create additional bureaucracy within the NHS. We will co-design our new arrangements with the sector and our partners.

People and culture

Better care and outcomes will be achieved by people – local residents, service users, carers, professionals and leaders – working together in different ways. Successful ICSs will develop a culture that attracts people to work in and for their community and supports them to achieve their full potential.

The NHS People Plan sets out the ambition of having 'more people, working differently, in a compassionate and inclusive culture'. Although individual employers remain the building blocks for delivering the People Plan, ICSs have an important role in leading and overseeing progress on this agenda – including strengthening collaboration among health and care partners – and have already developed their own local People Plans setting out how they will achieve this ambition in their area. These plans should be aligned with the ICS Partnership's Strategy as it is developed and be refreshed annually, taking account of national priorities.

From April 2022, ICS NHS bodies are expected to have specific responsibilities for delivering against the themes and actions set out in the NHS People Plan and the people priorities in operational planning guidance. ICS NHS bodies will play a critical role in shaping the approach to growing, developing, retaining and supporting the entire local health and care workforce. While the People Plan sets out specific objectives and responsibilities for NHS organisations, we expect ICS NHS bodies to adopt a 'one workforce' approach and develop shared principles and ambitions for people and culture with local authorities, the VCSE sector and other partners.

Those planning and delivering health and care services are employed by a range of different organisations (including the ICS NHS body in future). Each will have strategies for attracting, retaining and developing the people they need to deliver the services and functions they are responsible for. To deliver against the ICS's four core purposes and to make the local area a great place to work and live, the ICS NHS body – working with the ICS Partnership – will help bring these partners together to develop and support the 'one workforce' which contributes to providing care across the system. This includes supporting the expansion of primary care and integrated teams in the community and closer collaboration on workforce development across the health and care sector, and with local government, the third sector and volunteers.

The ICS NHS body will be expected to establish the appropriate people and workforce capability to discharge their responsibilities, including strong local leadership. In particular, the ICS NHS body will need to:

- have clear leadership and accountability for the organisation's role in delivering agreed local and national people priorities, with a named SRO with the appropriate expertise (registered people professional (CIPD accredited) or with equivalent experience)
- demonstrate how it is driving equality, diversity and inclusion. It should foster a culture of civility and respect, and develop a workforce and leadership that are representative of the population they serve.

To support local and national people priorities for the one workforce in the system, the ICS NHS body should work with organisations across the ICS to:

- Establish clear and effective governance arrangements for agreeing and delivering local strategic and operational people priorities. This will include ensuring there are clear lines of accountability and streamlined ways of working between individual organisations within the system, with other ICSs and with regional workforce teams
- Support the delivery of standardised, high-quality transactional HR services (eg payroll) across the ICS, supported by digital technology. These services should be delivered at the most effective level within the ICS footprint, based on the principle of subsidiarity, but proactively taking opportunities for collaboration and securing the benefits of delivering at scale. Local arrangements for delivering these services should be agreed by relevant employers across the system, facilitated by the NHS ICS Body, to support standardisation and remove duplication to allow for the reallocation resources to deliver on the strategic people agenda across the ICS
- Ensure action is taken to protect the health and wellbeing of people working within the ICS footprint, delivering the priorities set out in the 2021/22 planning guidance and in the People Promise, to improve the experience of working in the health and care system for all
- Establish leadership structures and processes (including leadership development, talent management and succession planning approaches) to drive the culture, behaviours and outcomes needed for

people working in the system and the local population, in line with the Leadership Compact[8]

- Undertake integrated and dynamic workforce, activity and finance planning based on population need, transformation of care models and changes in skills and ways of working – reflected in the system people plan and in the ICS Partnership's Strategy
- Plan the development – and where required, growth – of the one workforce to meet future need. This should include agreeing collaborative recruitment and retention approaches where relevant, planning local educational capacity and opportunities, and attracting local people into health and care employment and careers (including creating long-term volunteering opportunities)
- Develop new ways of working and delivering care that optimise staff skills, technology and wider innovation to meet population health needs and to create flexible and rewarding career pathways for those working in the system. This should be enabled by inclusive employment models, workforce sharing arrangements and passporting or accreditation systems
- Contribute to wider local social and economic growth and a vibrant local labour market, through collaboration with partner organisations, including the care home sector and education and skills providers.

To support ICS NHS bodies to discharge these responsibilities and deliver national and local people and workforce priorities, we will work with Health Education England to publish supplementary guidance and implementation support resources for ICSs on developing their strategic People capabilities, including a People operating model.

[8] The NHS Leadership Compact will set out the compassionate and inclusive behaviour we want all our leaders to show towards people. It will require every leader, at every level, to recognise, reflect and bring to life every day six core principles focused on: equality and diversity; continuous improvement; kindness, compassion and respect; trust; supporting people and celebrating success; and collaboration and partnership. The Compact will be published in due course.

Governance and management arrangements

Strong and effective governance and management arrangements are essential to enable ICSs to deliver their functions effectively. The pandemic has shown the success of partnership approaches that allow joined-up, agile and timely decision-making underpinned by common objectives. ICSs will build from this to establish robust governance and management arrangements that are flexibly designed to fit local circumstances and that bind partners together in collective endeavour.

This guidance provides an overview of our expectations for ICS governance and management arrangements. We will provide further resources throughout the year that share learning on the different approaches ICSs are developing.

The ICS NHS board

The statutory governance requirements for the NHS ICS body will be set out in legislation and NHS England and NHS Improvement will provide further guidance on the constitution of the board and process for this being agreed prior to establishment. This section provides an overview of our current expectations which will be developed, through engagement. As a new type of organisation, the governance arrangements for ICS NHS bodies will be different to those of existing commissioner and provider organisations in the NHS. They will need to reflect the different ways of working that will be required for ICS NHS bodies to effectively deliver their functions - as independent statutory NHS bodies, that bring together parties from across the NHS. The minimum requirements we set out are designed to provide a common framework for effective leadership and governance in this context.

The ICS NHS body will have a unitary board. The board will be responsible for ensuring the body plays its role in achieving the four purposes of the wider ICS and should be constituted in a way that ensures this focus on improving outcomes in population health and healthcare; tackling inequalities in outcomes, experience and access; enhancing productivity and value for money; and contributing to broader social and economic development.

All members of the ICS NHS board (referred to below as “the board”) will have shared corporate accountability for delivery of the functions and duties of the ICS

and the performance of the organisation. This includes ensuring that the interests of the public and people who use health and care services remain central to what the organisation does. The board will be the senior decision-making structure for the ICS NHS body.

The statutory minimum membership of the board of each ICS NHS body will be confirmed in legislation. To carry out its functions effectively we will expect every ICS NHS body to establish board roles above this minimum level, so in most cases they will include the following roles:

- Independent non-executives: chair plus a minimum of two other independent non-executive directors (as a minimum required to chair the audit and remuneration committees). These individuals will normally not hold positions or offices in other health and care organisations within the ICS footprint.
- Executive roles (employed by the body): chief executive (who will be the accountable officer for the funding allocated to the ICS NHS body), director of finance, director of nursing and medical director.
- Partner members: a minimum of three additional board members, including at least:
  - one member drawn from NHS trusts and foundation trusts who provide services within the ICS's area
  - one member drawn from the primary medical services (general practice) providers within the area of the ICS NHS body
  - one member drawn from the local authority, or authorities, with statutory social care responsibility whose area falls wholly or partly within the area of the ICS NHS body.

We expect all three partner members will be full members of the unitary board, bringing knowledge and a perspective from their sectors, but not acting as delegates of those sectors.

We expect the partner members from NHS trusts/foundation trusts and local authorities will often be the chief executive of their organisation or in a relevant executive-level local authority role.

The process of appointing the partner members, and the rules for qualification to be a member, will be set out in the constitution of the body.

The final composition of the board and the process of appointment of partner members will need to be consistent with any requirements set out in primary legislation and is therefore subject to Parliamentary process.

ICS NHS bodies will be able to supplement these minimum board positions as they develop their own ICS NHS body constitution, which will be subject to agreement with NHS England and NHS Improvement.

We expect all members of the board will be required to comply with the Nolan Principles of Public Life and meet the Fit & Proper Persons test, and boards must have clear governance and board level accountability for discharging the associated regulations.

Boards of ICS NHS bodies will need to be of an appropriate size to allow effective decision making to take place. Through a combination of their membership, and the ways in which members engage partners, the board and its committees should ensure they take into account the perspectives and expertise of all relevant partners. These should include all parts of the local health and care system across physical and mental health, primary care, community and acute services, patient and carer representatives, social care and public health, with directors of public health having an official role in the ICS NHS bodies and the Partnership.

It will be important that boards have strong leadership on issues that impact upon organisations and staff across the ICS, including the people agenda and digital transformation.

The ICS NHS body will be expected to promote open and transparent decision-making processes that facilitate finding consensus, drawing on agreed decision-making processes to manage areas of disagreement to ensure that the statutory duties of the ICS NHS body continue to be met. The board and its committees will have to make decisions transparently, holding meetings in public and publishing the papers.

NHS England and NHS Improvement will publish further guidance on the composition and operation of the board, including a draft model constitution. We will also provide guidance on the management of conflicting roles and interests,

ensuring partners can work together effectively and that the public can have confidence decisions are being made in their best interests as taxpayers and service users (see below for new provider selection regime).

Committees and decision-making

All ICS NHS bodies will need to put arrangements in place to ensure they can effectively discharge their full range of duties and functions. This is likely to include arrangements for committees and groups to advise and feed into the board, and to exercise functions delegated by the board. Boards may be supported by an executive group including, for example, other professional and functional leads, to manage the day-to-day running of the organisation.

These arrangements should address the cross-cutting functional responsibilities of the body including finance and resources, people, quality, digital and data performance and oversight. They should enable full involvement of clinical and professional leaders, leaders of place-based partnerships and providers, including relevant provider collaboratives. We expect the ICS NHS body will have arrangements that bring all relevant partners together to participate in decision-making.

We expect that each board will be required to establish an audit committee and a remuneration committee. The board may establish other decision-making committees, in accordance with its scheme of delegation. The board may also establish advisory committees to advise it on discharging certain duties, such as public and patient engagement.

The legislation is expected to give ICS NHS bodies flexibility in how they establish and deploy such committees. In particular, they will have the power to:

- appoint individuals who are not board members or staff of the ICS NHS body to be members of any committee it has established
- establish joint committees with NHS Trusts/FTs to which they may delegate responsibilities (decision making) in accordance with those bodies' schemes of delegation.

As ICSs will have significant flexibility in how and where decisions and functions are undertaken, every ICS NHS body should maintain a 'functions and decision map' showing its arrangements with ICS partners to support good governance and

dialogue with internal and external stakeholders. This should include arrangements for any commissioning functions delegated or transferred by NHS England and NHS Improvement.

The boards of ICS NHS bodies, and their committees, should conduct their business in a way that builds consensus, and should seek to achieve consensus on decisions. They should foster constructive challenge, debate and the expression of different views, reflecting the scope of their remit and their constituencies. They should have agreed processes for resolving differences in the first instance, if consensus cannot be reached; for example, through referencing the principles and behaviours set out in the ICS NHS body's constitution and by assessing the decision for consistency with overarching objectives (including the triple aim) and plans already agreed. The chair may make decisions on behalf of the board where there is disagreement. Where necessary boards may draw on third party support such as peer review or mediation by NHS England and NHS Improvement.

The ICS NHS body's constitution may provide for a vote to be taken where consensus cannot be reached and to set out how the vote will be conducted (for example, the chair having the casting vote). However, voting should be considered a last resort rather than a routine mechanism for board decision-making.

Place-based partnerships

Partnerships between organisations to collectively plan, deliver and monitor services within a locally defined 'place' have a long history. These place-based partnerships have typically been established by local agreement according to their context and this bottom-up approach has been an important enabler to meaningful collaboration. However, as part of the development of ICSs, we now expect that place-based partnerships are consistently recognised as key to the coordination and improvement of service planning and delivery, and as a forum to allow partners to collectively address wider determinants of health.

We have asked each system to define its place-based partnership arrangements, covering all parts of its geography, agreed collaboratively between the NHS, local government and other system partners working together in a particular locality or community.

There is no single way of defining place or determining a fixed set of responsibilities that a place-based partnership should hold. All systems should establish and

support place-based partnerships with configuration and catchment areas reflecting meaningful communities and geographies that local people recognise. In the smallest ICSs, the whole system may operate as a single place-based partnership. The arrangements for joint working at place should enable joined-up decision-making and delivery across the range of services meeting immediate care and support needs in those local places but should be designed flexibly to reflect what works in that area.

The ICS NHS body will want to agree with local partners the membership and form of governance that place-based partnerships adopt, building on or complementing existing local configurations and arrangements such as Health and Wellbeing Boards. At a minimum, these partnerships should involve primary care provider leadership, local authorities, including directors of public health, providers of acute, community and mental health services and representatives of people who access care and support.

The ICS NHS body will remain accountable for NHS resources deployed at place-level. Governance and leadership arrangements for place-based partnerships should support safe and effective delivery of the body's functions and responsibilities alongside wider functions of the partnership. Each ICS NHS body should clearly set out the role of place-based leaders within the governance arrangements for the body.

An NHS ICS body could establish any of the following place-based governance arrangements with local authorities and other partners, to jointly drive and oversee local integration:

- consultative forum, **informing** decisions by the ICS NHS body, local authorities and other partners
- committee of the ICS NHS body with delegated authority to take decisions about the use of ICS NHS body resources[9]
- joint committee of the ICS NHS body and one or more statutory provider(s), where the relevant statutory bodies delegate decision making on specific functions/services/populations to the joint committee in accordance with their schemes of delegation

[9] Contracts would be awarded and held, and payments made, by the ICS NHS body as the legal entity.

- individual directors of the ICS NHS body having delegated authority, which they may choose to exercise through a committee. This individual director could be a joint appointment with the local authority or with an NHS statutory provider and could also have delegated authority from those bodies
- lead provider managing resources and delivery at place-level under a contract with the ICS NHS body, having lead responsibility for delivering the agreed outcomes for the place.

Effective leadership at place level is critical to effective system working, but the specific approach is to be determined locally. The roles of place-based leaders will include convening the place-based partnership, representing the partnership in the wider structures and governance of the ICS and (potentially) taking on executive responsibility for functions delegated by the ICS NHS body CEO or relevant local authority.

Supra-ICS arrangements

There are some functions where ICS NHS bodies will need to work together; for example, commissioning more specialised services, emergency ambulance services and other services where relatively small numbers of providers serve large populations, and when working with providers that span multiple ICSs or operate through clinical networks. In many areas, multiple providers and ICS NHS bodies will need to work together to develop a shared plan for cancer services, with existing Cancer Alliances[10] continuing to use their expertise to lead whole-system planning and delivery of cancer care on behalf of their constituent ICSs, as well as providing clinical leadership and advice on commissioning. Similarly, provider collaboratives, including those providing specialised mental health, learning disability and autism services, will span multiple ICS footprints where this is right for the clinical pathway for patients.

The governance arrangements to support this will need to be co-designed between the relevant providers, NHS ICS bodies clinical networks or alliances and, where relevant, NHS England and NHS Improvement regional teams. In smaller ICSs it will be particularly important to establish joint working arrangements at the appropriate scale for the task, joining up planning for services across a wider

[10] Service Development Funding for cancer will continue to be provided to Cancer Alliances to enable them to continue to deliver their existing functions on behalf of their constituent ICS(s).

footprint where that makes sense to establish provider collaboratives at the appropriate scale to support service transformation across wider clinical networks.

ICSs and ambulance providers, which typically provide services to a population across multiple ICSs, should agree their working relationships carefully to ensure that, where appropriate, there is a joined-up dialogue between ICSs and their relevant ambulance provider, avoiding unnecessary variation in practice or duplication of communication. Alongside this, ambulance providers should consider how they can play their role effectively as part of individual systems, provider collaboratives and place partnerships, for example supporting the implementation of an effective integrated urgent care offer.

Quality governance

Quality is at the heart of all that we do. Each NHS organisation has individual responsibilities to ensure the delivery of high quality care. ICS NHS bodies will also have statutory duties to act with a view to securing continuous improvement in quality. We expect them to have arrangements for ensuring the fundamental standards of quality are delivered including to manage quality and safety risks and to address inequalities and variation; and to promote continual improvement in the quality of services, in a way that makes a real difference to the people using them.

ICSs are expected to build on existing quality oversight arrangements, with collaborative working across system partners, to maintain and improve the quality of care. ICS NHS bodies will need to resource quality governance arrangements appropriately, including leading System Quality Groups (previously Quality Surveillance Groups) and ensuring that clinical and care professional leads have capacity to participate in quality oversight and improvement. Operational support will also be provided through NHS England and NHS Improvement regional and national teams in line with National Quality Board's guidance, namely the refreshed *Shared Commitment to Quality* and the *Position Statement*. These key documents set out the core principles and consistent operational requirements for quality oversight that ICS NHS bodies are expected to embed during the transition period (2021/22) and beyond.

The role of providers

Organisations providing health and care services are the frontline of each ICS. They will continue to lead the delivery and transformation of care and support, working alongside those who access their services and the wider communities they serve. As ICSs have developed, providers have increasingly embraced wider system leadership roles, working with partners to join up care pathways, embed population health management, reduce unwarranted variation and tackle heath inequalities.

The arrangements put in place by each ICS Partnership and ICS NHS body must harness the expertise, energy and ambition of the organisations directly responsible for delivering integrated care.

As constituent members of the ICS Partnership, the ICS NHS body and place-based partnerships, providers of NHS services will play a central role in establishing the priorities for change and improvement across their healthcare systems and delivering the solutions to achieving better outcomes.

We expect the contracts health service providers hold (NHS Standard, or national primary care[11] supplemented locally) to evolve to support longer term, outcomes-based agreements, with less transactional monitoring and greater dialogue on how shared objectives are achieved.

Primary care in Integrated Care Systems

All primary care professionals have a fundamental role to play in ensuring that ICSs achieve their objectives. The success of efforts to integrate care will depend on primary care and other local leaders working together to deliver change across health and care systems.

Primary care should be represented and involved in decision-making at all levels of the ICS, including strategic decision-making forums at place and system level. It should be recognised that there is no single voice for primary care in the health and care system, and so ICSs should explore different and flexible ways for seeking primary care professional involvement in decision-making. In particular, primary care should have an important role in the development of shared plans at place and

[11] Primary care contracts will continue to be negotiated nationally

system, ensuring they represent the needs of their local populations at the neighbourhood level of the ICS, including with regards to health inequalities and inequality in access to services.

ICSs should explore approaches that enable plans to be built up from population needs at neighbourhood and place level, ensuring primary care professionals are involved throughout this process.

The role of primary care networks

Primary care networks (PCNs), serving the patients of the constituent general practices, play a fundamental role improving health outcomes and joining up services. They have a close link to local communities, enabling them to identify priorities and address health inequalities. PCNs will develop integrated multi-disciplinary teams that include staff from community services and other NHS providers, local authorities and the voluntary, community and social enterprise (VCSE) sector to support effective care delivery. Joint working between PCNs and secondary care will be crucial to ensure effective patient care in and out of hospital.

PCNs in a place will want to consider how they could work together to drive improvement through peer support, lead on one another's behalf on place-based service transformation programmes and represent primary care in the place-based partnership. This work is in addition to their core function and will need to be resourced by the place-based partnership.

ICSs and place-based partnerships should also consider the support PCN clinical directors, as well as the wider primary care profession, may need to develop primary care and play their role in transforming community-based services. Place-based partnerships may also wish to consider how to leverage targeted operational support to their PCNs, for example with regard to data and analytics for population health management approaches, HR support or project management.

Voluntary, community and social enterprise partners

The VCSE sector is a vital cornerstone of a progressive health and care system. ICSs should ensure their governance and decision-making arrangements support close working with the sector as a strategic partner in shaping, improving and delivering services and developing and delivering plans to tackle the wider determinants of health. VCSE partnership should be embedded as an essential part

of how the system operates at all levels. This will include involving the sector in governance structures and system workforce, population health management and service redesign work, leadership and organisational development plans.

We expect that by April 2022 Integrated Care Partnerships and the ICS NHS body will develop a formal agreement for engaging and embedding the VCSE sector in system level governance and decision-making arrangements, ideally by working through a VCSE alliance to reflect the diversity of the sector. These arrangements should build on the involvement of VCSE partners in relevant forums at place and neighbourhood level. A national development programme is in place to facilitate this in all areas.

Independent sector providers

All providers, including independent providers to the NHS and local authorities, will need to be engaged with other relevant partners in the ICS, through existing or newly formed arrangements, to ensure care meets the needs of the population and is well co-ordinated.

NHS trusts and foundation trusts

NHS trusts and foundation trusts will play a critical role in the transformation of services and outcomes within places and across and beyond systems.

As now, they will work alongside primary care, social care, public health and other colleagues in each of the places or localities they serve, to tailor their services to local needs and ensure they are integrated in local care pathways. They will also be more involved in collectively agreeing with partners how services and outcomes can be improved for that community, how resources should be used to achieve this and how they can best contribute to population health improvement as both service providers and as local ‘anchor institutions’. The most efficient and appropriate ways of doing this will vary for different types of providers and in different local contexts. ICS NHS bodies will need to work with providers that span multiple ICSs and cross ICS boundaries, including ambulance and community trusts, to agree arrangements that ensure they are fully engaged.

In future, we expect the ICS NHS body could ask NHS trusts and foundation trusts to take on what have been ‘commissioning’ functions for a certain population,

building on the model that NHS-led provider collaboratives for specialised mental health, learning disability and autism services have been developing.

The success of individual trusts and foundation trusts will increasingly be judged against their contribution to the objectives of the ICS, in addition to their existing duties to deliver safe and effective care. This will include delivering their agreed contribution to system financial balance, improving quality and outcomes and reducing unwarranted variation and inequalities across the system as a whole, in the context of the new 'triple aim' duty to promote better health for everyone, better care for all and efficient use of NHS resources.

The new provider selection regime

NHS England and NHS Improvement has recommended that Parliament legislates to remove the current rules governing NHS procurement of healthcare services; and these are replaced by a new regime specifically created for the NHS.

This regime would give decision-makers greater discretion in how they decide to arrange services, with competition and tendering a tool to use where appropriate, rather than the default expectation. We want to make it straightforward for local organisations to continue with existing service provision where the arrangements are working well and there is no value in seeking an alternative provider. Where the system wants or needs to consider making changes to service provision, we want there to be a flexible, sensible, transparent and proportionate process for decision-making that allows shared responsibility to flow through it, rather than forcing the NHS into pointless tendering and competition.

The central requirement of the proposed new regime is that decisions about who provides NHS services must be made in a transparent way, in the best interests of patients, taxpayers and the population. The regime would need to be applied by NHS bodies (NHS England and NHS Improvement, ICS NHS bodies, NHS trusts and foundation trusts) and local authorities when making decisions about who provides healthcare services (the new regime will not apply to other local authority services).

The regime sets out the steps that decision-making bodies should take when seeking to justify continuing existing arrangements with an existing provider; how to select the most suitable provider when a service is new or changing substantially, but a competitive procurement is not appropriate; and how to run a competitive

procurement where this is considered appropriate. The regime sets out some key criteria decision-makers need to consider when arranging services, as well as requirements around transparency and scrutiny of decisions. Further details can be found at www.england.nhs.uk/publication/nhs-provider-selection-regime-consultation-on-proposals/

Provider collaboratives

Provider collaboratives are partnership arrangements involving two or more trusts (foundation trusts or NHS trusts) working across multiple places to realise the benefits of mutual aid and working at scale. The response to COVID-19 has demonstrated both the need for and potential of this type of provider collaboration. During 2021/22 the dynamic management of capacity and resources, greater transparency and collective accountability seen during the pandemic must be continued and developed. Specifically, providers are expected to work together to agree and deliver plans to achieve inclusive service recovery, restoration and transformation across systems, and to ensure services are arranged in a way that is sustainable and in the best interests of the population.

From April 2022 trusts providing acute and/or mental health services are expected to be part of one or more provider collaboratives. Community trusts, ambulance trusts and non-NHS providers (eg community interest companies) should participate in provider collaboratives where this is beneficial for patients and makes sense for the providers and systems involved.[12]

The purpose of provider collaboratives is to better enable their members to work together to continuously improve quality, efficiency and outcomes, including proactively addressing unwarranted variation and inequalities in access and experience across different providers. They are expected to be important vehicles for trusts to collaboratively lead the transformation of services and the recovery from the pandemic, ensuring shared ownership of objectives and plans across all parties.

[12] Community trusts, ambulance trusts and other providers may need to maintain relationships with multiple provider collaboratives, and/or focus on relationships within place-based partnerships, in ways they should determine with partners.

Provider collaboratives will agree specific objectives with one or more ICS, to contribute to the delivery of that system's strategic priorities. The members of the collaborative will agree together how this contribution will be achieved.

Provider collaboratives will help facilitate the work of alliances and clinical networks, enabling specialty-level plans and decisions to be made and implemented in a more coordinated and systematic way in the context of whole system objectives. For example, Cancer Alliances already work with the providers in their local systems to lead a whole system approach to operational delivery and transformation, and in future Alliances will work with their relevant Provider Collaboratives.

It will be up to providers, working with partners, to decide on the specific model and best governance arrangements for their collaboratives.

ICS NHS bodies will contract with NHS trusts and foundation trusts for the delivery of services, using the NHS Standard Contract. For services delivered through collaborative arrangements, ICS NHS bodies could:

- contract with and pay providers within a collaborative individually. The providers would then agree as a provider collaborative how to use their respective resources to achieve their agreed shared objectives
- contract with and pay a lead provider acting on behalf of a provider collaborative (whole budget for in-scope services). The lead provider would agree sub-contracting and payment arrangements across the collaborative. The existing mental health provider collaboratives have been successfully based on lead provider arrangements.

The ICS NHS body and provider collaboratives should define their working relationship, including participation in committees via partner members and any supporting local arrangements, to facilitate the contribution of the provider collaborative to agreed ICS objectives.

Further guidance on provider collaboratives will be published in due course.

Clinical and professional leadership

All ICSs should develop a model of distributed clinical and care professional leadership, and a culture which actively encourages and supports such leadership to thrive. This includes ensuring professional and clinical leaders have protected time and resource to carry out system roles, and are fully involved as key decision-makers, with a central role in setting and implementing ICS strategy.

These arrangements should support and enhance those of the organisations within the ICS footprint, which are responsible for the professional and clinical leadership of their people and services.

They should reflect the learning and experience gained from CCG clinical leadership, building out from this to reflect the rich diversity of clinical and care professions across the wider ICS partnership, including health, social care and the VCSE sectors, embedding an inclusive model of leadership at every level of the system.

Specific models for clinical and care professional leadership will be for ICSs to determine locally and we recognise that ICSs are at different stages of development in this regard. We will provide further resources describing the features of an effective model, informed by more than 2,000 clinical and care professionals and illustrating case studies from systems with more advanced approaches. These features include:

- effective structures and communication mechanisms to connect clinical and care professional leaders at each level of the system
- a culture which systematically embraces shared learning, supporting its clinical and care professional leaders to collaborate and innovate with a wide range of partners, including patients and local communities
- protected time, support and infrastructure for clinical and care professional leaders to carry out their system leadership roles
- clearly defined and visible support for clinical and care profession leaders, including support to develop the leadership skills required to work effectively across organisational and professional boundaries
- transparent approaches to identifying and recruiting leaders, which promote equity of opportunity and a professionally and demographically diverse talent pipeline which reflects that community it serves.

We will expect ICSs to use the resources to support self-assessment of their clinical and professional leadership model and implement mechanisms to measure their progress and performance. We encourage systems to consider how they could use a peer review approach to support their development in this area, buddying with other systems to undertake their assessment and develop subsequent plans.

For the NHS ICS body, the clinical roles on the Board, described in the 'Governance and management arrangements' section, are a minimum expectation, ensuring executive-level professional leadership of the organisation. Individuals in these roles are expected to ensure leaders from across clinical and care professions are involved and invested in the purpose and work of the ICS.

The ICS NHS board will be expected to sign off a model and improvement plan for clinical and care professional leadership that demonstrates how this will be achieved, and to ensure that the five guiding principles described above are reflected in its governance and leadership arrangements.

Working with people and communities

The parties in an ICS, including those of the ICS Partnership, the NHS ICS body and place-based partnerships will be expected to agree how to listen consistently to, and collectively act on, the experience and aspirations of local people and communities. This includes supporting people to sustain and improve their health and wellbeing, as well as involving people and communities in developing plans and priorities, and continually improving services.

As part of the ICS-wide arrangements, we expect each ICS NHS body to build a range of engagement approaches into their activities at every level and to prioritise engaging with groups affected by inequalities. The solutions to reducing inequalities will often be found by engaging with communities through relational and strengths-based approaches drawing on the experience of local authority, VCSE and other partners with experience and expertise in this regard.

We expect that this will be supported by a legal duty for ICS NHS bodies to make arrangements to involve patients, unpaid carers and the public in planning and commissioning arrangements, and by the continuation of the existing NHS trust and foundation trust duties in relation to patient and public involvement, including the role of foundation trusts governors.

Working with a range of partners such as Healthwatch, the VCSE sector and experts by experience, the ICS NHS body should assess and where necessary strengthen public, patient and carers' voice at place and system levels. Places are an important component, as they typically cover the area and services with which most residents identify. We are working with ICSs, Healthwatch England and others to identify and disseminate some of the most effective place-based approaches, for example through place-level citizens' panel work.

Arrangements in a system or place should not just provide a mechanism for commentary on services but should be a source of genuine co-production and a key tool for supporting accountability and transparency of the system. Where decision-making affects communities, groups or specific services, these arrangements (including any formal consultation) should fully engage those affected, including populations, patients and carers across health and social care.

We have previously set out seven principles for how ICSs should work with people and communities. These are:

1. Use public engagement and insight to inform decision-making
2. Redesign models of care and tackle system priorities in partnership with staff, people who use care and support and unpaid carers
3. Work with Healthwatch and the voluntary, community and social enterprise sector as key transformation partners
4. Understand your community's experience and aspirations for health and care
5. Reach out to excluded groups, especially those affected by inequalities
6. Provide clear and accessible public information about vision, plans and progress to build understanding and trust
7. Use community development approaches that empower people and communities, making connections to social action.

Each ICS NHS body should use these principles as a basis for developing a system-wide strategy for engaging with people and communities, building on the existing relationships, good practice and networks across system partners.

As part of this strategy, the body should work with its partners across the ICS to develop arrangements for:

- ensuring the ICS Partnership and place-based partnerships have representation from local people and communities in priority setting and decision-making forums
- gathering intelligence about the experience and aspirations of people who use care and support, together with clear approaches to using these insights to inform decision making and quality governance.

More detailed information will be made available to systems in guidance on membership and governance of ICS NHS bodies and in the implementation support for how ICSs work with people and communities.

Accountability and oversight

The ICS NHS body will be a statutory organisation. The members of its unitary board will have collective and corporate accountability for the performance of this organisation and will be responsible for ensuring its functions are discharged. NHS England and NHS Improvement through its regional teams, will agree the constitutions and plans of ICS NHS bodies and hold them to account for delivery through the chair and chief executive.

ICSs more broadly bring together NHS, local government and other partners, who each retain formal accountability for the statutory functions they are responsible for. Building on the relationships and ways of working they have developed to date, these partners will need to maintain a working principle of mutual accountability, where, irrespective of their formal accountability relationships, all partners consider themselves collectively accountable to the population and communities they serve, and to each other for their contribution the ICS's objectives.

Providers of NHS services will continue to be accountable:

- for quality, safety, use of resources and compliance with standards through the provider licence (or equivalent conditions in the case of NHS trusts) and CQC registration requirements
- for delivery of any services or functions commissioned from or delegated to them, including by an NHS ICS body, under the terms of an agreed contract and/or scheme of delegation.

Executives of provider organisations will remain accountable to their boards for the performance of functions for which their organisation is responsible. Where an executive of an NHS provider organisation sits on the board of an NHS ICS body, they will in their capacity as a member of that board also be accountable – collectively with other board members – for the performance of the ICS body and ensuring its functions are discharged. And when acting as an ICS body board member, they must act in the interests of the ICS body and the wider system, not those of their employing provider. NHS England and NHS Improvement will provide guidance to support ICS NHS bodies to manage conflicting roles and interests of board members.

Approach to NHS oversight within ICSs

The oversight arrangements for 2022/23 will build on the final 2021/22 System Oversight Framework (SOF) reflecting the statutory status of ICS NHS bodies from April 2022. We expect these arrangements to confirm ICSs' formal role in oversight including:

- bringing system partners together to identify risks, issues and support needs and facilitate collective action to tackle performance challenges
- leading oversight and support of individual organisations and partnership arrangements within their system.

While ICS NHS bodies will, by default, lead local oversight and assurance, NHS England and NHS Improvement's future statutory regulatory responsibilities will be similar to its existing ones. This means that any formal regulatory action with providers will, when required, be taken by NHS England and NHS Improvement.

We will work with each ICS NHS body to ensure effective and proportionate oversight of organisations within the ICS area, with arrangements that reflect local delivery and governance arrangements and avoid duplication. In particular, where additional assurance or intervention is required, NHS England and NHS Improvement will work with the ICS partners to ensure such action is informed by the perspective of system stakeholders, and that any recovery plans agreed align with system objectives and plans.

NHS England and NHS Improvement and ICS NHS bodies may, over time, decide to take the role of provider collaboratives and place-based partnerships into account when determining how to address issues identified through system oversight. This may, for instance, include looking to these arrangements (and the partners involved) for support where poor performance is identified; or considering the effectiveness of collaborative working arrangements when considering whether systems/providers have an effective plan for improvement/recovery.

Systems will also benefit from existing local authority health overview and scrutiny committees reviewing and scrutinising their work. Scrutiny provides a mechanism for local democratic accountability through local government elected members. It enables valuable connections to be made between the experience and aspirations of residents and ICS governance, via the relationships that local councillors have with their constituents.

Accountability and transparency in ICSs will also be supported via:

- clearly agreed and articulated arrangements for how the system works with people and communities
- public meetings, published minutes, and regular and accessible updates on the ICSs' vision, plans and progress against priorities.

We are working with colleagues from the Care Quality Commission (CQC) and DHSC to agree the process and roles for reviewing and assessing systems. The aim is that this would complement the role of NHS England and NHS Improvement, avoiding duplication and overlap, and support the delivery of integrated care across system partners.

The proposed principles for NHS system oversight are:

- working with and through ICSs, wherever possible, to provide support and tackle problems
- a greater emphasis on local priorities and on system performance and quality of care outcomes alongside the contributions of individual organisations to system goals
- matching accountability for results with improvement support, as appropriate
- greater autonomy for ICSs and organisations with evidence of collective working and a track record of successful delivery of NHS priorities, including tackling inequality, health outcomes and access
- compassionate leadership behaviours that underpin all oversight interactions.

Financial allocations and funding flows

Systems are currently funded under the COVID financial regime through a system funding envelope for each ICS, which includes system top-up and COVID fixed allocation arrangements. In due course, system funding allocations will move back towards the population-based distribution and funding quantum allocated as part of the Long Term Plan funding settlement, taking account of subsequent funding allocations and the outcome of the Spending Review.

ICS allocations

NHS England and NHS Improvement will make financial allocations to each ICS NHS body for the performance of its functions. Decisions about spending will be devolved to ICS NHS bodies.

This will include the budgets for:

acute, community and mental health[13] services (currently CCG commissioned)

primary medical care (general practice) services (currently delegated to CCGs)

running cost allowances for the ICS NHS body.

This may also include the allocations for a range of functions currently held by NHS England and NHS Improvement, including:

- other primary care budgets
- relevant specialised commissioning services suitable for commissioning at ICS level (for example, excluding highly specialised services)
- the allocations for certain other directly commissioned services
- a significant proportion of nationally held transformation funding and service development funding
- the Financial Recovery Fund
- funding for digital and data services.

[13] Every ICS will be required to continue to meet the mental health investment standard and as such a minimum level of mental health funding remains ringfenced (ICSs are free to invest above this level).

Funding will continue to be linked to population need. Allocations will be based on longstanding principles of supporting equal opportunity of access for equal needs and contributing to the reduction of health inequalities. NHS England and NHS Improvement's approach will continue to be informed by the independent Advisory Committee on Resource Allocation (ACRA).[14] Allocations will be set in a way that avoids large swings in funding that would risk destabilising local health economies.

NHS England and NHS Improvement will allocate funding to ICSs, continuing to take into account both the need of their population ('the target allocation') and how quickly ICSs move towards their target allocations (known as pace-of-change). We would not make a centrally set allocation to 'place' within the ICS. Existing allocations tools can be adapted to support ICS NHS bodies in making decisions about how to deploy resource to places.

An open book relationship between providers of NHS services, supported by improved cost data (PLICS), will give further transparency for stakeholders that the NHS is meeting its commitment to deploy resource according to need and tackle inequalities.

Full capital allocations will be made to the ICS NHS body, based on:

- the outcome of the 2022/23 capital settlement for operational capital, building on the arrangements initially implemented in 2020/21
- capital budgets being a combination of system-level allocations (operational capital), nationally allocated funds (for large strategic projects) and other national programmes
- the methodology being kept under review to ensure available capital is best allocated against need. We hope future allocations can be set over a multi-year, subject to the outcome of the next Spending Review.

Distribution of funds by the ICS NHS body

The ICS NHS body will agree how the allocation will be used to perform its functions, in line with health and care priorities set at a local level.

[14] An independent committee of academics, public health experts, GPs and NHS managers that makes recommendations on the preferred, relative, geographical distribution of resources for health services.

Money will flow from the ICS NHS body to providers largely through contracts[15] for services/outcomes, which may be managed by place-based partnerships or provider collaboratives.

The existing provider collaboratives for specialised mental health, learning disability and autism services have paved the way in taking on budgets through lead provider arrangements. In conjunction with ICS leaders, we will consider supporting provider collaboratives to take on further responsibility for use of resources to deliver population health outcomes.

The ICS NHS body will be able to commission jointly with local authorities under a section 75 joint commissioning arrangement, as CCGs can.

Spending will be part of a plan to deliver financial balance within a system's financial envelope, which would also be set by NHS England and NHS Improvement. This envelope covers expenditure across the whole system, including spending by NHS trusts/foundation trusts for services delivered for commissioners from outside the system.

Each ICS will have an agreed framework for collectively managing and distributing financial resources to address the greatest need and tackle inequalities in line with the NHS system plan, having regard to the strategies of the Partnership and the Health and Wellbeing Board/s. This is in line with the duty we expect to remain for the system to have regard for reducing health inequalities.

Financial rules will apply to ensure delivery of key national commitments, such as the Mental Health Investment Standard and the primary medical and community health services funding guarantee.

Based on these local priorities and national rules (including the National Tariff Payment System), the ICS NHS body will agree:

- priorities and outcomes to be achieved in plan against NHS budget (with clinical advice and with regard to ICS Partnership plan)
- the distribution of the NHS revenue allocation (both total financial value and service lines) to:

[15] The ICS NHS body will also be able to make grants to VCSE organisations and to NHS Trusts/FTs. In future, the ICS NHS body may wish to use its expected power to delegate its functions to statutory providers.

  - each place-based partnership as appropriate
  - each NHS provider (individually contracted or via a lead provider contract, including where operating as part of a provider collaborative)
  - contracts with other service providers
  - other collaboratives partnerships.
- A capital plan including how capital spend should be prioritised locally (developed through collective decision making across NHS providers, and with ability to co-ordinate with the estates and assets managed by local authorities).

The ICS NHS board and chief executive (AO) will be ultimately responsible for services under delegation arrangements with place-based partnerships or through lead provider contracts. They will need to put in place proportionate mechanisms to provide assurance on the spending of public money.

Setting budgets for places

The ICS NHS body will have the freedom to set a delegated budget for place-based partnerships to support local financial decisions to spend ICS NHS resources. However, it must adopt the principle of equal access for equal need and the requirements to reduce health inequalities. The ICS NHS body should engage local authority partners on the ICS NHS resources for the NHS services to be commissioned at place and support transparency on the spending made at place level. It should explain any variation from previous CCG budgets and enable the shared planning or pooling of NHS and local authority budgets, including stated minimum NHS contributions to Better Care Fund arrangements.

Budget allocated to and managed within a place (under the agreed schemes of delegation) might include:

- primary medical care
- other primary care as delegated/transferred from NHS England and NHS Improvement – dental, pharmaceutical, ophthalmology services
- community services
- community mental health including IAPT
- community diagnostics
- intermediate care

- any services subject to Section 75 agreement with local authority
- any acute or secondary care services that is has been agreed should be commissioned at place-level.

Financial and regulatory mechanisms to support collaboration

ICS NHS bodies will have a duty to co-operate with other NHS bodies, including NHS trusts and foundation trusts, and local authorities. They also have a duty to promote integration. These duties, combined with the new triple aim duty, should be a key driver for ensuring NHS ICS partners work together to meet the four purposes of the ICS with the resources available.

Collaboration in the NHS has accelerated in recent years and this is already supported by a wide range of enablers to ensure a shared investment in system objectives and plans.

Enablers already established, or expected to be established, through NHS England and NHS Improvement's system-by-default approach include:

- Setting system financial envelopes, which describe the funding available to spend in an ICS, including CCG allocations and national sustainability funding. These budgets will be based on population need and will support systems to work together to free up resources, which can be spent elsewhere in the system
- Proposals to establish an aligned payment and incentive (API) approach, in which fixed payments are set for an agreed level of planned activity; variable payments would also be agreed for activity above or below these plans. This should give the ICS NSH body, NHS trusts and foundation trusts greater certainty over payments and the agreed level of activity these payments will cover
- Inclusion of a System Collaboration and Financial Management Agreement in the NHS standard contract, which is a collaborative document aimed to ensuring NHS system partners work together to deliver shared financial objectives. The ICB, NHS trusts and foundation trusts will agree in advance ways of working and the risk management approach to dealing with unplanned pressures

- Change in oversight focus in the System Oversight Framework (SOF) which works with and through the system to tackle problems with an emphasis on system performance and greater autonomy for organisations with evidence of effective joint working.
- Guidance to be issued on provider governance to support providers to work collaboratively as part of ICSs to deliver system objectives. This will include an updated Code of Governance for NHS provider trusts, updated guidance on the duties of foundation trust governors, and updated memorandums for accounting officers of foundation trusts and NHS trusts. New guidance will be issued under the NHS Provider Licence that good governance for NHS providers includes a requirement to collaborate.

In addition to these policy developments, further enablers to support system collaboration are expected from the proposed legislation and policy, including:

- A common duty for ICS NHS bodies, NHS trusts and foundation trusts in relation to the triple aim, which requires them to have regard to the wider effect of their decisions in each of the three strands of the triple aim improving population health, quality of care and the use of resources
- Imposition of duties on the ICS NHS body to act with a view to ensuring system financial balance and to meet other financial requirement and objectives set by NHS England and NHS Improvement. This would also apply to NHS trusts and foundation trusts. This should mean that ICS NHS bodies, NHS trusts and foundation trusts have shared investment in the delivery of system financial balance and strong reason to collaborate to agree a system plan for meeting this; supported by a review of the NHS provider licence
- Powers to ensure organisational capital spending is in line with system capital plans. A review of the NHS provider licence in light of the new legislation and policy developments and specifically to support providers to work effectively as part of ICSs to deliver system objectives.

Services currently commissioned by NHS England and NHS Improvement

The legislation will enable the direct commissioning functions of NHS England and NHS Improvement to be jointly commissioned, delegated or transferred at an appropriate time to ICS NHS bodies.

NHS England and NHS Improvement is considering how it might shift some of its direct commissioning functions to ICS NHS bodies. Subject to discussions with systems and our Regions and further work on HR, our intention is to enable ICS NHS bodies to take on responsibility as soon as they are ready to do so after the enactment of legislation.

Commissioning of primary medical services is currently delegated to CCGs and will transition immediately into ICS NHS bodies when they are established. ICS NHS bodies might also take on primary dental services, general ophthalmic and pharmaceutical services commissioning.

Further work is taking place at national and regional levels to explore how the commissioning model for specialised services could evolve , in line with the safeguards and four principles set out in *Integrating Care: Next steps to building strong and effective integrated care systems across England*.

NHS England and NHS Improvement has a range of other direct commissioning functions including health and justice, armed forces and aspects of public health. Engagement with ICSs will continue to establish how they could take on greater responsibility for these services in future.

Data and digital standards and requirements

The standards and requirements for digital and data will be centred around the What Good Looks Like framework, which will set out a common vision to support ICS leaders to accelerate digital and data transformation in their systems with partner organisations. Based on consultation with a wide range of NHS and care stakeholders, the framework identifies seven success measures and will be published in the first quarter of 21/22.

We expect digital and data experts to have a pivotal role in ICSs, supporting transformation and ensuring health and care partners provide a modern operating environment to support their workforce, citizens and populations.

From April 2022, systems will need to have smart digital and data foundations in place. The way that these capabilities are developed and delivered will vary from system to system. Systems will locally determine the right way to develop these capabilities and to ensure they are available at system and place level, and across provider collaboratives.

Specifically, ICS NHS bodies are expected to:

- Have a renewed digital and data transformation plan that is embedded within the ICS NHS body plan and details the roadmap to achieve 'What Good Looks Like'; and enables a cross system approach to transformation, so that changes to models of care and service redesign involve digital and data experts working with partners from all relevant sectors.
- Have clear accountability for digital and data, with a named SRO with the appropriate expertise, (registered professional or with equivalent experience), underpinned by governance arrangements that have clear oversight and responsibility for digital and data standards and requirements for the ICS and enabling partner organisation programmes and services.
- Invest in levelling-up and consolidation of infrastructure, linked to the future ICS reference target architecture and data model, adopting a simplified cloud-first infrastructure that provides agility and frictionless cross-site working experience for the workforce.

- Implement a shared care record, that allows information to follow the patient and flow across the ICS to ensure that clinical and care decisions are made with the fullest of information.
- Ensure adherence by constituent partners to standards and processes that allow for interoperability across the ICS, and alignment to forthcoming national guidance.
- Enable a single co-ordinated offer of digital channels for citizens across the system and roll out remote monitoring technologies to help citizens manage their care at home.
- Cultivate a cross-system intelligence function to support operational and strategic conversations, as well as building platforms to enable better clinical decisions. This will require ICSs to have linked data, accessible by a shared analytical resource that can work on cross-system priorities.
- Agree a plan for embedding population health management capabilities and ensuring these are supported by the necessary data and digital infrastructure, such as linked data and digital interventions. Online PHM support can also be found at https://future.nhs.uk/populationhealth/grouphome and here Population Health Management - e-Learning for Healthcare (e-lfh.org.uk).

Arrangements should be co-ordinated across the NHS and local government, as well as between NHS organisations.

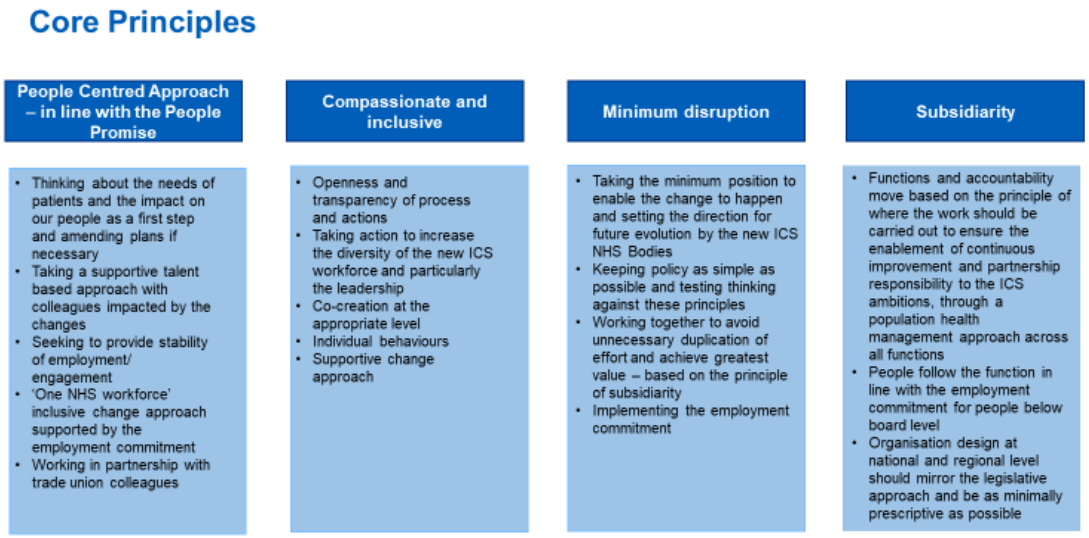
Managing the transition to statutory ICSs

We will work in partnership with systems, individual organisations affected, trade unions, voluntary organisations and central and local government to ensure the opportunities for improved outcomes for populations and improvements for our people are realised. We aim to create an environment that enables this change to take place with minimum uncertainty and employment stability for all colleagues who are involved.

The change and transition approach is guided by our Employment Commitment and a set of core principles designed to inform the thinking and actions of all colleagues throughout the process, acknowledging the wide variation in circumstances across systems.

> **The Employment Commitment**
>
> *"NHS people within the wider health and care system (below board level) affected directly by these legislative changes, including CCGs, NHS England and NHS Improvement and NHS providers, will receive an employment commitment to continuity of terms and conditions (even if not required by law) to enable all affected colleagues to be treated in a similar way despite a variety of contractual relationships. This commitment is designed to provide stability and remove uncertainty during this transition."*

The Employment Commitment is designed to minimise uncertainty and provide employment stability for people who will transfer directly from their employment or engagement directly into the statutory ICS NHS body. During the transition period the Employment Commitment asks affected organisations not to carry out significant internal organisational change and not to displace people. The commitment does not apply to those people in senior/board level roles who are likely to be affected by the new ICS Board structure and will have to go through organisational change as part of the abolition and establishment process.



Accountability for managing the change process will be with the current ICS and CCG leadership, with increasing involvement of the new leaders (eg chair, chief executive and others at board level) who may be appointed on a shadow or designate basis, pending the legislation.

Each ICS should make initial arrangements to manage the transition and ensure that there is capacity in place ready for implementation of the new ICS body. Plans should be agreed with regional NHS England and NHS Improvement teams.

Each ICS should ensure that planning adequately addresses the implications of organisational development implications as operations evolve from the current into the future configuration. This should be explicitly based in the local context.

It is important to note that any plans are subject to the passage of the legislation. Systems cannot pre-empt the decision of Parliament on whether to approve a bill or how it is to be amended. While plans can be made, systems should not take decisions or enter into arrangements which presume any legislation is already in place or that it is inevitable it will become law, before the Parliamentary process has been completed.

The overarching aim is to ensure and enable:

- the safe transfer of functions into the ICS NHS body (ie existing statutory functions that are to be exercised by the ICS NHS body) and prepare for the ICS body to take on new functions as appropriate
- the smooth transition of our people (ie legally compliant, with minimum disruption).

The indicative outputs expected in every ICS over the course of the transition period in 2021/22 are set out below. This is subject to legislation and other factors (including pending decisions on ICS boundaries in some areas).

By end Q1 Preparation	• Update System Development Plans (SDPs) against the key implementation requirements (functions, leadership, capabilities and governance) and identify key support requirements. • Develop plans in preparation for managing organisational and people transition, taking into account the anticipated process and timetable, and any potential changes to ICS boundaries and the need to transform functions to support recovery and delivery across the ICS.
By end Q2 Implementation	• Ensure people currently in ICS Chair, ICS lead or AO roles are well supported and consulted with appropriately. • Carry out the agreed national recruitment and selection processes for the ICS NHS body chair and chief executive, in accordance with guidance on competencies and job descriptions issued by NHS England and NHS Improvement. This will reflect the expected new accountabilities and responsibilities of ICS NHS bodies. • Confirm appointments to ICS Chair and chief executive. Subject to the progress of the Bill and after the second reading these roles will be confirmed as designate roles. • Draft proposed **new** ICS NHS body MoU arrangements for **2022/23**, including ICS operating model and governance arrangements, in line with the NHS England and NHS Improvement model constitution and guidance. • Plan for CCG teams to only operate at sub-ICS level where the SDP confirms that the ICS plans to establish a significant place-based function at that footprint. • Begin due diligence planning.
By end Q3 Implementation	• Ensure people in impacted roles are well supported and consulted with appropriately.

	• Carry out the recruitment and selection processes for designate finance director, medical director, director of nursing and other board level role in the NHS ICS body, using local filling of posts processes. • Confirm designate appointments to ICS NHS body finance director, medical director and director of nursing roles and other board and senior level roles. • ICS NHS bodies and ICS Partnerships to be ready to operate in shadow form. • Engagement on local ICS Constitution and governance arrangements for ICS NHS body and ICS Partnership.
By end Q4 Transition	• Ensure people in affected roles are consulted and supported. • Continue the recruitment and selection processes for all other designate ICS NHS body senior roles, including place-level leaders and non-executive roles, using local filling of posts processes. • Confirm designate appointments to any remaining senior ICS roles (in line with our relevant guidance) so that as much of the ICS NHS executive board and other senior leadership is ready (subject to formal decisions on appointments after the legislation is in place/in force). • Complete due diligence and preparations for staff and property (assets and liabilities, including contracts) transfers from CCGs and other NHS staff transfers to new ICS NHS body in line with our guidance. • Commence engagement and consultation on the transfer with trade unions. • Complete preparations to shift our direct commissioning functions to ICS NHS body, where this is agreed from 1 April 2022. • Ensure that revised digital, data and financial systems are in place ready for ‘go live’. • Submit the ICS NHS body constitution for approval and agree the 2022/23 ICS MoU with NHS England and NHS Improvement, setting out key elements of how the new ICS NHS body and ICS Partnership will operate in the future, in accordance with guidance to be issued by NHS England and NHS Improvement.

NHS England and NHS Improvement is working with a range of stakeholder groups, including a newly formed ICS Transition Partnership Group, which is a sub-group of the national Social Partnership Forum, to make available a range of resources and guidance to support the transition. The following document will be published in support of this:

- Employment Commitment Guidance – which builds on the commitment made in the FAQs published on 11 February 2021 and sets out what 'board level' means in this context. This also sets out the national support and senior level support that is available for colleagues affected by these changes.

After the legislation is introduced, we will publish further resources and guidance to support people transition planning and implementation.

Conclusion

As we move into the next phase of system development, we must capture and build on the spirit and practice of partnership now embedded across the NHS local councils, the VCSE sector and beyond. We continue to face an unprecedented challenge as a health and care system, but ICSs offer a clear way forward.

Strengthening local partnerships through ICSs is one of the most important and exciting missions in the public sector today. We would like to thank colleagues in every part of every system for your continued efforts to pursue it. This is an opportunity to deliver better care and population health; to ensure services treat us all as individuals and respond to our increasingly complex health and care needs. It is also an opportunity to work in partnership with local residents in new ways, removing even more of the traditional barriers to joined-up, personalised care and support.

Building on the achievements of system leaders over several years, the further ‘transformation by necessity’ prompted by the pandemic provides a platform for ongoing improvement of relationships, services and outcomes. Working together through ICSs will allow us to seize these opportunities, ensure our health and care systems are fit for the future and that we achieve world class health outcomes for our whole population.

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Guidance on the employment commitment

Supporting the development and transition towards statutory Integrated Care Systems

Version 1.0

June 2021

Equalities and health inequalities statement

"Promoting equality and addressing health inequalities are at the heart of NHS England's values. Throughout the development of the policies and processes cited in this document, we have:

- given due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it;
- given regard to the need to reduce inequalities between patients in access to, and outcomes from, healthcare services and in securing that these services are provided in an integrated way where this might reduce health inequalities."

Contents

1. Introduction

The NHS England and NHS Improvement executive paper *Integrating care: next steps to building strong and effective integrated care systems across England* and its accompanying letter to NHS leaders outlined an 'employment commitment' to colleagues directly affected by the proposed legislative change.

The purpose of this commitment was to provide those people in organisations directly affected by the proposed legislative changes with employment stability throughout the transition period while minimising uncertainty as much as reasonably possible.

A different approach is being taken with this transition towards integrated care: one characterised by care for our people without distracting them from the 'day job' and the critical challenges of recovery for the NHS and tackling population health management.

The ambition is to provide as much stability of employment as possible while Integrated Care Systems (ICSs) evolve and develop new roles and functions that not only improve health and care but also maximise the skills, experience and expertise of all our NHS people.

The employment commitment, therefore, sets the tone for all affected organisations to approach this transition.

2. Purpose of this guidance

This document provides guidance in respect of what the employment commitment is, its application in practice and how it affects people.

3. The employment commitment

3.1 What is the employment commitment?

The employment commitment as defined in the FAQs published on 11 February 2021 was:

> "NHS people within the wider health and care system (below board level) affected directly by these legislative changes, including CCGs, NHS England and NHS Improvement and NHS providers, will receive an employment commitment to continuity of terms and conditions (even if not required by law) to enable all affected colleagues to be treated in a similar way despite a variety of contractual relationships. This commitment is designed to provide stability and remove uncertainty during this transition."

The original aim of the employment commitment was set out in our consultation paper *Integrating care: next steps to building strong and effective integrated care systems* (paragraph 4.22), which stated that throughout the transition towards establishing the new ICSs, the commitment is:

- not to make significant changes to roles below the most senior leadership roles
- to minimise the impact of organisational change on current staff by focusing on the continuation of existing good work through the transition and not amending terms and conditions
- to offer opportunities for continued employment for all those who wish to play a part in the future.

Throughout the transition period, the employment commitment aims to ensure that the continuation of the good work being carried out by the current group of staff is prioritised by minimising disruption. In turn, it is hoped that this will support best practice to be promoted through engaging, consulting and supporting the workforce during a carefully planned transition that is free from the distraction of significant organisational change programmes.

3.2 Change approach and core principles

A set of core principles has been developed to support and guide the overall change approach. The aim of these principles is to provide a framework for a consistent approach to transition, including the employment commitment, but to enable local implementation, recognising the differences in systems across the country.

These are included at Appendix A along with some 'I' statements which set out what it might look and feel like for colleagues.

3.3 What does the employment commitment mean in practice?

It is envisaged that all functions of a clinical commissioning group (CCG) will transfer to the statutory ICS and therefore colleagues below board level should **lift and shift** from one organisation to the other, resulting in minimal change. The employment commitment seeks to provide stability **during the transition period,** particularly before the establishment of the statutory ICS.

To apply the commitment in practice, those organisations affected by and involved with the proposed changes should:

- ensure there is a continued and **sustained focus on the day-to-day delivery** that supports the restoration and recovery of services
- **avoid undertaking large-scale organisational change programmes** throughout the transitional period, wherever possible, and instead look to embed new ways of working through positive engagement and communication with the workforce
- where organisational change is identified and is unavoidable, confirm this to staff affected and their trade union representatives at the earliest possible opportunity and **only undertake change that is essential**
- **seek to retain talent** from affected organisations wherever possible by supporting the broadening of skills and capabilities
- maximise opportunities for the **development of the talent** by enabling the ongoing evolution and development of roles across the system

- **retain terms and conditions and continuity of service** of those staff affected by the transition
- **provide robust and proactive support** to those affected by the changes
- **communicate and engage with trade union representatives** at national, regional, system and place levels to support effective partnership working throughout the transition
- **engage regularly** with those affected by the changes and ensure an **open, transparent and constructive** approach to communication and engagement is adopted.

Colleagues in senior leadership/board-level roles are likely to be affected by the need to establish the designate executive/board-level roles of the ICS **ahead** of its establishment. It is therefore not possible to provide a commitment limiting organisational change ahead of establishment to this group of people.

'Board-level' in this context therefore means those colleagues who are likely to be affected by change following the confirmation of a statutory ICS executive/board-level structure.

Due the local determination of several roles on a statutory ICS board/executive and the variety of roles that currently exists at this level, this guidance is not intended to be prescriptive or definitive about the actual people determined as 'board level'. Detailed people impact assessments will take place locally when the new executive/ board level structures are confirmed, and these will identify specifically the colleagues affected.

However, it is anticipated that colleagues most likely to affected will be:

- chief executive officers of an ICS or accountable officers of a CCG
- director or executive-level roles that report to the chief executive officer of an ICS, or to an accountable officer of a CCG
- roles of a CCG governing body, as defined by the Health and Social Care Act (2012) and outlined in previous NHS Commissioning Board guidance, including GP board members

- senior posts within NHS England and NHS Improvement functions that are expected to be the responsibility/function of an ICS in the future
- other senior posts within the system that may or are expected to be the responsibility/function of an ICS in the future (eg senior provider collaborative posts).

Officer roles such as lay members or non-executive directors (see section 3.4) are not covered by the commitment.

All other employees, including those **engaged** in functions working in commissioning support units and clinical leads, are covered by the employment commitment.

3.4 Lay members and other office holders

Lay members and other office holders, while not employees, have played a significant role in the CCGs. While the statutory body will no longer exist when NHS ICS bodies are established, it is vital to retain their expertise and knowledge where possible.

For any current lay member or other office holder who is interested in continuing to support the NHS in a non-executive role, please contact Keely Howard at keely.howard1@nhs.net. You will be included in the talent database held by the NHS England and NHS Improvement non-executive talent and appointments team, who oversee appointments to all NHS trust chair and NED roles, and can also join a mailing list to receive notification of non-executive vacancies as these arise.

3.5 What does ‘even if not required by law’ mean?

The commitment to protect terms and conditions ‘even if not required to do so by law’ acknowledges the intention to minimise unnecessary disruption and uncertainty by providing assurance that irrespective of the mechanism of transfer and the technical protection afforded by the associated regulations, the employment and terms and conditions of staff will be protected and transferred to the new organisation.

Irrespective of contractual employer or contractual arrangement, if staff below board level are currently providing a function that is being transferred to the new ICSs their **employment or engagement** will transfer with it.

Examples of engagement include someone seconded from a provider into a CCG who could continue to be seconded if the function has transferred; the secondment agreement would move from being with a CCG to the statutory ICS. Colleagues from commissioning support units providing services under a contract for services should continue as the contract will transfer from the CCG to the ICS. GPs providing clinical lead roles should continue, as their contract for these roles will transfer from the CCG to the ICS.

This would also apply to other arrangements, such as hosting by a range of different employers. The commitment is designed to enable work to continue and to support the bringing together of colleagues from across the health and care landscape to deliver ICS functions as part of the 'one workforce' approach.

3.6 When does the employment commitment start?

The employment commitment was stated in the FAQs on 11 February 2021 and is therefore effective from that date until instructed otherwise or superseded by legislative changes or updated guidance.

3.7 When does the employment commitment expire?

Recognising that staff are expected to transfer by TUPE or COSOP, it should be noted that there is no end date on the legal protection provided to staff under these regulations.

However, the new ICSs will continue to evolve following their establishment, and it is therefore anticipated that they will want to review their operating models to deliver their new statutory requirements in the most effective way.

In doing so, ICSs will be expected to follow their own organisational policies on managing organisational change and crucially establish a robust economic, technical or organisational reason for changing any transferred colleagues' contractual terms and conditions of employment in the future. At this point the employment commitment would be superseded.

4. Supporting people through the transition

The employment commitment is made in the spirit of ensuring that our colleagues feel valued and supported during this transitional process.

It is recognised that any change can cause concern and anxiety for people. Support is available for all NHS colleagues to access in addition to that provided by organisations' employee assistance programmes. Please visit https://www.england.nhs.uk/supporting-our-nhs-people/.

Uncertainty can also increase where there is a lack of control, voice and information, and in a national change of this nature this can be compounded. All affected organisations are encouraged to take steps in the following ways:

- Maximise the availability of career conversations for all colleagues with the aim of supporting them to think about and understand where they are in their career and what their ideal next steps will be. Having good understanding of this at an individual level will help colleagues make good choices as this transition progresses and should increase a feeling of personal control over their careers.

- Enable staff voice, working closely with trade union colleagues to ensure that your trade union representatives are in a good position to provide support for colleagues and represent members in various partnership forums. Voices can also be heard in other ways through strong stakeholder engagement and involvement. Make engagement routes as transparent and visible as possible so that all colleagues can see how they can get their voice heard with the aim of resolving or addressing concerns and taking on board ideas and suggestions for the future.

- Regular provision of information: supporting this transition with robust communications and engagement strategies is key to ensuring colleagues are well informed about the current situation and developments in the transition.

4.1 Support for senior leaders and ‘board-level’ post holders

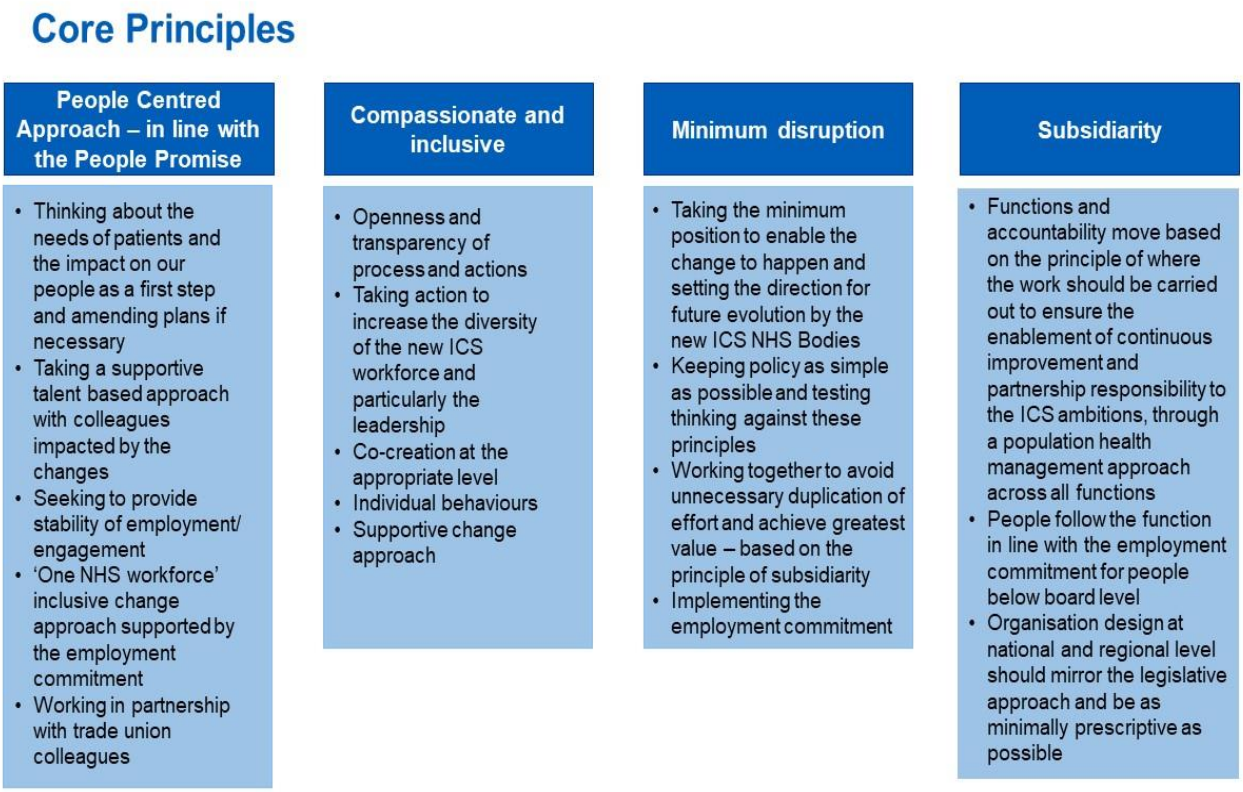
It is important to recognise that, while these ‘board-level’ roles are not covered by the employment commitment, it is critical that these colleagues are appropriately supported throughout the transition.

There is no distinction for board-level colleagues in the aim of the approach to minimise uncertainty and provide employment stability. However, there is a need to provide this in a different way, given the potential impact on colleagues in these roles.

The aim is to take a talent approach to this change. Our board-level leaders are colleagues who have led our organisations for many years and have achieved so much for patients and colleagues. It is crucial that, where possible, we retain our talented leaders and their experience and knowledge to ensure the future success of ICSs. A co-ordinated approach at national, regional and system level is being developed to provide this.

See **Appendix B** for details of the support available.

Appendix A



These 'I' statements have been developed to illustrate what employment stability and minimising uncertainty might feel like for individuals.

As an employee **(at board level)** and not protected by the employment commitment this means:

- I have access to coaching support to enable me to understand what I need and want from this change for my own personal career
- I have had an open conversation with the 'receiver' about my skills, experience and aspirations so that they are clearly understood and acted upon
- I feel like my contribution to the NHS as a senior leader has been recognised and I am actively supported to be able to continue to contribute in the NHS where my skills and experience are most needed and develop new skills where appropriate

- I am supported to leave the NHS if this is the right outcome for me at this time

As an **employee (below board level)** working in a function/organisation/role that is impacted by the proposed legislative changes this means:

- my employer will change but my contractual terms and conditions will remain the same
- my pay date might change
- my line manager might change
- my place of work will mostly likely remain the same
- some of my day-to-day duties and responsibilities might change in line with my band
- I feel valued and part of the ‘NHS One Workforce’
- I am confident that I am being engaged with openly and transparently and feel like I am being treated fairly
- I am supported to develop new skills and expertise to deliver the work needed to support our patients and population.

Appendix B – Executive Suite support

Executive Suite

The Executive Suite – Our NHS People has a range of offers to support the thinking and wellbeing of senior and executive leaders, including those affected by this change. In addition to wellbeing offers such as 1:1 psychological support, there are blogs, development programmes and thought-leading webinars to support you in refreshing and sustaining your leadership during this transition.

They are designed to support you to remain a resilient leader and continue to thrive in your current role while looking ahead to the next.

Our development support includes:

- mentoring from the Centre for Army Leadership
- access to career development resources
- 1:1 psychological support
- drop-in common rooms specifically for AOs and CCG governing body members
- Chief Executive Development Network: we are developing specific CCG/ICS reflective spaces for chairs and chief executives
- virtual actual learning sets
- workshops, masterclasses, and seminars.

1. Mentoring: Coaching and mentoring registration form (office.com)

Navigating the leadership challenges this transition will bring can often benefit from reflecting with an experienced mentor. The Centre for Army Leadership mentoring offer will support you in finding real-time solutions to move you forward and find positive ways to stay resilient and overcome immediate challenges. You will be matched with an experienced army leadership mentor who will support you in finding real-time solutions.

We are also in the process of developing a peer-to-peer support offer for chief executives and accountable officers to be released in the coming months.

2. Career development portal: Career management online resources – Our NHS People

Aimed specifically at senior leaders in health and care, our online career development resource portal brings together written tutorials, videos and tools to help support your career management, allowing you to reflect on your career, opportunities and next steps.

This would support any talent and career conversations you may be having as part of this transition.

3. One-to-one psychological support

We recognise that some of our senior leaders may be experiencing anxiety, depression or burnout for which they would value a brief psychological intervention. These sessions offer a confidential, expert ear and informed strategies to help with a wide range of issues. Clinical psychologists have training and expertise in evidence-based psychological support for a range of difficulties. They are skilled in recognising and supporting acute stress in the context of unusual demands, such as those experienced in hospital and service management. They can also help with problems and reactions such as anxiety, depression, obsessive compulsive disorder, post-traumatic stress disorder, burnout and the demands of managing complex and dynamic situations. To view available offers for psychological and mentoring support, networks and communities, see Support in difficult times – Our NHS People and Connecting and developing – Our NHS People.

To register for one-to-one psychological support, please use this link: Online Survey Software | Qualtrics Survey Solutions

4. Common rooms

Drop-in common rooms specifically for AOs and governing body members are designed to support you during this transition. They will provide you with short (90-minute) online network meetings for a maximum of 15 participants. Each confidential meeting provides an opportunity to connect with colleagues, to make sense of and compare experience, to refresh and focus on whatever feels important in a context of mutual support.

5. Chief Executive Development Network (CEDN)

The Chief executive development network – Our NHS People is a network of both established and new chief executives/accountable officers. Membership naturally changes over time, meaning that every conversation is as different as its participants.

- CEDN content is member-led, meaning that our offers can be agile, responding to and grounded in chief executives/accountable officers' changing realities.
- The network offers both development and peer connection. Members tell us that they particularly value the opportunity to meet and interact with peers nationally rather than only regionally.
- CEDN is open to both established and new chief executives/accountable officers. Experienced chief executives/accountable officers often mention how they value the opportunity to continue their development, as so much is new even for them as health and care move towards integration.
- The network actively welcomes and continues to provide dedicated transitions support for newly appointed, first time chief executives/ accountable officers.

Our current development support offer includes:

- themed sessions with expert speakers leading to facilitated communities of practice
- facilitated, mutually informative and developmental conversations with senior colleagues at national level to build their network while informing national thinking
- offers for specific members of the chief executive/accountable officer population such as ICS chief executives and separately CCG accountable officers
- topic-specific offers such as 'Implications of the White Paper', 'Beyond the fit and proper person test', 'New models of care' and 'Exploring the chair and chief executive relationship'

- developmental networking opportunities
- access to online chief executive/accountable officer resources
- drop-in chief executive/accountable officer common rooms
- transitions coaching for ‘new-to-role’ chief executives for up to two years
- we are in the process of developing CCG/ICS reflective spaces for chairs and chief executives.

6. Virtual action learning sets: Virtual Action Learning – Our NHS People

Virtual action learning sets (VALS) provide a safe, secure, and confidential space, through which individuals and collectives can explore the complexities of current leadership challenges and determine new and innovative ways forward. Action learning is a form of action research. VALS operate within a framework of ‘high challenge’ and ‘high support’, setting the context and conditions for sustained improvements in the experiences of both staff and the populations that we serve. VALS will enable you to focus on the real-world challenges of the upcoming changes and transitions with peers supported by an expert facilitator. Unlike brief virtual common rooms, they offer time out from the fast-moving challenges of leadership to focus on complex issues in depth, challenging ourselves to think differently and find better solutions.

You would come together in half-day sessions four times over eight months, at times defined and agreed within your action learning set.

7. Events and seminars

Where possible, recordings of the events that have taken place will be available on the Executive Suite.

a. Action for Change webinars: Action for Change – Our NHS People

Designed to catalyse collective action on current health and care priorities, the offer comprises an expert seminar series supported by half-day action learning sets,

which will be role-specific and will meet three times over six months to translate ideas into practice.

- **For 'the politics of leading integration'** previous seminars have taken place with Jon Rouse, City Director, City of Stoke on Trent; Andy Burnham, Mayor of Greater Manchester; and Raj Jain, Chief Executive of Northern Care Alliance NHS Group with local authority colleagues

- **Health inequalities,** comprising seminars and three theme-related facilitated action learning sets. In light of the clear impact of inequalities on the incidence and outcomes of COVID-19, Sir Michael Marmot, Professor of Epidemiology at University College London, Director of the UCL Institute of Health Equity, talked about the radical leadership practice required to influence for health equalities.

To register to join a seminar please click on this link: Join an AfC themed webinar – Our NHS People. Please note that from time to time, some seminars will only be open to chief executives/accountable officers and chairs, but many are open more widely, so please do check the Executive Suite website.

b. The King's Fund Masterclasses

Following the success of the first series of Masterclasses run by The King's Fund around leadership during the COVID-19 pandemic, the second series of Masterclasses will focus on the impact of the upcoming changes and integration and what it might mean for you and your leadership. There will be a series of three short, themed online masterclasses to support you in leading your organisations in these very particular circumstances.

The masterclasses will be led by two senior consultants of The King's Fund faculty, drawing on current research and theory.

c. Racial justice seminar series

This seminar series supports you as an executive leader to gain a deeper critical understanding of how to practically progress the work of inclusion through the lens of racial justice, developing courage and confidence for leadership effectiveness in this complex area of practice. You will learn how to create cultures and systems where equity and justice are the foundation stones of decision-making, benefiting staff and the populations that we serve.

Previous speakers include:

- Robin DiAngelo – author of *White fragility*
- Professor Kehinde Andrews – Professor of Black Studies at Birmingham City University; you can view a recording of this session here: Racial justice seminar series: In conversation with Professor Kehinde Andrews – Our NHS People
- David Olusoga OBE – Professor of Public History at the University of Manchester; you can view a recording of this session here: Racial justice seminar series: Confronting the remnants of historical myths and monsters – Our NHS People

Signposted bite sized learning

Relevant and curated bite-sized learning and resources related to current appropriate subjects and themes.

NHS England and NHS Improvement
Skipton House
80 London Road
London
SE1 6LH

NHS
Barnsley
Clinical Commissioning Group

GOVERNING BODY

8 July 2021

Covid-19 update

PART 1A – SUMMARY REPORT

1.	**THIS PAPER IS FOR**
	Decision ☐ *Approval* ☐ *Assurance* ✓ *Information* ✓
2.	**PURPOSE**
	To provide Governing Body with an update in relation to the current situation and the CCG response to the Coronavirus Disease (COVID19) pandemic. At the Governing Body meeting on 13 May, information was provided on the latest intelligence, the NHS planning priorities and the COVID-19 Vaccination Programme in Primary Care. This paper provides a further update on the latest position and the vaccination programme.
3.	**REPORT OF**

	Name	Designation
Clinical Lead	Nick Balac	Chair
Executive Lead & Author	Jamie Wike	Chief Operating Officer

4.	**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	Weekly MT Call	Updates and COVID related decisions

5.	**UPDATE REPORT**
5.1	**Introduction** Following the declaration by the World Health Organisation (WHO) on 11 March 2020 that the COVID19 outbreak be classified as a pandemic and the introduction of 'lock down' restrictions on 23 March 2020, the situation has been managed in line

with the NHS Emergency Planning, Resilience and Response Framework with national and regional command and control structures in place. Throughout most of this period the NHS EPRR COVID alert level as been at level 4 (national) with NHS England retaining control over commissioning functions.

On the back of reducing COVID case rates and hospitalisations, on 22 February 2021 a 4 step 'Road map out of lockdown' was published setting out the pathway to removing all restrictions. From 8 March 2021, restrictions began to be lifted as the first step of the road map was introduced. Subsequently further restrictions were removed in 12 April and 17 May in line with the road map plan.

The roadmap is set around 4 key steps with indicative dates for moving through these steps however all the dates are indicative and subject to change if there are any factors that could put recovery at risk. These are:

- Step 1 8th and 29th March – School and meet outdoors
- Step 2 12 April – Non essential retail, outdoor venues, beauty and gyms
- Step 3 17 May – More indoor venues, meet in larger groups outdoors, attendance at large events
- Step 4 21 June (19 July*) - All remaining rules that are stopping people from getting together to be removed.

* Due to increasing infection rates and an increased spread of the delta variant, Step 4 has been delayed initially by 4 weeks and is currently planned for 19 July 2021.

The decision on whether to move to the next step is based on four tests:

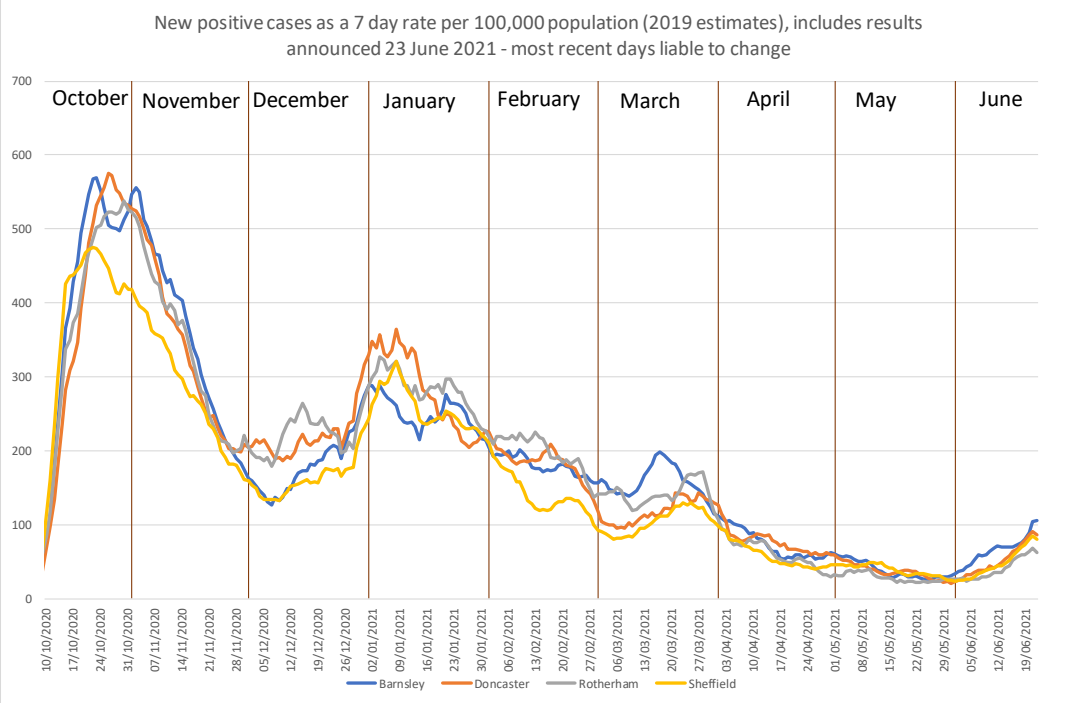
1. the vaccine deployment programme continues successfully;
2. evidence shows vaccines are sufficiently effective in reducing hospitalisations and deaths in those vaccinated;
3. infection rates do not risk a surge in hospitalisations which would put unsustainable pressure on the NHS;
4. assessment of the risks is not fundamentally changed by new variants of concern.

The latest position against these key tests, as at 24 June 2021, are set out in the table below:

TEST	MEASURE	VALUE	DIRECTION
VACCINE PROGRESS	Number with 1st dose (and 2nd dose) Proportion of pop with 1st dose (and 2nd) Comparable progress	164,249 (121,573) 76% (over 56%) Ahead of national	GOOD PROGRESS.
VACCINE IMPACT	Number of people in hospital Number of people in ITU CEV people in hospital	6 0 2	COVID LOW AND STABLE. NON-COVID NEED AND DEMAND IN BHNF AND WIDER HEALTHCARE IS HUGE VERY HIGH.
SEVERE INFECTIONS SURGE	Seven day case rate Positivity rate Seven day rate in over 60s	76.2 2.9 15.7	STABLE. RATES SIMILAR ACROSS SY. MID TABLE FOR YH. BELOW NATIONAL. NW REGION STILL HIGHEST.
DISRUPTION FROM VARIANTS	Local proportion UK variant Variants Of Concern	UK variant 7.4% Over 230 Delta cases	DELTA IS THE PREDOMINANT VARIANT LOCALLY AND ACROSS THE COUNTRY.

As can be seen in the chart below, the infection rate in Barnsley has increased from a low in mid-May and is now the highest in South Yorkshire.

<u>New positive cases as a 7 day rate per 100,000 population</u>



This increase is set against an increasing demand for health and care services including GP practices, community services and hospital services and therefore as we move towards the revised date for the final step of the road map, the CCG will continue to work with local partners in Barnsley and across the South Yorkshire and Bassetlaw Integrated Care System to deliver against our local priorities and plans as described in the Barnsley COVID19 Reset Plan as well as deliver the requirements of the 2021/22 NHS Operational Planning Guidance.

5.2 COVID-19 Vaccination Programme

The COVD vaccination programme, the biggest and most ambitious in NHS history began on 8 December 2020 and will continue to be a priority for the NHS through 2021/22 to ensure maximum uptake and be prepared to meet any requirement for booster vaccination during the Autumn.

Since the first vaccine was administered in Barnsley, Barnsley PCN supported by Barnsley Healthcare Federation has delivered over 217,000 vaccines which equates to the equivalent of over 1,000 vaccines per day. Including activity delivered for Health and Care workers in hospital hubs and vaccination at pharmacy and large-scale sites this number increases to over 300,000 vaccines for Barnsley registered patients.

All patients in Cohorts 1-9 (Aged 50+ or with specific clinical conditions or risk factors) were offered their first dose by mid-April. Over 95% of those in these cohorts have received their first vaccine with the vast majority (97%) having received both doses.

Vaccination continues for cohorts 10-12 (under 50's) and around 70% of this group have received their first dose.

	The national ambition is to have 66% of adults double vaccinated by 19th July – Currently 62% of the Barnsley population have had both doses. There is sufficient vaccine and planned activity locally and with additional through Pharmacy and large-scale sites to be confident of achieving this. To support achievement of the national target in July and to maximise overall uptake of the vaccination programme, the Barnsley Local Vaccination Service are offering a range of options for accessing the vaccine including bookable appointments, walk in clinics and pop up clinics to target populations with lower uptake. A key area of focus for the programme locally is to ensure equitable access and uptake to the vaccination and make sure that no one is left behind. Specific work is therefore ongoing to engage with all communities, utilising community champions and other teams to make every contact count and support those groups of the population who may be hesitant in coming forward or who may have difficulties accessing the vaccination.
6.	**THE GOVERNING BODY IS ASKED TO:**
	• Note the update provided in this paper including the priorities for the NHS and the progress in implementing the vaccination programme.

Agenda time allocation for report:	*10 minutes*

PART 1B – SUPPORTING INFORMATION & ASSURANCE

1. Links to Corporate Priorities, GBAF and Risk Register

This report provides assurance against the following corporate priorities on the Governing Body Assurance Framework

1.1 Urgent & Emergency Care	✓	6.1 Efficiency Plans	
2.1 Primary Care	✓	7.1 Transforming Care for people with LD	
3.1 Cancer	✓	8.1 Maternity	✓
4.1 Mental Health	✓	9.1 Digital and Technology	
5.1 Integrated Care @ System	✓	10.1 Compliance with statutory duties	✓
5.2 Integrated Care @ Place	✓	11.1 Delivery of Enhanced Health in Care Homes	✓

The report also provides assurance against the following red or amber risks on the Corporate Risk Register:	*N/A*

2. Links to statutory duties

This report has been prepared with regard to the following CCG statutory duties set out in Chapter A2 of the NHS Act

Management of conflicts of interest (s14O)		Duties as to reducing inequalities (s14T)	
Duty to promote the NHS Constitution (s14P)	✓	Duty to promote the involvement of each patient (s14U)	
Duty to exercise its functions effectively, efficiently and economically (s14Q)		Duty as to patient choice (s14V)	
Duty as to improvement in quality of services (s14R)		Duty as to promoting integration (s14Z1)	
Duty in relation to quality of primary medical services (s14S)		Public involvement and consultation (s14Z2)	

3. Governance Considerations Checklist *(these will be especially relevant where a proposal or policy is brought for decision or approval)*

3.1 Clinical Leadership

Have GB GPs and / or other appropriate clinicians provided input and leadership?	***Y***
Proposals to be signed off by virtual Governing Body meeting	

3.2 Management of Conflicts of Interest (s14O)

Have any potential conflicts of interest been identified and managed appropriately, having taken advice from the Head of Governance & Assurance and / or the Conflicts of Interest Guardian if appropriate?	***NA***

3.3 Discharging functions effectively, efficiently, & economically (s14Q)

Have any financial implications been considered & discussed with the Finance Team?	***NA***
Where relevant has authority to commit expenditure been sought from Management Team (<£100k) or Governing Body (>£100k)?	***NA***

3.4 Improving quality (s14R, s14S)

Has a Quality Impact Assessment (QIA) been completed if relevant?	***NA***
Have any issues or risks identified been appropriately addressed having taken advice from the Chief Nurse (or Deputy) if appropriate?	***NA***

3.5 Reducing inequalities (s14T)

Has an Equality Impact Assessment (EIA) been completed if relevant?	***NA***
Have any issues or risks identified been appropriately addressed having taken advice from Equality Diversity & Inclusion Lead if appropriate?	***NA***

3.6 Public Involvement & Consultation (s14Z2)

Has a s14Z2: Patient and Public Participation Form been completed if relevant?	***NA***
Have any issues or risks identified been appropriately addressed having taken advice from the Head of Comms & Engagement if appropriate?	***Y***
GB and PCCC meetings will not be held in public for the duration of the outbreak due to the need for social distancing.	

3.7 Data Protection and Data Security

Has a Data Protection Impact Assessment (DPIA) been completed if relevant?	***NA***
Have any issues or risks identified been appropriately addressed having taken advice from the SIRO, IG Lead and / or DPO if appropriate?	***NA***

3.8 Procurement considerations

Have any issues or risks identified been appropriately addressed having taken advice from the procurement Shared Service if appropriate?	***NA***
Has a Single Tender Waiver form been completed if appropriate?	***NA***
Has a Primary Care Procurement Checklist been completed where GPs, networks or Federations may be a bidder for a procurement opportunity?	***NA***

3.9 Human Resources

Have any significant HR implications been identified and managed appropriately, having taken advice from the HR Lead if appropriate?	***NA***

3.10 Environmental Sustainability

Have any significant (positive or negative) impacts on the environment or the CCG's carbon footprint been identified?	***NA***

NHS
Barnsley
Clinical Commissioning Group

GOVERNING BODY

8 July 2021

Integrated Care at Barnsley Place Assurance Report

PART 1A – SUMMARY REPORT

1.	**THIS PAPER IS FOR**
	Decision ☐ *Approval* ☐ *Assurance* ☑ *Information* ☐
2.	**PURPOSE**
	The purpose of the report is to update the CCG Governing Body on the development of integrated care at place level, priority area 5.2 of the NHS Barnsley CCG Governing Body Assurance Framework 2020-21. The report provides with an update on priority areas of work and principle areas of risk and should be read alongside the updated Governing Body Assurance Framework.
3.	**REPORT OF**

	Name	**Designation**
Clinical Lead	Nick Balac	Chair
Executive Lead	Jeremy Budd	Director of Strategic Commissioning and Partnerships
Author	Joe Minton	Professional Manager

4.	**SUMMARY OF PREVIOUS GOVERNANCE**
	The matters raised in this paper have been subject to prior consideration in the following forums:

Group / Committee	Date	Outcome
NA		

5.	**UPDATE REPORT**
5.1	**Introduction** Health and care organisations have been able to respond effectively to the COVID-19 pandemic, maintaining essential services for patients and service users, support staff and work with partners to protect vulnerable people and communities because of the strength of relationships and partnership working that has been developing over recent years. Since the last assurance report was provided to Governing Body in January 2021 the Government set out proposals to bring forward legislation that aims to further integrate service provision. It is explicit that there will be an expectation that ICS NHS bodies delegate 'significantly' to place level, as well as to provider collaboratives. Our vision is that decisions about how services are arranged should be made as closely as possible to those who use them. For most people their day-to-day health and care needs will be met locally in the town or district where they live or work. The legislative programme presents Barnsley place with an opportunity to further build on partnership working and learning from shared experiences through COVID to improve health and care services for local people. The CCG continues to coordinate the work of the Integrated Care Delivery Group and Partnership Group acting on behalf of the partnership. A place design team has been established to oversee the development plan for the partnership and to ensure a single voice for Barnsley into integrated system development. The place design team is jointly chaired by the CCG Accountable Officer and Chief Executive of Barnsley Council with clinical input from the chair of the CCG.
5.2	**Development of the primary care network and neighbourhood networks** The local vaccination programme exemplifies the strong partnership that has been developing in Barnsley in recent years and the Primary Care Network has been central to this achievement. In recent months the PCN has worked with GP practices and other partners to mobilise the community vaccination programme, establish a post-COVID assessment clinic for people still experiencing symptoms after 12 weeks following COVID infection, continue to provide a GP COVID service for those people currently experiencing symptoms and support the wider system response to operational pressures and escalation. The PCN has undertaken a successful recruitment programme to additional roles in primary care that are gradually becoming embedded in services and pathways and this recruitment is ongoing. New roles such as health and wellbeing coordinators and social prescribing link workers aim to increase access to preventative services and care coordinators are facilitating multi-

	disciplinary team working with community services for those with more complex needs
5.3	**Embedding population health management to improve outcomes across the borough and targeted local action on health inequalities** Before the pandemic, the partnership had established a population health management unit. The role of the unit was to provide health intelligence and insight to inform strategy development and operation planning that will improve health outcomes and reduce inequalities. Through the pandemic the unit evolved in a health intelligence cell to provide surveillance and intelligence for recovery, working with engagement and experience leads to seek out and sharing feedback from communities, patients, service users and wider stakeholders. The health intelligence cell has continued to produce regular health surveillance reports relating to COVID and the impact on health and care service delivery, wider community, and hidden harms as well as developing information sharing arrangement and population health intelligence capability. A population health management analyst has been appointed to support COVID surveillance and recovery. The role is hosted by Barnsley Hospital. Tackling health inequalities is a priority that cuts across all the work of the partnership. Health inequalities leads have come together to create a framework for tackling health inequalities that describes action across three tiers, is oriented on delivering our shared vision for Barnsley 2030 and underpinned by a gradual shift of focus and investment from treating advanced illness to keeping people happy and healthy. A rapid action group is supporting the partnership programme senior responsible officers (SROs) and delivery groups to target action on tackling health inequalities. Through the Care Closer to Home Board, the partnership is developing a model of proactive care to improve outcomes for frailty.
5.4	**Strengthen joint commissioning between the CCG and Barnsley Council** There has been a series of workshops with CCG and BMBC commissioners to agree a joint approach place commissioning around the life course. The next stage of development will be to agree a commissioning plan to support delivery of the Barnsley Health and Care Plan with CCG Governing Body.
5.5	**Growing the workforce for the future** Prior to the pandemic there were challenges right across the health and care workforce, and whilst there reasons to be optimistic with record numbers of people considering careers in healthcare, risks of burnout and staff choosing to leave the sector are also greater than before the pandemic. All partners recognise the extraordinary strain put on staff and the commitment and resilience shown throughout the pandemic. Employers in Barnsley have continued to assess the impact on the health and care workforce through regular staff “pulse surveys”. Enhanced support for staff health and wellbeing has been made available to colleagues in Barnsley and through local, regional and national programmes. Employers looking at initiatives to improve flexibility of working and review of rostering practices, supporting working carers, and older workers and improving access to flexible retirement.

	The focus of the partnership has been on school engagement, careers and progression. A significant pressure resulting from COVID has been availability of student placements to support expansion of trainee numbers, particularly in nursing. A coordinator has been appointed to support local placement expansion and there is local agreement to explore a place-based allocation model beginning with pre-registration nursing students. An innovative project using a coaching model in practice supervision (CLiP) has been completed at Barnsley Hospital with evaluation ongoing. The model has been well received by students and supervisors. Through the pandemic the Barnsley Project Echo hub has successfully delivered its first programme of clinical skills training for care home and homecare workers. Two further cohorts are starting the programme in the summer and the additional courses are in development. The partnership has successfully appointed to the vacant role of Barnsley place workforce lead to work with the ICS workforce hub and continues to be represented at the Local Workforce Action Board in South Yorkshire.
5.6	**Optimum use of the health and care estate across the borough and investment to facilitate shift of activity from hospital into community** Prior to the pandemic, the Barnsley Strategic Estates Group (SEG) had agreed a direction of travel for developing an estates strategy. Starting with overall coordination of partner estates strategies which were all in the process of refresh. Currently, the SEG is working on increasing out of hospital access and capacity in our community assets. Community Health Partnerships (CHP), a national body has agreed to fund an options appraisal that will consider how our LIFT estate could be adapted and updated to respond to a pandemic situation, now and in the future.
5.7	**Supporting and promoting the role of the community, voluntary and social enterprise sector in Barnsley in health and care** The voluntary community and social enterprise sector (VCSE) is a vital cornerstone of a progressive health and care system. ICSs will need to ensure that their governance and decision-making arrangements support close working with the sector as a strategic partner in shaping, improving and delivering services and developing and delivering plans to tackle the wider determinants of health. Barnsley CVS is working closely with Barnsley Council, the CCG and the sector to develop the infrastructure to have that strategic voice in the Barnsley partnership and to identify the opportunities for joint working at community level with the PCN and neighbourhood networks for example.
5.8	**Principal threats to delivery** Finance remains a risk to delivery our strategic objective of integrated care in Barnsley. Extraordinary financial arrangements were put into place for COVID and these will continue for at least the first half of 2021/22. The overall financial position is expected to become more challenging due to the NHS and wider economic recovery from COVID. Working together as a place and system to deliver cost improvements will be vital.

	Whilst the Government's white paper sets out proposals that will support greater collaboration in our place and system there are some uncertainties that present threats to this objective. For example, the role and expectations of provider partnerships and the role of Barnsley Health and Wellbeing Board and local democratic accountability in the new system. The anticipated legislative programme for adult social care may also impact significantly on the local partnership arrangements. With the reading of the draft Bill and publication of guidance for the NHS on transition delayed, the timescales for organisation change will be even more challenging.
5.9	**Next steps** The Barnsley Health and Care Plan 2021/22 sets out a series of priories for the coming months. The next steps to delivering against these priorities, including the strengthening of our local partnership and developing integrated care system in South Yorkshire and Bassetlaw include - • Establishing a programme management function to support delivery of the health and care plan • Creating a place development plan and system development plan • Development of collaborative commissioning arrangements and a joint commissioning plan • Refreshing the Barnsley integrated workforce strategy • Developing the work programme for the Efficiencies Executive
6.	**THE GOVERNING BODY IS ASKED TO:**
	Note this update for information and assurance.
7.	**APPENDICES / LINKS TO FURTHER INFORMATION**
	None included.

Agenda time allocation for report:	10 minutes

PART 1B – SUPPORTING INFORMATION & ASSURANCE

1. Links to Corporate Priorities, GBAF and Risk Register

This report provides assurance against the following corporate priorities on the Governing Body Assurance Framework:

1.1 Urgent & Emergency Care	✓	6.1 Efficiency Plans	✓
2.1 Primary Care	✓	7.1 Transforming Care for people with LD	
3.1 Cancer	✓	8.1 Maternity	
4.1 Mental Health	✓	9.1 Digital and Technology	✓
5.1 Integrated Care @ System	✓	10.1 Compliance with statutory duties	✓
5.2 Integrated Care @ Place	✓	11.1 Delivery of Enhanced Health in Care Homes	✓

The report also provides assurance against the following red or amber risks on the Corporate Risk Register:	*N/A*

2. Links to statutory duties

This report has been prepared with regard to the following CCG statutory duties set out in Chapter A2 of the NHS Act

Management of conflicts of interest (s14O)		Duties as to reducing inequalities (s14T)	✓
Duty to promote the NHS Constitution (s14P)	✓	Duty to promote the involvement of each patient (s14U)	✓
Duty to exercise its functions effectively, efficiently and economically (s14Q)	✓	Duty as to patient choice (s14V)	✓
Duty as to improvement in quality of services (s14R)	✓	Duty as to promoting integration (s14Z1)	✓
Duty in relation to quality of primary medical services (s14S)	✓	Public involvement and consultation (s14Z2)	✓

3. Governance Considerations Checklist *(these will be especially relevant where a proposal or policy is brought for decision or approval)*

3.1 Clinical Leadership

Have GB GPs and / or other appropriate clinicians provided input and leadership?	***Y***
Proposals to be signed off by virtual Governing Body meeting	

3.2 Management of Conflicts of Interest (s14O)

Have any potential conflicts of interest been identified and managed appropriately, having taken advice from the Head of Governance & Assurance and / or the Conflicts of Interest Guardian if appropriate?	***NA***

3.3 Discharging functions effectively, efficiently, & economically (s14Q)

Have any financial implications been considered & discussed with the Finance Team?	***NA***
Where relevant has authority to commit expenditure been sought from Management Team (<£100k) or Governing Body (>£100k)?	***NA***

3.4	**Improving quality (s14R, s14S)**	
	Has a Quality Impact Assessment (QIA) been completed if relevant?	***NA***
	Have any issues or risks identified been appropriately addressed having taken advice from the Chief Nurse (or Deputy) if appropriate?	***NA***
3.5	**Reducing inequalities (s14T)**	
	Has an Equality Impact Assessment (EIA) been completed if relevant?	***NA***
	Have any issues or risks identified been appropriately addressed having taken advice from Equality Diversity & Inclusion Lead if appropriate?	***NA***
3.6	**Public Involvement & Consultation (s14Z2)**	
	Has a s14Z2: Patient and Public Participation Form been completed if relevant?	***NA***
	Have any issues or risks identified been appropriately addressed having taken advice from the Head of Comms & Engagement if appropriate?	***Y***
	GB and PCCC meetings will not be held in public for the duration of the outbreak due to the need for social distancing.	
3.7	**Data Protection and Data Security**	
	Has a Data Protection Impact Assessment (DPIA) been completed if relevant?	***NA***
	Have any issues or risks identified been appropriately addressed having taken advice from the SIRO, IG Lead and / or DPO if appropriate?	***NA***
3.8	**Procurement considerations**	
	Have any issues or risks identified been appropriately addressed having taken advice from the procurement Shared Service if appropriate?	***NA***
	Has a Single Tender Waiver form been completed if appropriate?	***NA***
	Has a Primary Care Procurement Checklist been completed where GPs, networks or Federations may be a bidder for a procurement opportunity?	***NA***
3.9	**Human Resources**	
	Have any significant HR implications been identified and managed appropriately, having taken advice from the HR Lead if appropriate?	***NA***
3.10	**Environmental Sustainability**	
	Have any significant (positive or negative) impacts on the environment or the CCG's carbon footprint been identified?	***NA***

NHS
Barnsley
Clinical Commissioning Group

GOVERNING BODY

8th July 2021

Local Maternity Service Update

PART 1A – SUMMARY REPORT

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

	Name	Designation
Executive / Clinical Lead	Chris Edwards	Accountable Officer
Author	Patrick Otway	Head of Commissioning (Mental Health, Children's and Maternity)
	Viv Williams	Senior 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
SY&B ICS Local Maternity Board	Monthly in 2020	Noted
Governing Body	June 2020	Noted
Maternity Commissioner Forum	16/12/2020	Noted and recommended action undertaken
Governing Body	14/01/2021	Noted

4. EXECUTIVE SUMMARY

Governing Body continues to be kept 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.'

One of the key challenges highlighted, and a priority as one of the Long Term Plan ambitions, is the drive towards continuing to implement delivery of maternity services utilising the Continuity of Carer (CoC) model. The national CoC target to be achieved by the end of March 2021 is 35% and this was comfortably achieved in Barnsley (this is not the case in some of the other South Yorkshire localities). The target to be achieved by March 2022 is 51% and Barnsley Maternity Services are confident that they will have achieved this before March 2022.

Barnsley maternity services are making good progress in all areas including implementing The Saving Babies Lives Care Bundle 2 (launched in 2019). Further details of this national programme can be found at https://www.england.nhs.uk/mat-transformation/saving-babies/

As Members will be aware a number of actions were required by local maternity services in response to the recommendations contained within the first report of the Ockenden report (published In December 2019). Barnsley maternity services implemented the immediate actions required within the given timeframes and have been working towards implementing the remaining actions. They have also submitted their Assurance Assessment Tool to NHS England. The main challenge for Barnsley is focused around the level of training required and ensuring that Consultant ward rounds are undertaken twice each day.

Mental Health and Wellbeing

In terms of maternal wellbeing the Specialist Mental Health Midwife continues to see her workload increasing but is still managing to provide an appropriate level of support given the current limitations. In respect of the Maternal Mental Health programme for which SYB ICS are early implementers, funding and recruitment has taken place for a part time Specialist MMH Midwife and Psychologist (hosted by Sheffield Teaching Hospital). The psychologist will no longer be fixed term but will be recruited on a permanent basis as recruiting to a fixed term position has been extremely difficult. Once in post the focus over the next few months will be to scope the service, develop policy guidance / guidelines relating to service provision and develop a referral pathway into the service. In doing so the postholder will review all local maternal mental health pathways (e.g. Perinatal mental health service, priority referrals to IAPT, Specialist Mental Health Midwife post, early implementer provision) to ensure that all of the pathways are seamless and provide the best possible outcomes for the women and their families.

With regards to Perinatal Mental Health members will be aware that the Specialist Perinatal Mental Health Service provided by SWYPFT has been funded to achieve the recommended access targets within the NHS LTP for 2021/22 of 8.6%. In quarter 1 of 2021 /22 the service starting point was well below the target as a result of COVID 19. However, agreements have now been made as to those elements which can be counted towards the access target, and these are as follows:

- Face to face appointments
- Video consultation
- Appointments that started as telephone but then resulted in subsequent face to face appointments. Other telephone appointments could not be counted within the calculation for the access target.

The service is now confident that on receipt of the additional funding from the CCG they will achieve the access target by the end of quarter 3 in 2021/22.

In addition, joint discussions have taken place between commissioners from Barnsley, Wakefield, Calderdale and Huddersfield CCGs, to develop local KPIs for the community specialist PNMH services.

The additional, national investment provided by NHS E/I is to support further service developments for perinatal mental health. This includes:

- Increasing the availability of specialist PMH community care for women who need ongoing support from 12 months after birth to 24 months
- Improving access to evidence-based psychological therapies for women and their partners (this is the aspect for which SYB ICS are early implementers)
- Mental health checks for partners of those accessing specialist PMH community services and signposting to support as required.

With regards for the Extension of service from birth to 24 months there is no clear time frame for when this will be in place, just that it needs to be in place by 2023/24 (see Mental Health Implementation Plan 2019/20 – 2023/24.

Currently there are discussions and work ongoing looking at: Thresholds, Identification of current and future psychological interventions and identification of PMH training and learning, which will inform immediate and future commissioning activities in meeting the NHS Long Term Plan ambitions. Other areas being discussed relate to the role and relationship of Community Mental Health Teams (CMHT).

CNST

NHS Resolution is operating a third year of the Clinical Negligence Scheme for Trusts (CNST) maternity incentive scheme to continue to support the delivery of safer maternity care. The maternity incentive scheme applies to all acute Trusts that deliver maternity services and are members of the CNST.

As in year two, members will contribute an additional 10% of the CNST maternity premium to the scheme creating the CNST maternity incentive fund. In order to mitigate the financial impact of Covid-19, CNST MIS contributions were not taken in April 2020 as would otherwise have occurred. Effectively this means that trusts have had a ‘year off’ paying their contributions and additional time to implement the year three scheme, albeit with some revisions to the requirements when relaunched on 1 October 2020. With the delay in the funding element of the maternity incentive scheme in 2020/21, contributions into the incentive fund and distributions from it will be carried out in 2021/22 as per the usual timeframes.

As in year two, the scheme incentivises ten maternity safety actions. Trusts that can demonstrate they have achieved all of the ten safety actions will recover the element of their contribution relating to the CNST maternity incentive fund and will also receive a share of any unallocated funds.

	Trusts that do not meet the ten-out-of-ten threshold will not recover their contribution to the CNST maternity incentive fund, but may be eligible for a small discretionary payment from the scheme to help them to make progress against actions they have not achieved. Such a payment would be at a much lower level than the 10% contribution to the incentive fund. The 10 Safety Actions for 2021/22 are as follows: Safety Action 1 – Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard? Safety Action 2 – Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard? Safety Action 3 – Can you demonstrate that you have transitional carte services to support the recommendations made in the Avoiding Term Admissions into Neonatal units Programme? Safety Action 4 – Can you demonstrate an effective system of clinical workforce planning to the required standard? Safety Action 5 - Can you demonstrate an effective system of midwifery workforce planning to the required standard? Safety Action 6 – can you demonstrate compliance with all five elements of the Saving Babies Lives Care bundle Version 2? Safety Action 7 – can you demonstrate that you have a mechanism for gathering service user feedback and that you work with service users through your Maternity Voices Partnership to coproduce local maternity services? Safety Action 8 – can you evidence that at least 90% of each maternity unit staff groups have attended an in-house multiprofessional maternity emergencies training session within the last training year? Safety Action 9 – can you demonstrate that the Trust Safety Champions (obstetric, midwifery and neonatal) are meeting bimonthly with Board level champions to escalate locally identified issues? Safety Action 10 – have you reported 100% qualifying cases to HSIB and (for 2019/20 births only) reported to NHS Resolutions Early Notification (EN) Scheme? In order to demonstrate achievement of all of the above 10 Actions, BHNFT submit a significant amount of evidence to NHS Resolutions. The evidence that has been gathered by BHNFT has already been considered by local mental health commissioners and we are assured that Barnsley Maternity services are complying with all of the 10 Safety Actions outlined above. This is also reflected in the Maternity Safety Dashboard (Appendix A) which has been developed within Yorkshire and Humber.

5.	**THE GOVERNING BODY IS ASKED TO:**
	• Note the contents of this report
6.	**APPENDICES / LINKS TO FURTHER INFORMATION**
	• Appendix A – SYB LMS Safety Dashboard

Agenda time allocation for report:	*10 minutes*

PART 1B – SUPPORTING INFORMATION & ASSURANCE

1. Links to Corporate Priorities, GBAF and Risk Register

This report provides assurance against the following corporate priorities on the Governing Body Assurance Framework:

1.1 Urgent & Emergency Care		6.1 Efficiency Plans	
2.1 Primary Care		7.1 Transforming Care for people with LD	
3.1 Cancer		8.1 Maternity	✓
4.1 Mental Health		9.1 Digital and Technology	
5.1 Integrated Care @ System		10.1 Compliance with statutory duties	
5.2 Integrated Care @ Place		11.1 Delivery of Enhanced Health in Care Homes	

The report also provides assurance against the following red or amber risks on the Corporate Risk Register:	*N/A*

2. Links to statutory duties

This report has been prepared with regard to the following CCG statutory duties set out in Chapter A2 of the NHS Act

Management of conflicts of interest (s14O)		Duties as to reducing inequalities (s14T)	✓
Duty to promote the NHS Constitution (s14P)	✓	Duty to promote the involvement of each patient (s14U)	✓
Duty to exercise its functions effectively, efficiently and economically (s14Q)	✓	Duty as to patient choice (s14V)	✓
Duty as to improvement in quality of services (s14R)	✓	Duty as to promoting integration (s14Z1)	✓
Duty in relation to quality of primary medical services (s14S)	✓	Public involvement and consultation (s14Z2)	✓

3. Governance Considerations Checklist *(these will be especially relevant where a proposal or policy is brought for decision or approval)*

3.1 **Clinical Leadership**

Have GB GPs and / or other appropriate clinicians provided input and leadership?	***NA***

3.2 **Management of Conflicts of Interest (s14O)**

Have any potential conflicts of interest been identified and managed appropriately, having taken advice from the Head of Governance & Assurance and / or the Conflicts of Interest Guardian if appropriate?	***NA***

3.3	**Discharging functions effectively, efficiently, & economically (s14Q)**	
	Have any financial implications been considered & discussed with the Finance Team?	***NA***
	Where relevant has authority to commit expenditure been sought from Management Team (<£100k) or Governing Body (>£100k)?	***NA***
3.4	**Improving quality (s14R, s14S)**	
	Has a Quality Impact Assessment (QIA) been completed if relevant?	***NA***
	Have any issues or risks identified been appropriately addressed having taken advice from the Chief Nurse (or Deputy) if appropriate?	***NA***
3.5	**Reducing inequalities (s14T)**	
	Has an Equality Impact Assessment (EIA) been completed if relevant?	***NA***
	Have any issues or risks identified been appropriately addressed having taken advice from Equality Diversity & Inclusion Lead if appropriate?	***NA***
3.6	**Public Involvement & Consultation (s14Z2)**	
	Has a s14Z2: Patient and Public Participation Form been completed if relevant?	***NA***
	Have any issues or risks identified been appropriately addressed having taken advice from the Head of Comms & Engagement if appropriate?	***NA***
3.7	**Data Protection and Data Security**	
	Has a Data Protection Impact Assessment (DPIA) been completed if relevant?	***NA***
	Have any issues or risks identified been appropriately addressed having taken advice from the SIRO, IG Lead and / or DPO if appropriate?	***NA***
3.8	**Procurement considerations**	
	Have any issues or risks identified been appropriately addressed having taken advice from the procurement Shared Service if appropriate?	***NA***
	Has a Single Tender Waiver form been completed if appropriate?	***NA***
	Has a Primary Care Procurement Checklist been completed where GPs, networks or Federations may be a bidder for a procurement opportunity?	***NA***
3.9	**Human Resources**	
	Have any significant HR implications been identified and managed appropriately, having taken advice from the HR Lead if appropriate?	***NA***
3.10	**Environmental Sustainability**	
	Have any significant (positive or negative) impacts on the environment or the CCG's carbon footprint been identified?	***NA***

Appendix A

SYB LMS Safety Dashboard

Stillbirths (per 1000 births)

Baseline	
National	4.7 per 1000 total births
SYB	4.81 per 1000 total births

SYB Improvement Trajectories	Trajectory March 2020	Trajectory March 2021	Trajectory March 2025
	3.76	3.48	2.35
	-20%	-26%	-50%

Current SYB Position		
	ONS, 2019	3.61
	YH CN, YTD Q4 20/21	3.37

Current Local Position		
Trust	ONS, 2019	Y&H ODN 20/21 Q4
Barnsley	2.97	2.9
Bassetlaw	2.66	1.9
Doncaster	3.17	3.7
Rotherham	3.54	5.3
Sheffield	4.37	2.8

Neonatal Deaths (per 1000 births)

Baseline	
National	2.5 per 1,000 live births
SYB	2.39 per 1,000 live births

SYB Improvement Trajectories	Trajectory March 2019	Trajectory March 2020	Trajectory March 2025
	2.25	2.00	1.25
	-10%	-20%	-50%

Current SYB Position		
	ONS, 2018	3.09
	ONS, 2019	2.25

Current Local Position		
Trust	ONS, 2018	ONS, 2019
Barnsley	2.66	0.7
Bassetlaw	5.37	6.2
Doncaster	3.23	3.5
Rotherham	5.10	1.4
Sheffield	1.81	1.9

Brain Injuries

Baseline	
National	5.19 per 1,000 live births
SYB	5.44 per 1000 live births

SYB Improvement Trajectories	Trajectory March 2019	Trajectory March 2020	Trajectory March 2025
	4.67	4.15	2.60
	-10%	-20%	-50%

Current SYB Position	NNRD, 2017	4.60

Maternal Deaths

Baseline	
National	8.76 per 100,000 maternities
SYB	*Local Data Unavailable*

National Improvement Trajectories	Trajectory March 2020	Trajectory March 2021	Trajectory March 2025
	7.01	6.48	4.38
	-20%	-26%	-50%

Current SYB Position	Equal or less than 5 deaths

Antenatal Steroids

Baseline	
National	86% of eligible preterm births
SYB	88% of eligible preterm births

SYB Improvement Trajectories	Trajectory March 2020	Trajectory March 2021	Trajectory March 2025
	90%	90%	≥90%

Current SYB Position	NNAP, 2019	94%
	ODN, 2020/21 YTD Q2	93%

Current Local Position		
Trust	NNAP, 2019	ODN, 2020/21 YTD Q2
Barnsley	93%	95%
Bassetlaw	88%	0%
Doncaster	88%	100%
Rotherham	98%	100%
Sheffield	96%	91%

Magnesium Sulphate Administration

Baseline	
National	44% of eligible preterm births
SYB	41% of eligible preterm births

SYB Improvement Trajectories	Trajectory March 2020	Trajectory March 2021	Trajectory March 2025
	>85%	>87%	>95%

Current SYB Position	NNAP, 2019	87%
	ODN, 2020/21 YTD Q2	93%

Current Local Position		
Trust	NNAP, 2019	ODN, 2020/21 YTD Q2
Barnsley	89%	91%
Bassetlaw	0%	0%
Doncaster	76%	91%
Rotherham	100%	100%
Sheffield	90%	93%

<27 wk Non-NICU Admissions

Baseline	
National	*National Data Unavailable*
SYB	7 babies <27w born in SCU/LNU

SYB Improvement Trajectories	Trajectory March 2020	Trajectory March 2021	Trajectory March 2025
	1	1	0

Current SYB Position		
	YH ODN, 2019/20	14
	ODN, 2020/21 YTD Q2	3

Current Local Position		
Trust	NNAP, 2019	ODN, 2020/21 YTD Q2
Barnsley	1	1
Bassetlaw	0	0
Doncaster	12	2
Rotherham	1	0
Sheffield	N/A	N/A

Preterm Births

Baseline	
National	8%
SYB	6.7

SYB Improvement Trajectories	Trajectory March 2020	Trajectory March 2021	Trajectory March 2025
	<6.5%	<6.4%	≤6%

Current SYB Position		
	MSDS, Ap 18-Feb 19	6.70%
	YH CN, YTD Q4 20/21	7.74%

Current Local Position		
Trust	ODN, 2019/20	ODN, 2020/21 YTD Q4
Barnsley	6.3%	7.6%
Bassetlaw	In DRI	In DRI
Doncaster	7.9%	7.0%
Rotherham	8.7%	8.1%
Sheffield	8.4%	8.2%

Smoking In Pregnancy

Baseline	
National	12% of women SATOD
SYB	18.2% of women SATOD

SYB Improvement Trajectories	Trajectory March 2020	Trajectory March 2021	Trajectory March 2022
	≤10%	≤8%	≤6%

Current SYB Position	NHSD SATOD 2019/20	14.0%
	SATOD YTD 2020/21 (Q3)	12.5%

Current Local Position		
Trust	2019/21 NHS SATOD	2020/21
Barnsley	14.6%	13.7%
Bassetlaw	11.8%	13.2%
Doncaster	17.0%	15.5%
Rotherham	16.2%	13.8%
Sheffield	11.5%	9.6%

Continuity of Carer

Baseline	
National	*No data available*
SYB	*No data available*

SYB Improvement Trajectories	Trajectory March 2020	Trajectory March 2021	Trajectory March 2022
	35%	35%	51%

Current SYB Position	Reported Mar-2020	24.0%
	Actual Mar-2021	25.9%

Current Local Position			
Trust	Reported Mar-20		Actual Apr-2021
Barnsley	28%		36%
Bassetlaw	21%		81%
Doncaster	16%		3%
Rotherham	0%		41%
Sheffield	30%		15%

Homebirths

Baseline	
National	2.1% of total women giving birth
SYB	*No Baseline Data*

SYB Improvement Trajectories	Trajectory March 2020	Trajectory March 2021	Trajectory March 2022

Current SYB Position		
	Y&H ODN March 2020	0.64%
	2020/21 YTD (Q3)	0.68%

Current Local Position		
Trust	2019/20	2020/21 YTD (Q3)
Barnsley	0.20%	**0.10%**
Bassetlaw	reported as DBTH	5.05%
Doncaster	0.61%	0.55%
Rotherham	1.01%	1.78%
Sheffield	1.09%	**0.21%**

NHS
Barnsley
Clinical Commissioning Group

GOVERNING BODY

8th July 2021

Out of Area Locked Rehabilitation Update Report

PART 1A – SUMMARY REPORT

1. THIS PAPER IS FOR

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

2. PURPOSE

The report will update Governing Body on the issues, risks and mitigating actions regarding a cohort of high risk, high cost patients within the current Out of Area Locked Rehabilitation system. It will demonstrate that this issue has interface with a number of other service issues and will make recommendations on further work needed.

3. REPORT OF

	Name	Designation
Executive / Clinical Lead	Jayne Sivakumar	Chief Nurse
Author	Jo Harrison	Specialist Clinical Portfolio Manager

4. SUMMARY OF PREVIOUS GOVERNANCE

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

Group / Committee	Date	Outcome
Quality and Patient Safety Committee	14/12/2020	Noted
Governing Body	10/03/2021	Noted and update requested.
Governing Body	13/05/2021	Noted and quarterly updates requested

5. EXECUTIVE SUMMARY

5.1 Introduction and background

Issues and risks regarding the commissioned out of area Locked Rehabilitation (OOALR) beds for adults with Mental Health Needs, delegated to SWYPFT via a devolved budget, have been discussed in previous Governing Body meetings.

The issues and risks were raised initially out of concern that the devolved budget was significantly overspent – at the end of Q4 2020/21, it was overspent by over £2 million.

Initial discussions, data, and intelligence lead to a hypothesis that the key factor in the overspend was a cohort of young women who are extremely complex and who challenge services. At the time it was noted that all except one of them had been a Child in Care (CiC, previously known as Looked After Child, LAC).

Further discussions and attendance at other funding panels have enabled a number of other interdependent issues to be identified and provides a picture of wider systems problems:

- The cohort of complex young women and lack of community pathways
- Inappropriate use of the OOA LR budget – patients coded to that funding route who did not meet the criteria
- A strong link to the transition of CiC in Barnsley, both in social care and mental health
- Lack of Tier 4 equivalent acute mental health beds for children and young people
- High acuity in acute adult mental health beds, including pressure on Section 136 suites – this has recently led to a rise in requests for OOA general beds
- Barriers to patient flow and Delayed Transfers of Care
- Issues with case management and care coordination
- Staffing issues and shortages in the acute inpatient system
- SWYPFT sub-commissioning with independent hospitals

Potential / emerging risks are:

- CCG and SWYPFT financial position becomes unsustainable due to the reliance on independent hospital provision
- Patient care and outcomes are compromised – there is a risk to patient safety
- Reputational risk to the CCG and SWYPFT from potential inpatient Serious Incidents in SWYPFT acute units and in OOA hospital units

5.2 Mitigating actions to date and potential impact

A detailed review of the SWYPFT inpatient system and OOA budget has commenced, which is to be progressed and managed through the SWYFT / CCG Commissioning Priorities meetings and SWYFT Clinical Quality Board (CQB) meetings.
Thus far the following actions have been taken / agreed:

- SWYPFT General Manager for MH services has already completed a detailed study in 2019. This has been reviewed in November 2020 and was felt to remain a valid and reliable document. The Specialist Clinical Portfolio and General Manager have been asked to present this to the next CQB in July.
- The inclusion criteria and process for accessing OOALR beds via the SWYPFT devolved budget have been reviewed and further revised. This will allow for more accurate coding. It means that patients who do not meet the criteria for OOALR will no longer be routed to this pathway and their ongoing care needs will be identified case by case. Potential impact

will be:

- Increase in pressure on the inpatient system and patient flow, from patients not suitable for locked rehabilitation, who are creating problems and issues on the wards and where the MDTs feel they can no longer meet their needs
- Increase in pressure on CCG budgets. However, once coded correctly it will be possible for CCG Finance colleagues to align the spend to sections of the SWYPFT block budget and determine the required commissioning approach, or forecast more accurately for specific specialist funding

- Discussions are progressing to explore the feasibility of community options for step-down and admission prevention. This is being linked in with wider commissioning plans locally and across the ICS. Referrals have been made to the Leeds Personality Disorder Pathway Team to attempt to progress the most complex cases.
- Meetings and discussions have taken place with BMBC partners regarding transition of CiC from child to adult social care services and as care leavers and also from CAMHS to Adult MH services. The complex young women in the system are being looked at from this perspective.
- Work is already ongoing from a Commissioning and Transformation perspective around the provision of Tier 4 services, as this has been identified as a problem both regionally and nationally. This issue is on the Regional Chief Nurse's radar, with particular focus on Tier 4, CAMHS and Eating Disorder pathways. Discussions have taken place at a recent Regional Chief Nurse meeting.
- CCG Specialist Clinical Portfolio Manager and the Complex Case and Care Quality Manager are case finding and attending key forums, e.g. SWYPFT Challenges to Discharge meetings, Collaborative Care Planning Meetings, Leeds PD Pathway Case Conferences.

5.3 Recommendation

There is a significant amount of work to do on fully understanding the overall position, its significance and the approaches needed to address this. However, it is recommended that to progress things at pace and address immediate pressures:

- A multi - agency Task Team Project is set up within the acute bed base to manage patient flow from front door to discharge. This approach has been known to work well in acute general hospitals, especially when supported by BI and will hopefully inform longer term planning. This will require:
  - commitment from all multi - agency stakeholder partners
  - a formal Memorandum of Understanding
  - increased Registered Nurse resource on the acute wards
  - appropriate governance arrangements
  - support from Business Intelligence (BI)
- This work needed is recognised as a transformation programme and requiring leadership through the Commissioning and Transformation Team, with an identified lead to set out the programme and work with the Specialist Clinical Portfolio on specific appropriate projects. Within this recommendation, it would also be beneficial for a Business Intelligence resource to be utilised to provide expedience and validity and reliability in the analysis and interpretation of key data.

6.	**THE GOVERNING BODY / COMMITTEE IS ASKED TO:**
	• Note the updated position and progress made to initiate and develop mitigating actions to reduce risks. • Support the recommendations.
7.	**APPENDICES / LINKS TO FURTHER INFORMATION**
	None

Agenda time allocation for report:	10 minutes

PART 1B – SUPPORTING INFORMATION & ASSURANCE

1. Links to Corporate Priorities, GBAF and Risk Register

This report provides assurance against the following corporate priorities on the Governing Body Assurance Framework

1.1 Urgent & Emergency Care		6.1 Efficiency Plans	x
2.1 Primary Care		7.1 Transforming Care for people with LD	
3.1 Cancer		8.1 Maternity	
4.1 Mental Health	**x**	9.1 Digital and Technology	
5.1 Integrated Care @ System		10.1 Compliance with statutory duties	x
5.2 Integrated Care @ Place	**x**		

The report also provides assurance against the following red or amber risks on the Corporate Risk Register:	*N/A but impacts into domains 1 and 5*

2. Links to statutory duties

This report has been prepared with regard to the following CCG statutory duties set out in Chapter A2 of the NHS Act

Management of conflicts of interest (s14O)	**See 3.2**	Duties as to reducing inequalities (s14T)	**See 3.5**
Duty to promote the NHS Constitution (s14P)		Duty to promote the involvement of each patient (s14U)	x
Duty to exercise its functions effectively, efficiently and economically (s14Q)	**See 3.3**	Duty as to patient choice (s14V)	
Duty as to improvement in quality of services (s14R)	**See 3.4**	Duty as to promoting integration (s14Z1)	
Duty in relation to quality of primary medical services (s14S)	**See 3.4**	Public involvement and consultation (s14Z2)	**See 3.6**

3. Governance Considerations Checklist *(these will be especially relevant where a proposal or policy is brought for decision or approval)*

3.1 Clinical Leadership

Have GB GPs and / or other appropriate clinicians provided input and leadership?	***Y***

3.2 Management of Conflicts of Interest (s14O)

Have any potential conflicts of interest been identified and managed appropriately, having taken advice from the Head of Governance & Assurance and / or the Conflicts of Interest Guardian if appropriate?	***NA***

3.3 Discharging functions effectively, efficiently, & economically (s14Q)

Have any financial implications been considered & discussed with the Finance Team?	***Y***
Where relevant has authority to commit expenditure been sought from Management Team (<£100k) or Governing Body (>£100k)?	***Y***
Business case for fixed term Complex Case Manager	

3.4	**Improving quality (s14R, s14S)**	
	Has a Quality Impact Assessment (QIA) been completed if relevant?	***NA***
	Have any issues or risks identified been appropriately addressed having taken advice from the Chief Nurse (or Deputy) if appropriate?	***Y***
3.5	**Reducing inequalities (s14T)**	
	Has an Equality Impact Assessment (EIA) been completed if relevant?	***NA***
	Have any issues or risks identified been appropriately addressed having taken advice from Equality Diversity & Inclusion Lead if appropriate?	***NA***
3.6	**Public Involvement & Consultation (s14Z2)**	
	Has a s14Z2: Patient and Public Participation Form been completed if relevant?	***NA***
	Have any issues or risks identified been appropriately addressed having taken advice from the Head of Comms & Engagement if appropriate?	***NA***
3.7	**Data Protection and Data Security**	
	Has a Data Protection Impact Assessment (DPIA) been completed if relevant?	***NA***
	Have any issues or risks identified been appropriately addressed having taken advice from the SIRO, IG Lead and / or DPO if appropriate?	***NA***
3.8	**Procurement considerations**	
	Have any issues or risks identified been appropriately addressed having taken advice from the procurement Shared Service if appropriate?	***NA***
	Has a Single Tender Waiver form been completed if appropriate?	***NA***
	Has a Primary Care Procurement Checklist been completed where GPs, networks or Federations may be a bidder for a procurement opportunity?	***NA***
3.9	**Human Resources**	
	Have any significant HR implications been identified and managed appropriately, having taken advice from the HR Lead if appropriate?	***NA***
3.10	**Environmental Sustainability**	
	Have any significant (positive or negative) impacts on the environment or the CCG's carbon footprint been identified?	***NA***

NHS
Barnsley
Clinical Commissioning Group

GOVERNING BODY

8th July 2021

PRACTICE DELIVERY AGREEMENT - PRIMARY CARE SCHEMES 2021/22

PART 1A – SUMMARY REPORT

1. THIS PAPER IS FOR

Decision		Approval	X	Assurance		Information	

2. PURPOSE

The purpose of this report is to provide Governing Body with the proposed Primary Care PDA Schemes for 2021/22 for approval.

3. REPORT OF

	Name	Designation
PC Clinical Lead	Dr M Guntamukkala	Medical Director
Authors	Terry Hague Sarah Pollard Julie Frampton	Primary Care Transformation Manager Health Improvement Nurse - Vascular Disease Head of Primary Care

4. SUMMARY OF PREVIOUS GOVERNANCE

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

Group / Committee	Date	Outcome
PDA 2021/22 Development Group	28/05/2021	Scheme developments
PDA 2021/22 Development Group	11/06/2021	Scheme developments

5. EXECUTIVE SUMMARY

Since 2014/15 Barnsley CCG has developed and implemented a Practice Agreement Scheme between itself and its 32 Member GP Practices called the Barnsley Practice Delivery Agreement (PDA). This is commissioned via an NHS Standard Contract.

The aim of the PDA is to invest in the capacity needed to deliver a consistently high standard of General Practice across Barnsley and has been reviewed and refreshed with consideration to the challenges for Primary Care, particularly during

the COVID 19 Pandemic.

The focus of the PDA has always been to invest in the infrastructure to deliver and enhance quality of care which reduces health inequalities of patients living in Barnsley. As part of this contract GP practices will receive a consistent income level to assist with staffing capacity and be resilient to meet to changing landscape of the NHS.

The objectives of the 2021/22 PDA are to maintain and develop core services, with a focus on estate planning, evidence based commissioning policies, NHS priorities as outlined in the operational planning guidance, digital projects, promoting services that are clinically safe and appropriate following the Covid pandemic as services reinstate.

The PDA 2021/22 has a total financial value sum of £4.2million and will be allocated to practices in the same format as 2019-20. The allocation per scheme will be calculated on weighted January 2021 list sizes.

PDA 2021/22 Development Meetings have been well attended with representation from the CCG, BBS IT Services, Practice Managers and the LMC. The purpose of the PDA 2021/22 Development Group is to develop, shape and agree, the 2021-22 PDA schemes, no financial decisions will be made at the meeting.

Final drafts of the schemes have now been produced, which have been distributed to the LMC, CCG, and Practice Managers for comment before seeking approval at Governing Body. Final approval, which will include the finances, will be undertaken at Primary Care Commissioning Committee in July 2021.

The 2021/22 Primary Care Schemes of the Practice Delivery Agreement is broken down into 6 core schemes:

Scheme	**PDA funding allocation**
Scheme 1: Support the delivery of Primary Care Services and enact plans to meet current and future GP core contractual and enhanced services requirements.	***9%***
Scheme 2: Support the CCG and PCN with estate planning including the Estate 6 facet surveys; updating data within the Shape tool and PCN planning	***2%***
Scheme 3: Use the funds to ensure staff are appropriately trained and update equipment that supports delivery of primary care services, including anticoagulation, spirometry, 12 Lead ECG and phlebotomy.	***9%***
Scheme 4: Adherence to Evidence Based Commissioning Policies	***5%***
Scheme 5: Support the NHS 2021/22 priorities as outlined in the operational planning guidance including increasing access to primary care services and accelerating the restoration of cancer care.	***9%***
Scheme 6: Support IT and digital projects for 2021/22, including for example Office 365; digital citizen; and coding for consultation method, oximetry and long COVID; the digital first core services offer and engaging with group consultations for chronic disease management.	***9%***

A breakdown of each scheme is provided below and also within the appendix.

Plans for Delivery of Primary Care Services

The scheme requires completion of a survey to ascertain the current positon of service delivery, reinstatement of all primary care services, and plans for meeting current and future requirements that considers national and local requirements.

The rationale for inclusion of this scheme in the 2021/22 PDA is for GP practices to inform the CCG of their current position of service delivery across General Practice. It also aims to ascertain GP Practice plans to reinstate all primary care services when appropriate.

Estate Planning

Expanding primary care capacity to improve access, local health outcomes and address health inequalities forms part of the 2021/22 priorities and operational planning guidance.

Local investment and support for PCN development, including as an enabler of workforce expansion for example through the Additional Roles Reimbursement schemes, is one method of increasing access to primary care.

This scheme promotes the requirement for engagement in the Primary Care Estate 6 facet surveys, data for use in the Shape tool, and support with premises planning working with PCN, community provider, and other partners to agree space as appropriate, particularly to assist with the deployment of the additional role reimbursement scheme to enable staff to be effectively deployed.

Current information regarding estates and future planning is pivotal to ensuring we are able to commission, deliver and address challenges to meet the demand for effective health services.

Staff trained as appropriate and equipment updated

This scheme supports the delivery of primary care services and recognises the additional resource required, ensuring equipment is calibrated, replaced and that staff are appropriately trained to deliver the services.

Operational Planning Guidance

Expanding primary care capacity to improve access, local health outcomes and address health inequalities forms part of the 2021/22 priorities and operational planning guidance. Additionally, restoration of cancer care and working collaboratively across systems to deliver these priorities is key to achieving the NHS goals within the Long Term Plan.

This scheme promotes increasing access to primary care through engagement with projects, the deployment of additional roles, development of the extension of the Community Pharmacy Consultation Service enabling them to receive referrals from General Practice, and support for GP recruitment and retention initiatives such as the return to practice and mentor schemes, new to partnership and fellowship programme.

Restoration of cancer care is also a key focus including monitoring the number of pre-assessment FIT test kits used by practices, implementation of the C-The signs tool, and taking part in the behavioural insight nudge project.

IT and Digital Projects

This scheme promotes practices to support IT and digital projects for 2021/22 including, for example, Office 365, digital citizen, coding for consultation method, oximetry and Long Covid, the digital first core services offer and engaging with

	group consultations for chronic disease management. The Long Term Plan outlines how digitally enabled care will go mainstream across the NHS. Good progress has been made in achieving the ambitions set out in the Five Year Forward View, with many new or enhanced digital and technology systems and services delivered. Advancements have also been accelerated during the pandemic with alternative ways of delivering appointments within GP practices. The NHS response (phase 3) to the pandemic included, as an urgent action, the development of digitally enabled care pathways in ways which increase inclusion, including reviewing who is using new primary, outpatient, and mental health digitally enabled care pathways by 31 March 2022. A core digital service offer to patients was also included as a priority within the update to the GP contract agreement 2020/21 – 2023/24 with more online services for patients and using digital tools to increase flexibility in how staff work and care for patients. The GP contract update also included the commitment to release time to care and reduce administrative burdens, for example the digitisation of Lloyd George records. The engagement of practices within IT and digital projects and in preparing and recording information within systems to assist with further advancement and data collection is crucial and key to achieving these outcomes.
6.	**THE GOVERNING BODY IS ASKED TO:**
	1. Approve the proposed schemes for inclusion within the 2021/22 PDA
7.	**APPENDICES / LINKS TO FURTHER INFORMATION**
	• Appendix 1 – Draft Schemes

Agenda time allocation for report:	10 mins

PART 1B – SUPPORTING INFORMATION & ASSURANCE

1. Links to Corporate Priorities, GBAF and Risk Register

This report provides assurance against the following corporate priorities on the Governing Body Assurance Framework (*place ✓ beside all that apply*):

1.1 Urgent & Emergency Care		6.1 Efficiency Plans	
2.1 Primary Care	✓	7.1 Transforming Care for people with LD	
3.1 Cancer	✓	8.1 Maternity	
4.1 Mental Health		9.1 Digital and Technology	✓
5.1 Integrated Care @ System		10.1 Compliance with statutory duties	✓
5.2 Integrated Care @ Place			

The report also provides assurance against the following red or amber risks on the Corporate Risk Register:	*Provide ref(s) or state N/A*

2. Links to statutory duties

This report has been prepared with regard to the following CCG statutory duties set out in Chapter A2 of the NHS Act:

Management of conflicts of interest (s14O)	**See 3.1**	Duties as to reducing inequalities (s14T)	**See 3.4**
Duty to promote the NHS Constitution (s14P)		Duty to promote the involvement of each patient (s14U)	
Duty to exercise its functions effectively, efficiently and economically (s14Q)		Duty as to patient choice (s14V)	
Duty as to improvement in quality of services (s14R)		Duty as to promoting integration (s14Z1)	
Duty in relation to quality of primary medical services (s14S)	✓	Public involvement and consultation (s14Z2)	

2A. Links to delegated primary care commissioning functions

This report is relevant to the following responsibilities for primary care commissioning delegated to the CCG

Decisions in relation to the commissioning, procurement and management of GMS, PMS and APMS contracts (inc breach notices etc)	✓	Decisions in relation to the management of poorly performing GP Practices	
Planning the primary medical services provider landscape in Barnsley (inc closures, mergers, dispersals)		Decisions in relation to the Premises Costs Directions Functions	
Planning the Commissioning of Primary Medical Services in Barnsley		Co-ordinating a common approach to the commissioning of primary care services	✓
Manage the delegated allocation for commissioning of primary medical care services in Barnsley			

3. Governance Considerations Checklist *(these will be especially relevant where a proposal or policy is brought for decision or approval)*

3.1 Clinical Leadership

Have GB GPs and / or other appropriate clinicians provided input and	***Y***

	leadership?	
	If relevant provide brief details here OR cross refer to detailed report if used	

3.2 Management of Conflicts of Interest (s14O)

Have any potential conflicts of interest been identified and managed appropriately, having taken advice from the Head of Governance & Assurance and / or the Conflicts of Interest Guardian if appropriate?	***Y***
If relevant provide brief details here OR cross refer to detailed report if used	

3.3 Discharging functions effectively, efficiently, & economically (s14Q)

Have any financial implications been considered & discussed with the Finance Team?	***Y***
Where relevant has authority to commit expenditure been sought from Management Team (<£100k) or Governing Body (>£100k)?	***NA***
If relevant provide brief details here OR cross refer to detailed report if used	

3.4 Improving quality (s14R, s14S)

Has a Quality Impact Assessment (QIA) been completed if relevant?	***NA***
Have any issues or risks identified been appropriately addressed having taken advice from the Chief Nurse (or Deputy) if appropriate?	***NA***
If relevant provide brief details here OR cross refer to detailed report if used	

3.5 Reducing inequalities (s14T)

Has an Equality Impact Assessment (EIA) been completed if relevant?	***NA***
Have any issues or risks identified been appropriately addressed having taken advice from Equality Diversity & Inclusion Lead if appropriate?	***NA***
If relevant provide brief details here OR cross refer to detailed report if used	

3.6 Public Involvement & Consultation (s14Z2)

Has a s14Z2: Patient and Public Participation Form been completed if relevant?	***NA***
Have any issues or risks identified been appropriately addressed having taken advice from the Head of Comms & Engagement if appropriate?	***NA***
If relevant provide brief details here OR cross refer to detailed report if used	

3.7 Data Protection and Data Security

Has a Data Protection Impact Assessment (DPIA) been completed if relevant?	***NA***
Have any issues or risks identified been appropriately addressed having taken advice from the SIRO, IG Lead and / or DPO if appropriate?	***NA***
If relevant provide brief details here OR cross refer to detailed report if used	

3.8 Procurement considerations

Have any issues or risks identified been appropriately addressed having taken advice from the procurement Shared Service if appropriate?	***NA***
Has a Single Tender Waiver form been completed if appropriate?	***NA***
Has a Primary Care Procurement Checklist been completed where GPs, networks or Federations may be a bidder for a procurement opportunity?	***NA***
If relevant provide brief details here OR cross refer to detailed report if used	

3.9 Human Resources

Have any significant HR implications been identified and managed appropriately, having taken advice from the HR Lead if appropriate?	***NA***

	If relevant provide brief details here OR cross refer to detailed report if used	
3.10	**Environmental Sustainability**	
	Have any significant (positive or negative) impacts on the environment or the CCG's carbon footprint been identified?	***NA***
	If relevant provide brief details here OR cross refer to detailed report if used	

Appendix A

BARNSLEY PRACTICE DELIVERY AGREEMENT (PDA)
April 2021 to March 2022

1.1 INTRODUCTION

Barnsley CCG has an agenda to improve the health and wellbeing of the people of Barnsley. It shares this ambition with partners from across health and care as well as voluntary and community based organisations. The aim of the 2021/22 Barnsley Practice Delivery Agreement (PDA) has been reviewed and refreshed with consideration to the challenges for Primary Care, particularly during the COVID 19 Pandemic.
The focus of the PDA has always been to invest in the infrastructure to deliver and enhance quality of care which reduces health inequalities of patients living in Barnsley. As part of this contract GP practices will receive a consistent income level to assist with staffing capacity and be resilient to meet to changing landscape of the NHS.

The objectives of the 2021/22 PDA are to maintain and develop core services, with a focus on estate planning, evidence based commissioning policies, NHS priorities as outlined in the operational planning guidance, digital projects and prioritising medicines optimisation areas which 'add value', are clinically safe and appropriate to progress during the pandemic.

1.2 2021/22 PDA SCHEMES

The 2021/22 Practice Delivery Agreement is broken down into 7 core schemes:

Scheme	PDA funding allocation
Scheme 1: Support the delivery of Primary Care Services and enact plans to meet current and future GP core contractual and enhanced services requirements.	***9%***
Scheme 2: Support the CCG and PCN with estate planning including the Estate 6 facet surveys; updating data within the Shape tool and PCN planning	***2%***
Scheme 3: Use the funds to ensure staff are appropriately trained and update equipment that supports delivery of primary care services, including anticoagulation, spirometry, 12 Lead ECG and phlebotomy.	***9%***
Scheme 4: Adherence to Evidence Based Commissioning Policies	***5%***
Scheme 5: Support the NHS 2021/22 priorities as outlined in the operational planning guidance including increasing access to primary care services and accelerating the restoration of cancer care.	***9%***
Scheme 6: Support IT and digital projects for 2021/22, including for example Office 365; digital citizen; and coding for consultation method, oximetry and long COVID; the digital first core services offer and engaging with group consultations for chronic disease management.	***9%***
Scheme 7: Deliver the requirements of the Medicines Management Optimisation Scheme (Already approved)	***57%***

NHS Barnsley CCG continues to invest recurrently into primary care and in line with previous agreements.

The total investment enables the CCG to set a guaranteed and consistent income level giving practices the investment to increase resilience and deliver quality improvement. The aim being to meet demand and deliver improved access and better outcomes for patients.

Plans for Delivery of Primary Care Services 2021/22

		National Priority	Local Priority
Scheme 1 (Contractual Requirement)	Support the delivery of primary care services and enact plans to meet current and future GP core contractual and enhanced services requirements. Practices should work towards re-instating normal primary care services; ensuring safety is maintained within current COVID guidance.	x	x
RATIONALE FOR INCLUSION (Intended Outcomes)	The COVID-19 pandemic has posed unprecedented demands on general practice. To alleviate some of these demands, additional support and contractual flexibilities were put in place. This included enabling general practice to clinically prioritise services to ensure it remained open and safe for patients, and, was able to contribute to, and support the roll out of the COVID-19 vaccination programme. The latest direction from NHSE, as outlined in the GP SOP V4.2, is that as capacity allows general practice teams and PCNs should continue to: • focus on restoring routine activity where clinically appropriate, including delivery of the flu vaccination programme, and reaching out to clinically vulnerable patients, including those most at risk of avoidable hospital admission • proactively address health needs that may have increased, developed, or gone unmet during the pandemic – considering health inequalities • support patients with self-care and self-management, where appropriate. Therefore, the rationale for inclusion of this scheme in the 2021/22 PDA is for GP practices to inform the CCG of their current position of service delivery across General Practice. It also aims to ascertain GP Practice plans to restore all primary care services when appropriate.		
HOW TO…	Completion of a survey to ascertain the current positon of service delivery, restoration of all primary care services, and plans for meeting current and future requirements that considers the following national and local requirements: a) Appointment availability including surgery/ branch opening and hours b) Service provision c) Vaccination and Immunisations d) LES/DES provision, including:		

	• Increase uptake of SMI physical health checks to target of 60% by March 2022 • Increase uptake of LD health checks to target of 67% by March 2022 e) Continuing to support clinically extremely vulnerable patients and maintain the shielding list, including supporting outcome measures for those with long COVID as per national guidance f) Continuing to make inroads into the backlog of appointments including those for chronic disease management and routine vaccinations and immunisations: g) Utilising nationally available tools to support prioritisation, for example UCLPartners Proactive Frameworks for hypertension, atrial fibrillation, cholesterol, diabetes, asthma, and COPD h) Contributing to national priority programmes, for example, BP@Home, referrals for people with T2 Diabetes who are suitable for the low calorie diet pilot, where appropriate, to improve uptake and optimise disease management i) Minimise harm to patients on prolonged pathways - take part in the process between Primary Care and Secondary care to support the management and clinical review of patients with prolonged referrals including those patients on 52 weeks RTT j) To minimise the risk to patients by continuing to encourage and support patients to be ready for surgery and to manage their condition beforehand e.g. stop smoking, increase physical activity. k) Collaborating across primary and secondary care to treat more patients without the need for an onward referral, including increasing the uptake of Advice and Guidance or other measures such as referral triage to avoid unnecessary first attendances. l) Continue to engage with and support community and acute services, for example Breathe in the community, home visiting service m) Resume routine phlebotomy n) Submission of workforce data as required via the National Workforce Reporting system (NWRS) o) Support the delivery of any additional PCN requirements or specifications as they are introduced, for example cardiovascular disease		

	prevention, personalised care. p) Support the review of the Extended Hours DES and development of the single combined access offer. Work with the CCG to enable flex between in hours and extended hours capacity so the latter is better used, for example for vaccinations, annual reviews of patients with long term conditions and screening appointments		
MEASUREMENT	Completion of survey to ascertain the current positon of service delivery, restoration of all primary care services and plans for meeting current and future requirements.		
FREQUENCY AND DEADLINES	Each practice will need to submit a completed version of the GP services self-declaration 2021-22 Survey at the end of • Q2 • Q3 • Q4		
READ CODES	None.		
TEMPLATES	GP services self-declaration 2021-22 Survey to be provided by CCG		
CCG LEAD OFFICERS	Dr Guntamukkala madhavi.guntamukkala@nhs.net Julie Frampton julie.frampton@nhs.net		

Estate Planning 2021/22

		National Priority	Local Priority
Scheme 2 (Contractual Requirement)	Support the CCG with estate planning including the Estate 6 facet surveys; updating data within the Shape tool and PCN planning.	x	x
RATIONALE FOR INCLUSION (Intended Outcomes)	Current information regarding estates and future planning is pivotal to ensuring we are able to commission, deliver and address challenges to meet the demand for effective health services. Expanding primary care capacity to improve access, local health outcomes and address health inequalities forms part of the 2021/22 priorities and operational planning guidance. Local investment and support for PCN development, including as an enabler of workforce expansion for example through the Additional Roles Reimbursement schemes, is one method of increasing access to primary care. Estate planning and the support of practices is crucial and key to achieving these outcomes.		
HOW TO…	To support the CCG and PCN Estate Planning GP practices are asked as part of the PDA to engage with the CCG and PCN estate planning projects and completion and return of paperwork regarding: a) the Primary Care Estate 6 facet surveys b) Data for use in the Shape tool. c) Support premises planning with the PCN working with community provider partners to agree space as appropriate, particularly to assist with the deployment of the additional role reimbursement scheme to enable staff to be employed effectively		
MEASUREMENT	Recorded engagement from the practice during liaison with the project including completion of requested information and documentation.		
FREQUENCY AND DEADLINES	To respond to requested engagement within 14 days as and when required.		
READ CODES	None.		
TEMPLATES	None		
CCG LEAD OFFICER	Julie Frampton, julie.frampton@nhs.net		

Staff trained as appropriate and equipment updated 2021/22

		National Priority	Local Priority
Scheme 3: (Contractual Requirement)	Use the funds to ensure staff are appropriately trained and update equipment that supports delivery of primary care services, including anticoagulation, spirometry, 12 Lead ECG and phlebotomy.	x	x
RATIONALE FOR INCLUSION (Intended Outcomes)	This supports the delivery of primary care services and recognises the additional resource required, ensuring equipment is calibrated, replaced and that staff are appropriately trained to deliver the services.		
HOW TO…	a) Participate in a survey (during Q2) to understand the current spirometry skillset/register (and expiry dates). b) Use the funds from the PDA to ensure appropriate training is accessed in Q3/4 (depending on current guidelines for spirometry in primary care) to ensure sufficient numbers of staff are trained in performing and interpreting spirometry by March 2022 and to ensure adequate coverage across the PCN. The Model of delivery is dependent on future planning of the service. Guidance was published in April: ARTP re-start of spirometry - 2.4.19 (artp.org.uk) alongside suggestions for potential to undertake this on a PCN network basis rather than by individual practices. c) Update equipment that supports delivery of primary care services, for example, anticoagulation, spirometry, 12 lead ECG and phlebotomy d) Completion of a GP services declaration 2021-22 survey to understand the level of delivery and planning of core contract and additional primary care services (See Scheme 1)		
MEASUREMENT	Recorded engagement from the practice during liaison with the project including completion of requested information and documentation.		
FREQUENCY AND DEADLINES	To respond to requested information/engagement within 14 days as and when required.		
READ CODES	None.		
TEMPLATES	None		
CCG LEAD OFFICERS	Dr Guntamukkala madhavi.guntamukkala@nhs.net Julie Frampton julie.frampton@nhs.net		

Adherence to Evidence Based Commissioning Policies 2021/22

		National Priority	Local Priority
Scheme 4: (Contractual Requirement)	**Adherence to Evidence Based Commissioning Policies** Ensure that all referrals adhere to the South Yorkshire and Bassetlaw Commissioning for Outcome Policy particularly around the additional evidence based interventions (EBI) introduced in 2021 as part of Phase 2 of the national EBI programme.	x	x
RATIONALE FOR INCLUSION (Intended Outcomes)	National Guidance published at the end of 2020 introduced an additional 31 national evidence based interventions. Several of the local evidence based checklists have also been updated based on annual review and feedback. This scheme will support the implementation and adherence to the commissioning policies contained within the updated SYB Commissioning for Outcomes Policy and enable practices to familiarise themselves with updated guidance. The intended outcomes of the EBI programme are to: • Improve the quality and variance of referrals - frees up valuable resources so they can be put to better use elsewhere in the NHS. This is going to be more important than ever as the NHS recovers from the impact of COVID-19 and restores services. • Reduce inappropriate referrals, medical or surgical interventions as well as some other tests and treatments which the evidence tells us are inappropriate for some patients in some circumstances and can sometimes do more harm than good.		
HOW TO…	To support practices the CCG will: • Provide an overview of commissioning policies/list of pathways practices are expected to follow (please see Appendix A). • Work with the Clinical Applications Team to publish update clinical threshold checklists in clinical systems in line with national guidance. Practices should: a) Update clinical systems with additional and revised checklists b) Familiarise and follow the South Yorkshire and		

	Bassetlaw Commissioning for Outcomes Policy. c) Practices should ensure they use the appropriate referral method: • Where a clinical threshold applies ensure the referral is accompanied by the appropriate referral form in all circumstances. • Completing IFR questionnaires • Writing clinical letters in cases of exceptionality for procedures not routinely commissioned • Utilising updated checklists where appropriate.		
MEASUREMENT	Recorded engagement from the practice during liaison with the project including completion of requested information and documentation. Practices will not be set targets for this scheme but confirmation of engagement i.e. that new checklists are in place, following support from the Clinical Applications Team will be required.		
FREQUENCY AND DEADLINES	To respond to requested engagement within 14 days as and when required.		
READ CODES	None.		
TEMPLATES	Checklists provided		
CCG LEAD OFFICER	David Lautman, Lead Commissioning and Transformation Manager , Barnsley CCG David.lautman@nhs.net		

Appendix A

Evidence Based Interventions (Clinical Thresholds)

Complete checklist and attach to referral.
- Ref 1E, 1H and 2D require prior approval by IFR
- * Refer via the SWYPFT Community MSK Service

Phase 1 National Pathways (Category 2)

Ref	Intervention
1E	Breast reduction / asymmetry and gynaecomastia
1F	Removal of Benign Skin Lesions
1G	Grommets in children
1H	Tonsillectomy (Adults/Children) *updated*
1I	Haemorrhoid surgery
1J	Hysterectomy for heavy menstrual bleeding *Only applies to Secondary Care
1K	Chalazia removal (Meibomian Cyst) *updated*
1L	Arthroscopic shoulder decompression for sub-acromial shoulder pain* *updated*
1M	Carpal tunnel release* *updated*
1N	Dupuytren's surgery* *updated*
1O	Ganglion surgery*
1P	Trigger finger release* *updated*
1Q	Varicose vein surgery

*All Barnsley referrals for Orthopaedics or Rheumatology should be referred via the SWYPFT MSK Triage service.

Phase 2 National Pathways (Category 2)

There are 31 interventions in phase 2. This in an edited list for primary care.

Ref	Intervention
2B	Surgical Repair of Hernias
2C	Surgical intervention for chronic rhinosinusitis
2D	Removal of adenoids for treatment of glue ear
2H	Cystoscopy for men with uncomplicated lower urinary tract symptoms
2M	Upper GI Endoscopy
2N	Appropriate Colonoscopy
2U	Knee MRI for Meniscal tear*

Local SY&B Pathways

1	Grommets in Adults
2	Benign Perianal Skin Tags
3	Management of Gall Bladder Disease – Interval Cholecystectomy *updated* *Only applies to Secondary Care
4	Blepharoplasty *updated*
5	Cataract Surgery
6	Hallux Valgus (Bunions) *
7	Osteoarthritis • Hip Replacement*
8	Osteoarthritis • Knee Replacement*
9	Ingrown Toe Nail* *updated*
10	Male circumcision

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Procedures not routinely commissioned or offered

Exceptionality can be applied for via a clinical letter to the IFR panel

Phase 1 National Pathways (Category 1)

Ref	Intervention
1A	Snoring Surgery (in the absence of Obstructive Sleep Apnoea (OSA))
1B	Dilation and curettage (D&C) for heavy menstrual bleeding (HMB) in women
1C	Knee arthroscopy for patients with osteoarthritis
1D	Injection for non-specific low back pain (Spinal Joint Injection)

Phase 2 National Pathways (Category 1)

Ref	Intervention
2K	Lumbar radiofrequency facet joint denervation
2L	Exercise ECG for screening for coronary heart disease
2V	Vertebral augmentation (vertebroplasty or kyphoplasty) for painful osteoporotic vertebral fractures
2Y	Fusion surgery for mechanical axial low back pain
2Z	Helmet therapy for treatment of positional plagiocephaly/brachycephaly in children

Local SY&B Pathways

Ref	Intervention
-	Acupuncture (except for chronic tension type headaches and migraine)
-	Vasectomy under General Anaesthetic*
-	**IVF** (commissioned in accordance with policy, approval via IFR)
-	Reversal of male / female Sterilisation
-	Specialist plastic surgery procedures

Vasectomy
*Refer to non-scalpel locally commissioned community services on the E-Referral System.

Referrals for vasectomy under general anaesthetic require IFR approval.

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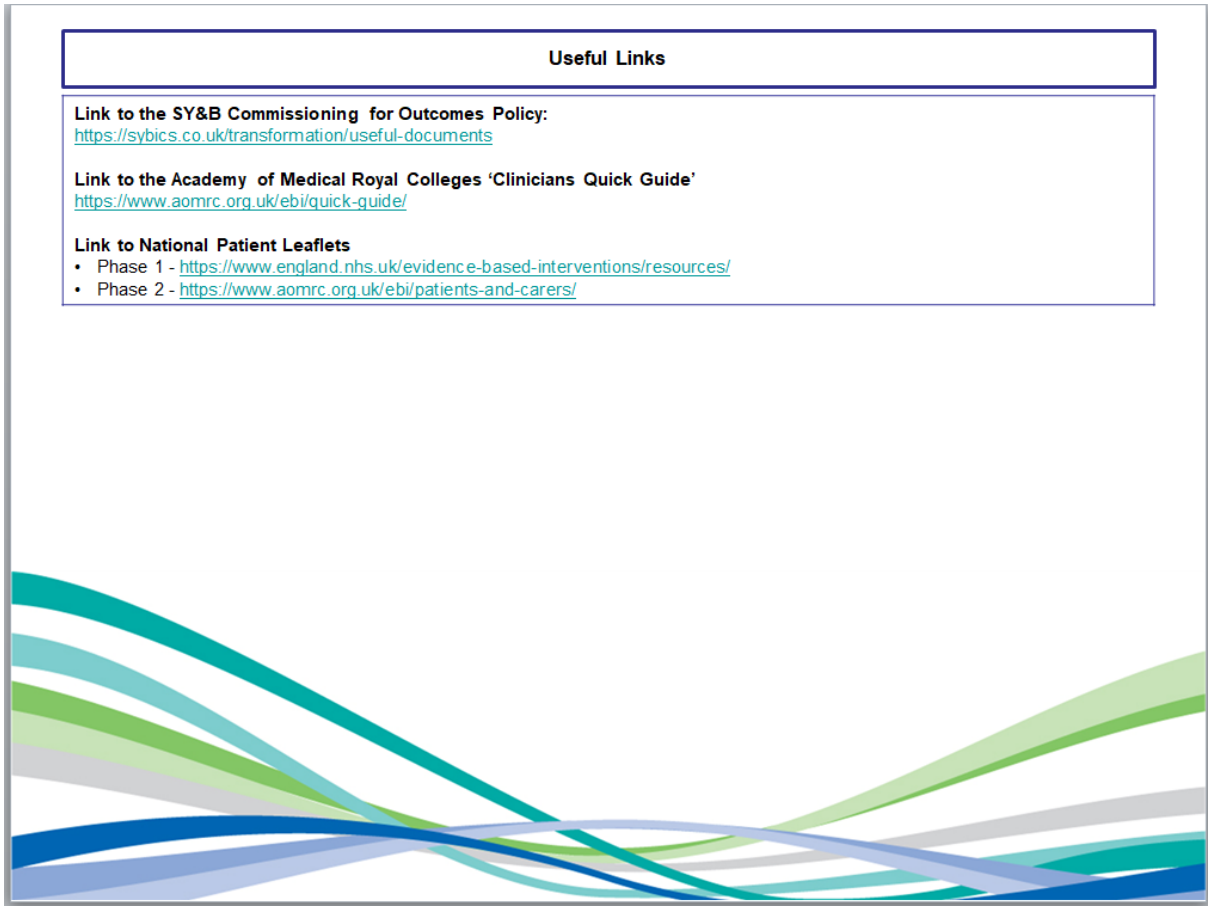

Useful Links
Link to the SY&B Commissioning for Outcomes Policy:
https://sybics.co.uk/transformation/useful-documents
Link to the Academy of Medical Royal Colleges 'Clinicians Quick Guide'
https://www.aomrc.org.uk/ebi/quick-guide/
Link to National Patient Leaflets
• Phase 1 - https://www.england.nhs.uk/evidence-based-interventions/resources/
• Phase 2 - https://www.aomrc.org.uk/ebi/patients-and-carers/

Operational Planning Guidance 2021/22

		National Priority	Local Priority
Scheme 5 (Contractual Requirement)	Support the NHS 2021/22 priorities as outlined in the operational planning guidance including increasing access to primary care services and accelerating the restoration of cancer care.	x	x
RATIONALE FOR INCLUSION (Intended Outcomes)	Expanding primary care capacity to improve access, local health outcomes and address health inequalities forms part of the 2021/22 priorities and operational planning guidance. Additionally, restoration of cancer care and working collaboratively across systems to deliver these priorities is key to achieving the NHS goals within the Long Term Plan.		
HOW TO…	a) Restoring and increasing access to primary care services: i. Support planning with the PCN to assist with the deployment of the additional role reimbursement scheme to enable staff to be employed effectively ii. Support the development of the extension of the Community Pharmacy Consultation Service able to receive referrals from General Practice iii. Support GP recruitment and retention initiatives such as the return to practice and mentor schemes, new to partnership, fellowship programme b) Accelerating the restoration of cancer care i. Delivery of core contract which continues to call on practices to adapt, remaining fully and safely open, in order to offer accessible healthcare to all, with a particular focus on inequalities; specifically, for patients with suspected or confirmed cancer: Including, for example, using pre-assessment FIT test. ii. To fully implement the C-The Signs tool by September 2021 iii. Take part in behavioural insight nudge project		
MEASUREMENT	Recorded engagement from the practice during liaison with the project including completion of requested information and documentation as below: a) Restoring and increasing access to primary care		

	services i. Support planning with the PCN to assist with the deployment of the additional role reimbursement scheme to enable staff to be employed effectively • *Declaration to confirm where the practice has supported a member of staff employed through the additional roles reimbursement scheme that tasks delegated to them supported the PCN aims and objectives as outlined in the Network DES specification particularly in relation to the defined job role* ii. Support the development of the extension of the Community Pharmacy Consultation Service able to receive referrals from General Practice • *Engagement within the project as roll out developed.* iii. Support GP recruitment and retention initiatives such as the return to practice and mentor schemes, new to partnership, fellowship programme • *Declaration from the practice that the schemes and programmes are embedded into appropriate policies for example where recruitment is considered and within appraisal.* b) Accelerating the restoration of cancer care i. Delivery of core contract which continues to call on practices to adapt, remaining fully and safely open, in order to offer accessible healthcare to all, with a particular focus on inequalities; specifically, for patients with suspected or confirmed cancer: Including, for example, using pre-assessment FIT test. • *Monitoring will be externally collated regarding the number of kits that have been used by practices compared to initial introduction of pathway* • *Cancer Alliance will be undertaking an evaluation of the impact of FIT testing by primary care* ii. To fully implement the C-The Signs tool by September 2021 into all Practices and to:		

	• *Complete further questionnaires, as required, to improve cancer referrals and safety netting process as built into the C the Signs system.*
	• *The practice will attend training about using the CDM tool.*
	• *Data will be collected by the Provider - C- the Signs - via the clinical decision making clinical system tool and via PCN Neighbourhood level safety netting dashboard data, for example:*
	  ○ *number of GPs in the practice using the system*
	  ○ *how many referrals into secondary care were made through C the signs and not directly to ERS*
	  iii. Take part in behavioural insight nudge project
	• *During Q2 take part in practice or PCN Neighborhood based virtual or face to face workshop of 1 hour (at least 1 GP, 1 Nurse, Receptionist type role and Care Coordinator to attend)*
	• *Work with CCG and Cancer Alliance to amend practices letters, texts and telephone messages using the behavioral insight workbook and tools*
	• *By Q3 to be using at least one tool in the workbook to increase the uptake of patients who are low attendees for at least 1 screening programme and 1 cancer tumour referral pathway (could be for a specific group of patients). The workbook will be provided by the CCG.*		

FREQUENCY AND DEADLINES	To respond to requested engagement within 14 days as and when required.		
TEMPLATES	• PDA Survey • C-The Signs questionnaires • Behavioural insight workbook		
CCG LEAD OFFICER	Siobhan Lendzionowski, siobhan.lendzionowski@nhs.net		

IT and Digital Projects 2021/22

		National Priority	Local Priority
Scheme 6 (Contractual Requirement)	Support IT and digital projects for 2021/22, including for example Office 365, digital citizen and coding for consultation method, oximetry and long COVID; the digital first core services offer and engaging with group consultations for chronic disease management.	x	x
RATIONALE FOR INCLUSION (Intended Outcomes)	The Long Term Plan outlines how digitally enabled care will go mainstream across the NHS. Good progress has been made in achieving the ambitions set out in the Five Year Forward View, with many new or enhanced digital and technology systems and services delivered. Advancements have also been accelerated during the pandemic with alternative ways of delivering appointments within GP practices. The NHS response (phase 3) to the pandemic included as an urgent action the development of digitally enabled care pathways in ways which increase inclusion, including reviewing who is using new primary, outpatient, and mental health digitally enabled care pathways by 31 March. A core digital service offer to patients was also included as a priority within the update to the GP contract agreement 2020/21 – 2023/24 with more online services for patients and using digital tools to increase flexibility in how staff work and care for patients. The GP contract update also included the commitment to release time to care and reduce administrative burdens, for example the digitisation of Lloyd George records. The engagement of practices within IT and digital projects and in preparing and recording information within systems to assist with further advancement and data collection is crucial and key to achieving these outcomes.		
HOW TO…	To support the CCG's IT and Digital projects for 2021/22, including for example Office 365, digital citizen; coding; the digital first core services offer and engaging with group consultations for chronic disease management: a) Engagement with projects to enable successful completion, including office 365 and digital citizen b) Engage in the implementation of national		

	guidance to support more accurate coding including: i. Consultation method to enable data collection can be carried out, to identify who is accessing face-to-face, telephone, or video consultations, broken down by relevant protected characteristic and health inclusion groups, including ethnicity ii. Practices to utilise published SNOMED codes for oximetry and long COVID to aid data returns (data returns will be undertaken centrally by the CCG where possible). iii. Ensuring all appointments reflect the National definitions to support reporting of core service delivery and appointments data with participation in national data collection c) Delivery of the digital first core services offer i. Practices offering online consultations that can be used by patients, carers and by practice staff on a patient's behalf, to gather submitted structured information and to support triage, enabling the practice to allocate patients to the right service for their needs ii. The ability to hold a video consultation between patients, carers, and clinicians iii. Two-way secure written communication between patients, carers, and practices iv. An up to date accessible online presence, such as a website, that, amongst other key information, links to online consultation system and other online services prominently v. Signposting to validated symptom checker and self-care health information (e.g. nhs.uk) via the practice's online presence and other communications vi. Practices should utilise The Sound Doctor and aim to increase referrals into the Self-management tool. To achieve this, practices should engage with the Sound Doctor and the BBS IT team to run text campaigns for the service and to embed the links into the Data Entry Templates in clinical systems.		

	vii. Shared record access, including patients being able to add to their record viii. Request and management of prescriptions online ix. Online appointment booking x. For online consultations and video consultations, practices will need to not only install online and video consultation tools but also use them ordinarily. Practices will be enabled with the tools and functionality, as part of CCG infrastructure responsibilities. NOTE: Extending of arrangement from April 2021 that those practices which have implemented and operate a 'total-triage' / 'triage-first' model do not have to meet the 25% online booking contract requirement. d) Engaging with group consultation for chronic disease management pilots in Q1 and Q2. By Q4 to have run at least one group consultation patient group (either face-to face or virtual) to manage chronic disease management backlogs. *A development session about running a virtual group consultation will be provided to practices via the PCN and in conjunction with the CCG.* e) Support national initiatives for example digitisation of Lloyd George records		
MEASUREMENT	1. Recorded engagement from the practice during liaison with the project including completion of requested information and action. a) Engagement with projects to enable successful completion, including office 365 and digital citizen. *The CCG Primary Care Team will link in with the BBS IT team on outcome achievement.* b) Engage in the implementation of national guidance to support more accurate coding including: i. Consultation method to enable data collection can be carried out, to identify who is accessing face-to-face, telephone, or video consultations, broken down by relevant protected characteristic and health inclusion groups,		

	including ethnicity ii. Practices to utilise published SNOMED codes for oximetry and long COVID to aid data returns and outcome measurement as directed by national guidance (data returns will be undertaken centrally by the CCG where possible). iii. Ensuring all appointments reflect the National definitions to support reporting of core service delivery and appointments data with participation in national data collection *Declaration of compliance and successful CCG/ national extraction of data for the practice.* c) Delivery of the digital first core services offer i. Practices offering online consultations that can be used by patients, carers and by practice staff on a patient's behalf, to gather submitted structured information and to support triage, enabling the practice to allocate patients to the right service for their needs ii. The ability to hold a video consultation between patients, carers, and clinicians iii. Two-way secure written communication between patients, carers, and practices iv. An up to date accessible online presence, such as a website, that, amongst other key information, links to online consultation system and other online services prominently v. Signposting to a validated symptom checker and self-care health information (e.g. nhs.uk) via the practice's online presence and other communications vi. Shared record access, including patients being able to add to their record vii. Request and management of prescriptions online viii. Online appointment booking ix. For online consultations and video consultations, practices will need to not only install online and video consultation tools but also use them ordinarily. Practices will be enabled with the tools and functionality, as part		

	of CCG infrastructure responsibilities. NOTE Extending of arrangement from April 2021 that those practices which have implemented and operate a 'total-triage' / 'triage-first' model do not have to meet the 25% online booking contract requirement. *Declaration of compliance and appropriate provision of evidence (for example practice website page where appropriate) and successful CCG/ national extraction of data for the practice.* d) Engaging with group consultation for chronic disease management pilots in Q1 and Q2. By Q4 to have run at least one group consultation patient group (either face-to face or virtual) to manage chronic disease management backlogs. *A development session about running a virtual group consultation will be provided to practices via the PCN and in conjunction with the CCG.* *Attendance at the development session and delivery of a group consultation patient group* e) Support national initiatives for example digitisation of Lloyd George records *Engagement and successful completion of the project.*		
FREQUENCY AND DEADLINES	To respond to requested engagement within 14 days as and when required.		
READ CODES	None.		
TEMPLATES	None		
CCG LEAD OFFICER	Julie Frampton julie.frampton@nhs.net		

NHS
Barnsley
Clinical Commissioning Group

GOVERNING BODY

8 July 2021

Commissioning for Outcomes Policy

PART 1A – SUMMARY REPORT

1. THIS PAPER IS FOR

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

2. PURPOSE

To present the revised South Yorkshire and Bassetlaw Commissioning for Outcomes Policy (v22) for approval. The latest version of the policy incorporates an additional 31 interventions as outlined in the Phase 2 national Evidence Based Interventions (EBI) guidance alongside changes made following an annual review.

3. REPORT OF

	Name	**Designation**
Executive Lead	Jamie Wike	Chief Operating Officer
Clinical Lead	Dr Madhavi Guntamukkala	Secondary Care
Author	David Lautman	Lead Commissioning and Transformation Manager

4. SUMMARY OF PREVIOUS GOVERNANCE

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

Group / Committee	**Date**	**Outcome**
Clinical Forum	6 August 2020, 4 Feb 2021 3 June 2021	*August 2020:* Comments provided on the national EBI phase 2 consultation document to feed into the ICS response. *Feb 2021:* Commented provided on the proposed SY&B approach for managing each of the 31 conditions in phase 2 to ensure that the proposals are sensible and workable from a primary care

			perspective. June 2021: Commented on and noted the 16 new checklists that will apply in primary care as a result of changes to the SY&B CFO Policy (6 new phase 2 checklists and 10 existing checklists have been refreshed).
	Membership Council	11 August 2020	Comments provided on the national EBI phase 2 consultation documents to feed into the ICS response.
	ICS Acute Trust Clinical Reference Group	12 Feb, 9 April & 14 May 2021	Engagement with Acute Trust Medical Directors in order to raise awareness with clinicians and seek their feedback on implementation approach / checklists.
	CCG / BHNFT Clinical Quality Board	6 May & 1 July 2021	Engagement with Barnsley Hospital for local feedback on implementation approach / guidance.
	Joint Committee of CCGs	28 July 2021	Policy to be endorsed following individual CCG Governing Body approval (postponed from 24 June 2021).

5. EXECUTIVE SUMMARY

South Yorkshire and Bassetlaw Integrated Care System Commissioners (Rotherham, Barnsley, Doncaster, Sheffield and Bassetlaw CCG's) have been working together to refresh the joint South Yorkshire and Bassetlaw Commissioning for Outcomes Policy (CFO) to incorporate the latest national Evidence Based Interventions Phase 2 Guidance (EBI).

Appendix A (Governing Body report) provides a full update on the revised SY&B Commissioning for Outcomes Policy v22 that is presented for approval. This cover paper provides some further context that is specific to Barnsley place around the anticipated next steps for implementation.

The engagement undertaken in reaching this position is detailed in section 4 (above).

<u>Implementation in Primary Care</u>
Adherence to the new guidelines will be supported by inclusion in the 2021/22 Practice Delivery Agreement (PDA). In addition to providing an overview of the policies primary care is expected to follow, the Clinical Application Teams will publish the new and revised clinical threshold checklists and clinical system alert protocols to ensure these are available in clinical systems.

The checklists will be made available to primary care from the beginning of July to support a soft launch rollout throughout July, pending policy approval. All

practices will be expected have engaged with the clinical systems team by 30 July 2021.

A patient information leaflet will also be shared with practices, with relevant condition specific leaflets (nationally authored) and copies of the checklist available on the CCGs website.

Implementation in Secondary Care

Phase 2 of the EBI guidance is different to the previous phases as the remit has been expanded to include diagnostic tests and investigations as well as surgical interventions. In addition, there is a larger focus on interventions (tests / investigations/ procedures) that may only be ordered or originate in secondary care. As a consequence, individual providers will be responsible for internal implementation and process.

It is anticipated that alerts will be added to the Sunquest ICE system for the diagnostic tests and investigations to support management. Commissioners have also included secondary care checklists with the policy, to aid providers to implement internally, but these will not be mandatory.

Table 1 – Phase 2 Evidence Based Interventions that can be monitored and have suggested national activity goals to bring in line with other areas:

2A – Diagnostic coronary angiography for low risk, stable chest pain
2B – Repair of minimally symptomatic inguinal hernia
2C – Surgical intervention for chronic rhinosinusitis
2D – Removal of adenoids for treatment of glue ear
2E – Arthroscopic surgery for meniscal tears
2G – Surgical removal of kidney stones
2H – Cystoscopy for men with uncomplicated lower urinary tract symptoms
2I – Surgical intervention for Benign Prostatic Hyperplasia (BPH)
2J – Lumbar discectomy
2K – Lumbar radiofrequency facet joint denervation
2L – Exercise ECG for screening for coronary heart disease
2M – Upper GI endoscopy

Whilst only 12 out of the 31 Phase 2 interventions can be accurately monitored using clinical coding (see Table 1), the data that is available already suggests a high degree of compliance locally. This is because the guidance included in Phase 2 is not newly published NICE guidance. The EBI programme is merely highlighting areas where guidance has moved along in recent years and where providers can free up resource in response to COVID recovery and restoration.

In addition, the guidance has been included in the 2021/22 operational and planning guidance to support the waiting list prioritisation (as part of the national clinical prioritisation programme) For Phase 1 interventions patients on the waiting list should have already met the criteria. For Phase 2 interventions the

	guidance is a tool to help prioritise / free up resources on the surgical and diagnostic pathways. Following approval of the policy it is recommended that the revised policy is added to provider contracts to aid implementation. • For NHS providers, the CCG does not have formal documentation at this time, so these providers will be formally notified of the policy implementation until the contract position changes. • For independent sector providers the policy can be added to local contracts. The CCG will monitor the phase 2 interventions outlined in Table 1 to understand the impact of implementation. Where activity is above nationally suggested activity levels this will prompt a discussion with providers via the Clinical Quality Boards to seek further understanding and intelligence. Elective recovery programmes such as the accelerator programme may increase activity above national activity levels.
6.	**THE GOVERNING BODY IS ASKED TO:**
	• Approve the revised South Yorkshire and Bassetlaw Commissioning for Outcomes Policy v22 that incorporates the EBI guidance and annual review changes. Noting the place implementation from 1 July 2021. • Note the local approach to implementation in primary and secondary care.
7.	**APPENDICES / LINKS TO FURTHER INFORMATION**
	• Appendix A – Governing Body Report • Appendix 1 – Summary of changes between v21 and v22 • Appendix 2 – SYB Commissioning for Outcomes Policy v22

Agenda time allocation for report:	*10 mins*

PART 1B – SUPPORTING INFORMATION & ASSURANCE

1. Links to Corporate Priorities, GBAF and Risk Register

This report provides assurance against the following corporate priorities on the Governing Body Assurance Framework

1.1 Urgent & Emergency Care		6.1 Efficiency Plans	
2.1 Primary Care	✓	7.1 Transforming Care for people with LD	
3.1 Cancer		8.1 Maternity	
4.1 Mental Health		9.1 Digital and Technology	
5.1 Integrated Care @ System		10.1 Compliance with statutory duties	✓
5.2 Integrated Care @ Place		11.1 Delivery of Enhanced Health in Care Homes	

The report also provides assurance against the following red or amber risks on the Corporate Risk Register:	*N/A*

2. Links to statutory duties

This report has been prepared with regard to the following CCG statutory duties set out in Chapter A2 of the NHS Act

Management of conflicts of interest (s14O)	**See 3.2**	Duties as to reducing inequalities (s14T)	**See 3.5**
Duty to promote the NHS Constitution (s14P)		Duty to promote the involvement of each patient (s14U)	
Duty to exercise its functions effectively, efficiently and economically (s14Q)	**See 3.3**	Duty as to patient choice (s14V)	
Duty as to improvement in quality of services (s14R)	**See 3.4**	Duty as to promoting integration (s14Z1)	
Duty in relation to quality of primary medical services (s14S)	**See 3.4**	Public involvement and consultation (s14Z2)	**See 3.6**

3. Governance Considerations Checklist *(these will be especially relevant where a proposal or policy is brought for decision or approval)*

3.1 **Clinical Leadership**

Have GB GPs and / or other appropriate clinicians provided input and leadership?	***Y***
The Lead Medical Advisor from the IFR panel has supported the policy authoring and revisions. There has also been further clinical input via the CCG's Clinical Forum, Membership Council, and ICS CRG as detailed in the summary of previous governance. Each SY&B place Clinical Reference Group has also considered the paper.	

3.2 **Management of Conflicts of Interest (s14O)**

Have any potential conflicts of interest been identified and managed appropriately, having taken advice from the Head of Governance & Assurance and / or the Conflicts of Interest Guardian if appropriate?	***NA***

3.3 Discharging functions effectively, efficiently, & economically (s14Q)

Have any financial implications been considered & discussed with the Finance Team?	***Y***
Where relevant has authority to commit expenditure been sought from Management Team (<£100k) or Governing Body (>£100k)?	***NA***
As a result of implementing the EBI phase 2 guidance, some medical or surgical interventions, tests and treatments which the evidence tells us are inappropriate will no longer be carried out. This will free up valuable resources so they can be put to better use elsewhere in the NHS rather than necessarily result in efficiencies. As outlined in the main paper 12 out of the 31 proposed phase 2 interventions will be monitored to understand the impact. Any financial implications are anticipated to be secondary compared with the quality of care, freeing up of resources.	

3.4 Improving quality (s14R, s14S)

Has a Quality Impact Assessment (QIA) been completed if relevant?	***Y***
Have any issues or risks identified been appropriately addressed having taken advice from the Chief Nurse (or Deputy) if appropriate?	***N***
The existing QIA has been reviewed. The actions previously identified to support implementation e.g. clinical engagement, publication of resources to support patient-clinician engagement and regular review of data remain applicable to phase 2. It is also noted that the EBI Phase 2 programme is led by the Association of Medical Royal Colleges rather than the CCG and as such is led by clinicians and experts in their field to improve quality of care. It is designed to reduce the number of medical or surgical interventions as well as some other tests and treatments which the evidence tells us are inappropriate for some patients in some circumstances and can sometimes do more harm than good.	

3.5 Reducing inequalities (s14T)

Has an Equality Impact Assessment (EIA) been completed if relevant?	***Y***
Have any issues or risks identified been appropriately addressed having taken advice from Equality Diversity & Inclusion Lead if appropriate?	***N***
An Equality and Health Inequalities Impact Assessment has been completed nationally by NHS England for the Evidence Based Interventions Programme.	

3.6 Public Involvement & Consultation (s14Z2)

Has a s14Z2: Patient and Public Participation Form been completed if relevant?	***N***
Have any issues or risks identified been appropriately addressed having taken advice from the Head of Comms & Engagement if appropriate?	***NA***
National engagement on the guidance of each test, treatment or procedure has been led by the AoRMC. Full details are included in section 2 of the main report. Local public and patient information will build on previous phases of the EBI / CFO work.	

3.7 Data Protection and Data Security

Has a Data Protection Impact Assessment (DPIA) been completed if relevant?	***Y***
Have any issues or risks identified been appropriately addressed having taken advice from the SIRO, IG Lead and / or DPO if appropriate?	***NA***

	The DPIA previously completed for the CFO policy has been reviewed and no additional action has been identified.
3.8	**Procurement considerations**

Have any issues or risks identified been appropriately addressed having taken advice from the procurement Shared Service if appropriate?	***NA***
Has a Single Tender Waiver form been completed if appropriate?	***NA***
Has a Primary Care Procurement Checklist been completed where GPs, networks or Federations may be a bidder for a procurement opportunity?	***NA***

3.9	**Human Resources**

Have any significant HR implications been identified and managed appropriately, having taken advice from the HR Lead if appropriate?	***NA***

3.10	**Environmental Sustainability**

Have any significant (positive or negative) impacts on the environment or the CCG's carbon footprint been identified?	***N/A***

South Yorkshire and Bassetlaw Integrated Care System

Appendix A

Evidence Based Interventions Phase 2

CCG GOVERNING BODY REPORT

June 2021

Author(s)	Michele Clarke, Strategy and Delivery, DCCG
Sponsor	SYB Commissioner Leads for Implementation of Evidence Based Interventions
Is your report for Approval / Consideration / Noting	
Noting	
Links to the ICS Five Year Plan (please tick)	

Developing a population health system	**Strengthening our foundations**
☐ **Understanding health in SYB including prevention, health inequalities and population health management**	☑ **Working with patients and the public**
☑ **Getting the best start in life**	☐ **Empowering our workforce**
☑ **Better care for major health conditions**	☐ **Digitally enabling our system**
☐ **Reshaping and rethinking how we flex resources**	☑ **Innovation and improvement**

Building a sustainable health and care system	Broadening and strengthening our partnerships to increase our opportunity
☑ Delivering a new service model	☐ Partnership with the Sheffield City Region
☐ Transforming care	☐ Anchor institutions and wider contributions
☑ Making the best use of resources	☐ Partnership with the voluntary sector
	☑ Committment to work together

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

No

Summary of key issues

The purpose of this report is to request that members of Governing Body note the revised Evidence Based Interventions (EBI) - Commissioning for Outcomes policy (CFO).

The latest guidance (November 2020) sets out an additional 31 tests, treatments and procedures where the evidence around their effectiveness or appropriateness has been endorsed by the Academy of Medical Royal Colleges. It builds on an earlier list of 17 interventions which became part of the NHS's statutory guidance in March 2019.

SYB commissioners have updated the current Commissioning for Outcomes Policy (CFO) with Phase 2 EBI (31 interventions). Appropriate checklists have been developed, either for Primary or Secondary Care clinical systems in line with previous processes and integrated into the current CFO Policy. The CFO Policy has been developed in order of speciality to ensure a user-friendly document.

The revised SYB CFO Policy has been received by the JCCCG sub group and the SYB ICS Acute Clinical Reference Group and at place level with each respective Clinical Reference Group / Forum. It has been agreed it will be received by the JCCCG on 24 June 2021.

It is proposed that the policy will be implemented and embedded into the appropriate provider contracts from 1 July 2021. As part of implementation the changes will be communicated to patients via their clinician with further information available via patient leaflets

SYB commissioners will notify primary care of the revised policy via the appropriate routes i.e., locality meetings and other relevant forums. Communication to secondary care providers will be by appropriate effective routes.

It should be noted that the SYB commissioners, supported by Dr Clare Freeman, Lead Medical Advisor, NHS Sheffield CCG, are in support of the implementation of the revised CFO Policy.

Commissioners will work with providers to implement the appropriate guidance into the appropriate Primary Care/Secondary Care IT systems to ensure adherence to the Commissioning for Outcomes (CFO) policy.

Recommendations

The Governing Body are asked to:

- Approve the revised South Yorkshire and Bassetlaw Commissioning for Outcomes Policy v22 that incorporates the EBI guidance and annual review changes. Noting the JCCCG endorsement on 24 June 2021 and place implementation from 1 July 2021.

Phase 2 Evidence Based Interventions

1. Background

In 2018, the Evidence-Based Interventions (EBI) programme was established as a joint and rolling enterprise between four national partners: the Academy of Medical Royal Colleges (AOMRC), NHS Clinical Commissioners (NHS CC), the National Institute for Health and Care Excellence (NICE) and NHS England and Improvement (NHS E/I).

The Evidence-based Interventions programme Phase 2 is an initiative which has been led by AOMRC rather than NHS E/I and as such is led by clinicians and experts in their field to improve quality of care. It is designed to reduce the number of medical or surgical interventions as well as some other tests and treatments which the evidence tells us are inappropriate for some patients in some circumstances and can sometimes do more harm than good.

It means the quality of care patients receive will improve and frees up valuable resources so they can be put to better use elsewhere in the NHS. This is going to be more important than ever as the NHS recovers from the impact of COVID-19 and restores services.

2. SYB Development

A SYB Commissioning for Outcomes Policy was developed in 2017 agreeing procedures across South Yorkshire and Bassetlaw (SYB)

https://www.healthandcaretogethersyb.co.uk/about-us/useful-documents

Since this time, National EBI developed further guidance Phase 1, which was supported by all partners: the Academy of Medical Royal Colleges (AMORC), NHS Clinical Commissioners (NHS CC), the National Institute for Health and Care Excellence (NICE) and NHS England and Improvement (NHS E/I).

The SYB policy was updated to incorporate this and was built into contracts with the appropriate providers. The latest guidance (November 2020) sets out an additional 31 tests, treatments and procedures where the evidence about their effectiveness or appropriateness has changed. It builds on an earlier list of 17 interventions (Phase 1) which became part of the NHS's statutory guidance in March 2019. It has been compiled by an Independent Expert Advisory Committee, comprising doctors, patients and commissioners and takes full account of the views of specialist societies and international evidence. The committee is hosted by the Academy of Medical Royal Colleges, which also coordinated the engagement throughout July and August 2020.

The Planning and Operational Guidance for 2021/22 sets out how adherence to guidance on Evidence Based Interventions will support waiting list management and elective recovery.

Engagement

National engagement on the guidance of each test, treatment or procedure has been led by the AoRMC and included advice from the medical royal colleges, specialist societies, clinicians, clinical commissioners, professional leaders and specialist medical charities. The opinions of patients were gained from working with patients and patient representative groups (including the Strategic Co-Production Group at NHS England and NHS Improvement, the Academy of Medical Royal Colleges' Patient and Lay Committee and the Patients Association) to test the proposals and understand patients' priorities.

Patient Engagement

The Patients Association have supported patient engagement via webinars and surveys.

Three patient-focused webinars, hosted by the Patients Association with 29 participants; A full report including the engagement findings, can be found in 'Evidence-Based Interventions: List 2 Proposal' document:

https://www.aomrc.org.uk/ebi/wp-content/uploads/2021/05/EBI_list2_proposals_1220.pdf

Feedback and comments were also submitted through an online survey or by email for both the public and professionals. 68 responses were received via the online survey and 442 email responses. There was a broad range of feedback from a wide spectrum of individuals and organisations including: patients, clinicians, voluntary organisations, patient representative groups, members of the public, NHS providers, CCGs, Medical Royal Colleges and specialist societies. Specifically, there were 68 responses to the online survey setting out a position of agreement or disagreement on the proposals; 63 email responses from organisations and clinicians providing detailed feedback and 374 further email responses from patients and the public, the majority of which were the same or materially similar and from campaign group "Keep our NHS public".

Patient Information

Patient Leaflets have been published on the AOMRC website https://www.aomrc.org.uk/ebi/ that outline the Benefits, Risk, Alternatives and what

would happen if the patient chose to do nothing as a result of their conversation with patients.

National Clinical Engagement

Three clinically focused webinars have taken place (one on the surgery and devices interventions, one on the radiology and cardiology diagnostics interventions and one on pathology and other investigative procedures) with 180 participants. A data-focused webinar with 66 participants and a post-engagement review session with 84 participants.

An online checker is also being developed to support clinicians in understanding the criteria. (The policy is also broken down via the AOMRC website).

3. List of Interventions in Phase 2

Phase 2 covers a number of diagnostics / investigative procedures, not available to primary care and therefore not appropriate for primary care management via the use of a checklist.

A summary list of the interventions is provided in the below table.

The full proposed clinical criteria is available
https://www.aomrc.org.uk/wp-content/uploads/2020/12/EBI_list2_guidance_150321.pdf

Checklists have been developed by Doncaster CCG on behalf of the SYB region with clinical input from Dr Freeman, Lead Medical Advisor, IFR panel.

INTERVENTION	
Cardiology – caring for the heart	
A	Diagnostic coronary (invasive) angiography for low risk, stable chest pain
General surgery	
B	Surgery for minimally symptomatic inguinal hernia
ENT – surgery on the ear, nose and throat	
C	Surgery for sinusitis
D	Removal of the adenoids (for glue ear and not OSA)
Orthopaedics – caring for bones and joints	
E	Surgery to treat knee problems - Arthroscopic surgery for meniscal tears
Blood tests	
F	Specialised blood tests (troponin) for investigation of chest pain
Urology – caring for the parts of the body that make urine	
G	Removal of stones from the kidneys
H	Camera test of the bladder in men - Cystoscopy for men with un-complicated lower urinary tract symptoms
I	Surgery for enlarged prostate - benign prostatic hyperplasia

INTERVENTION	
Back pain treatment – caring for the back	
J	Discectomy - Spinal surgery for a slipped disc
Orthopaedics – caring for bones and joints	
K	Radiofrequency facet joint denervation - a procedure to numb nerves for low back pain
Cardiology – caring for the heart	
L	Exercise ECG - Treadmill test for heart disease
Gastroenterology – care of the digestive system	
M	Upper GI Endoscopy to investigate gut problems
N	Appropriate Colonoscopy of the lower intestine
O	Repeat / Follow up colonoscopy of the lower intestine
General surgery – operations on the stomach and intestines	
P	Test of the gallbladder - ERCP in acute gallstone pancreatitis without cholangitis
Q	Cholecystectomy - Removal of an inflamed gallbladder
R	Appendicectomy without confirmation of appendicitis - Tests to confirm appendicitis
Orthopaedics – caring for bones and joints	
S	Tests to investigate low back pain - Low back pain imaging
T	Tests to investigate knee pain - Knee MRI when symptoms are suggestive of osteoarthritis
U	Tests to investigate knee pain - Knee MRI for suspected meniscal tears
V	Procedures to build up brittle spine bones - Vertebroplasty for painful osteoporotic vertebral fractures
W	Scans for shoulder pain
X	MRI scan of the hip for arthritis
Y	Surgery to fuse the bones in the back for back pain - Fusion surgery for mechanical axial low back pain
Paediatrics – caring for children	
Z	Helmets to reshape flat heads in babies (Helmet therapy for treatment of position
Anaesthetics – care before, during and after operations	
AA	Pre-operative Chest X-ray (before an operation)
BB	Pre-operative ECG - Heart tracing (ECG) before an operation
Blood Tests	
CC	Prostate- specific antigen (PSA) testing
DD	Lipid Lowering Therapy - Regular blood tests when taking cholesterol lowering tablets
EE	Blood transfusions

4. Progress across SYB

SYB commissioners have updated the current Commissioning for Outcomes Policy (CFO) to incorporate with Phase 2 EBI (31 interventions) and appropriate checklists have been developed for Primary or Secondary Care clinical systems in line with previous processes. The other interventions in the policy have also been reviewed as part of annual review. A summary of these changes are included in Appendix 1. The CFO Policy has been developed in order of speciality to ensure a user-friendly document. The policy does not remove clinician's individual acumen but allows clinicians to make arguments for patients to receive treatments via IFR if outside the guidance.

The revised SYB CFO policy has been received by the sub group of the JCCCG in April and shared with the SYB ICS Acute Clinical Reference Group, in addition to the policy being shared at place level with each respective Clinical Reference Group. It is the intention it is endorsed by the JCCCG on 24 June 2021.

It is proposed that the policy will be implemented and embedded into the appropriate provider contracts from 1 July 2021. As part of implementation the changes will be communicated to patients via their clinician with further information available via patient leaflets.

It is proposed that SYB commissioners will notify primary care of the revised policy via the appropriate routes i.e., PCN, locality meetings and other relevant forums. Communication to secondary care providers will be by appropriate effective routes including finance/contracting to enable monitoring of procedures.

5. Recommendations

Governing body is asked to:

- approve the revised South Yorkshire and Bassetlaw Commissioning for Outcomes Policy v22 that incorporates the EBI guidance and annual review changes. Noting the JCCCG endorsement on 24 June 2021 and place implementation from 1 July 2021.

Author: Michele Clarke, Strategy and Delivery Manager, Doncaster CCG

On behalf of: SYB commissioners for EBI

Date: 25 May 2021

SYB CFO Policy – V22 – 1 April 2021

Summary of changes between V21 and V22 to incorporate additional EBI policies (not routinely commissioned), annual review of policy and EBI Phase 2 interventions.

Page	Section	Change
1	Cover Sheet	Policy updated to v22
2	Version Control Table	Rationale for changes added. Date updated to 1 April 2021.
3	Contents	Updated to reflect accurate page numbering
4	Introduction	Updated to include paragraph to reflect National Evidence Based guidance has been incorporated in the policy
7	Scope of the document	Updated to reflect National Evidence Based Interventions Phase 2 have been incorporated into the document
7	Review	Date of review updated to March 2022
9 - 18	Table 1: Clinical Responsibilities	Table 1 now lists all interventions in Speciality order (including National Evidence Based Interventions Phase 1 and Phase 2 and Local Evidence Based Interventions)
10	Table 1: Clinician Responsibilities	For tonsillectomy added notification to IFR panel for biopsy or removal of lesion.
10, 29, 69	Tonsillectomy Referral Route & Checklist	Addition that 'biopsy or removal of lesion on tonsil' requires notification to IFR (for clinical overview) but not IFR approval. This will remove delay in treatment but ensure all tonsillectomy requests continue to go via IFR Additional text added: "*Secondary Care clinicians should send (clinical letter and copy of the referral) to IFR for notification and monitoring (prior approval not required)." Additional referral criteria now includes: **A Clinically significant episode is characterised by at least three of the following (Centor criteria):* • *Tonsillar exudate*

		• *Tender anterior cervical lymphadenopathy or lymphadenitis* • *History of fever (over 38'C)* • *Absence of cough* Refer to ENT for opinion and treatment for possible sleep apnoea or biopsy / removal of lesion. Secondary Care clinicians should send (clinical letter and copy of the referral) to IFR for notification and monitoring (prior approval not required). Obstructive sleep disorded breathing is defined as: • Grade 3 or 4 tonsils AND • Symptoms persisting for more than three months AND • Night time symptoms- consistent snoring AND consistent wakefulness OR secondary enuresis OR witnessed apnoeas OR restlessness/excessive sweating AND • Daytime symptoms- impaired school performance OR hyperactivity/aggression OR altered mood OR excessive tiredness
20	Health Improvement Programmes	Incorporated Fitter Better Sooner programme for Rotherham patients
25-64	Part 3: Summary of Commissioning Position and Evidence Base	Incorporates all procedures in speciality order including Nation Evidenced Based Interventions Phase 1 & 2 and Local Evidence Based Interventions.
62	Vascular – Varicose Veins	Incorporated Fitter Better Sooner programme for Rotherham patients
63	16.1 - Fertility procedures	Updated individual CCGs link to revised Y&H policy v 11 (adopted Q4 2019/20) Policy name changed from 'Y&H Fertility Policy' to 'Y&H Access to Infertility Treatment Policy' Table amended for clarity on process: **Commissioning Position** IVF is commissioned in line with the Y&H Fertility policy **Process** GP referral to secondary care for preliminary investigations. The patient will be assessed against

		the commissioning criteria. If these are not met and there is evidence of exceptionality then an application to IFR should be made
63	Fertility procedures	Obstetrics and Gynaecology links updated
72-114	Referral Checklists and Process	Clarity to be added to include statement that: If patient meets the above criteria then prior approval is not required. Instructions for use statement amended for clarity to state: “Please refer to policy for full details. Primary Care clinicians need to complete the checklist and submit with referral via eRS / Secondary Care complete the checklist and file for future compliance audit.” **Note: Added to checklists that have been updated only to minimise changes required in clinical systems.** ***This section now includes all <u>new</u> checklists for Primary and Secondary Care relating to National Evidence Based Interventions Phase 2***
73	Hysterectomy for Management of Heavy Menstrual Bleeding	Remove reference to ‘mefenamic acid’ as a specific NSAID. Clarify that patient choice regarding opting out of conservative treatment only applies to levonorgestrel intrauterine system and not whole pathway. Removal of LNG IUS abbreviation for levonorgestrel intrauterine system. Additional sentence added to state “Please note that if a patient declines any element an application for exceptional funding must be made to the IFR team.” Editing of statement covering dilation and curettage (D&C) to state: “Please note that dilatation and curettage (D&C) is NOT routinely commissioned to either diagnose or treat heavy menstrual bleeding, in line with the Evidence Based Interventions policy” This also repeated on page 41 as well as the checklist

74	Meibomian cyst (Chalazion)	Amendment of typo: “The CCG will only fund surgical treatment of chalazia when the following criteria are met:” Replaces “The CCG will only fund management of benign skin lesions when the following criteria are met:”
75	Arthroscopic Subacromial Decompression of the Shoulder (ASAD**)**	Deletion of “Primary sub-acromial decompression in isolation is not normally funded unless the patient has a massive sub-acromial spur scoring the muscle and may otherwise require a cuff repair” from checklist.
76	Carpal Tunnel	Amended timescales for conservative management from 6 months to 3 months in line with EBI guidance: “If there is no improvement in mild-moderate symptoms after 3 months conservative management which includes nocturnal splinting used for at least 8 weeks (documentation of dates and type(s) of conservative measures is required)
77	Dupuytren’s Disease	The degree of contracture at the proximal interphalangeal (PIPJ) joint has been amended from 30 degrees to 20 degrees. This is in line with EBI guidance. It has been previously thought that that the asterix noting that this would be measured by the inability to flatten the hand on the table rather than using a protactor was clear. There have been no IFR applications for patients between 20 and 30 degrees which suggests this change will not change application of the policy.
79	Trigger Finger	The checklist has been reviewed to ensure treatment for diabetic patients is clearer. These patients are more likely to be unresponsive to steroid injections so surgery should be considered at an earlier stage. The sentence in bold has been added: “Failure to respond to up to two steroid injections (one in the case of patients with diabetes mellitus) or splinting of the finger for 3-12 weeks (does not apply if the patient has had 2 previous trigger digits

<table>
<tr><td></td><td></td><td>unsuccessfully treated with non-operative methods) AND

Loss of complete active flexion”</td></tr>
<tr><td>80</td><td>Varicose veins</td><td>Amended checklist to incorporate Fitter Better Sooner Rotherham programme</td></tr>
<tr><td>84</td><td>Cholecystectomy</td><td>Clarity on sentence in relation to asymptomatic / mild gallstones added.

“Barnsley and Rotherham CCG patients who are asymptomatic will not be funded for cholecystectomy. Patients will be funded after one episode of mild pain”</td></tr>
<tr><td>85</td><td>Surgical Repair of Hernias (Checklist)</td><td>Editing of sentence in relation to suspected femoral hernia criteria to provide clarity.

“All suspected femoral hernia must be referred to secondary care due to the increased risk of incarceration/strangulation

Replaces: “<u>The CCG will only fund femoral hernia surgery when the following criteria is met:</u>

<table><tr><td>All suspected femoral hernias must be referred to secondary care due to the increased risk of incarceration/ strangulation</td><td>Yes</td><td>No</td></tr></table>”</td></tr>
<tr><td>86</td><td>Upper Eyelid Blepharoplasty (Checklist)</td><td>Removal of ‘management of’ from the following sentence:

“The CCG will only fund ~~management of~~ blepharoplasty when the following criteria are met”</td></tr>
<tr><td>91</td><td>Hip Replacement</td><td>Amended checklist to incorporate Fitter Better Sooner Rotherham programme</td></tr>
<tr><td>93</td><td>Knee Replacement</td><td>Amended checklist to incorporate Fitter Better Sooner Rotherham programme</td></tr>
<tr><td>95</td><td>Surgery for Ingrown Toenails</td><td>Removal of ‘in clinical need of surgical removal of</td></tr>
</table>

	(Checklist)	ingrowing toe nail' from sentence Patient ~~is in clinical need of surgical removal of ingoing toe nail~~ has been seen by a community podiatrist and has a documented allergic reaction to local anaesthetic preventing treatment in the community and a general anaesthetic will be needed. •
114-123	Appendix 2 – Information on ICE	Appendix 2 details all the interventions from National Evidence Based EBI Phase 2 which do not require a checklist and recommend refer to message on ICE
132	Appendix 4 - Patient Information Sheet	List of interventions in Table 1 updated to incorporated two additional not routinely commissioned procedures added with additional explanation of intervention. • Exercise **Electrocardiogram** (ECG) for screening for coronary heart disease **(also called an exercise tolerance test).** • Helmet therapy in the treatment of positional plagiocephaly in children (**also known as flat head syndrome)**
133	List of interventions	Details full list of interventions in speciality order including National Evidence Based Interventions Phase 1 and Phase 2 and Local Evidence Based Interventions.
136	Appendix 5	Updated to match SQL codes v4 (Dec 2019) created by CCG Analysts to incorporate working feedback from stakeholders. Please note the latest code is available electronically on request from roccg.intelligence@nhs.net Key changes from version published in v22 of policy are summarised below. Please note that appendix 5 is subject to amendment by the national team. *From May 2019:* 1. SYB policies presented in same format as national coding to remove any ambiguities. (Referenced as interventions under 'z') 2. Additions to EBI policies for

		interventions where the original SYB CFO policy was broader than the EBI guidance: ▪ F – Benign Skin Lesions (additions) ▪ H – Tonsillectomy Additions ▪ L - Shoulder Decompression (additions) *From 26 July 2019: Revisions to specific coding to ensure activity pulled through accurately reflects policy (based on exclusions identified in-year):* 3. **F - Benign Skin (additions)** - The definition "any procedure code where primary diagnosis is D17 or L82X" pulled through activity that was clearly not a benign skin lesion. Definition refined to PRIMARY DIAGNOSIS IN (D170, D171, D172, D173). Retain primary diagnosis L82X 4. **Z - Ingrowing Toe Nail (SYB)** – The description pulls through activity which is not ingrowing toe nail. Description changed to add the criteria PRIMARY_DIAGNOSIS = L600 (the diagnosis code for Ingrowing toe nail). 5. **L -Shoulder Decompression (Additions)** - Definition picks up major procedures that are probably not intended to be covered by this policy. Additional clause added: left(SPELL_DOMINANT_PROCEDURE, 1) <> T as this will exclude the majority of repair and other major procedures whilst still including a broad range of procedures 6. **Z – Grommets for Adults / children.** EBI was only interested in this for children and Otitis Media with Effusion 'glue ear'. The SYB policy covers wider use of grommets than the NHSE policy. The national policy only covers childrens. The SYB policy includes adults and children. Additional category added SYB – Grommets for Childrens

		which can be used to measure the impact of the local policy. 7. **Z – Cataract Surgery** Amended the definition to only include procedures with a spell primary diagnosis of H25 (Senile cataract) or H26 (Other cataract). excludes where cataracts are removed for other purposes e.g. Macula degeneration, Retinopathy, Glaucoma etc. *9 September 2019* 8. Addition of codes for **Vasectomy and Acupuncture.** (Coding only applies to inpatients). Note for vasectomy the coding doesn't differentiate if with or without GA. For commissioners where providers only perform vasectomy under GA this will be sufficient. Where providers undertake this procedure with or without GA further discussion required to clarify how this is coded. 9. Note that procedure and diagnostic criteria for **fertility and plastics** interventions has not been specified. November / December 2019 10. Relabelling of national policies – EBI added in brackets where there are local policies Updated to incorporate all National Evidence Based Interventions Phase 2
147	Definitions	Updated definitions to reflect definitions from National EBI Phase 2
150	Appendix 8	Removed from Policy. Duplication and serves no purpose.

Health and care working together
in South Yorkshire and Bassetlaw

South Yorkshire and Bassetlaw - Commissioning for Outcomes Policy

FINAL (v22)

Version Control

Version	Date	Author	Changes
V1.0	01/04/2015	Dr Sarah Lever	
V1.1	19/06/2015	Hilary Porter	Added wording specifically excluding tonsillectomy as part of cancer treatment/management
V1.2	24/08/2015	Rebecca Chadburn	Change of email address
V2	28/07/16	Dr Sarah Lever	Renamed Clinical thresholds policy with 7 additional clinical thresholds added. Changes to process for referral and approval for treatment. Prior approval only required when deemed exceptional
V3		Dr Sarah Lever	Renamed South Yorkshire and Bassetlaw Commissioning for Value policy. Additional clinical thresholds added and commissioning policy made expressly clear for all procedures including, cosmetic, plastic and fertility procedures.
V8	4/09/2017	Jack Harding	Formatting
V15	20/12/17	Jack Harding	Includes updated links to IFR policies and ACS website
V16	13/02/2018	Adele Spence	Includes previous omission regarding BMI for Doncaster breast augmentation
V17	16/02/18	Abigail Tebbs	Includes changes for Sheffield position on Orthopaedic and cataract procedures
V18	07/08/18	Debbie Stovin	Indicates the elements where Sheffield have opted out
V19	16/11/18	Julie Shaw	Includes changes to Cataracts policy and checklist and the Varicose Veins checklist
V20	01/02/19	David Lautman	Updated to incorporate National Evidence Based Interventions (EBI) Guidance. Local evidence based interventions and specialist plastics policies also reviewed and updated as part of annual review.
V21	01/05/19	David Lautman	To incorporate EBI mobilisation feedback and Governing Body feedback.
V22	01/04/2020	David Lautman	To incorporate additional National EBI guidance and annual review.
V22	25/05/2021	Michele Clarke	To incorporate the 31 EBI Phase 2 interventions 2020

This policy is hosted on the South Yorkshire and Bassetlaw Integrated Care System website and can be accessed at: https://sybics.co.uk/transformation/useful-documents

Contents

1. Executive Summary

Now more than ever, it is important for the NHS to demonstrate that it is making the most effective use of public monies to maximise the health and wellbeing of the people of South Yorkshire and Bassetlaw (SY&B). We need to ensure that our resources are used wisely to maximise the impact of the services we commission to improve health, reduce health inequalities and ensure our population receives appropriate high quality evidence based clinical care.

We seek to ensure that our commissioning decisions are fully informed and based on the best evidence available and provide best value for money. To fulfil these aims, SY&B Commissioners have agreed a regional wide Commissioning for Outcomes (CFO) Evidence Based Interventions Policy. The Policy sets out our approach and governance arrangements to ensure that as far as possible, our decisions are robust, rational and justifiable.

2. Introduction

The purpose of this Policy is to establish a system for transparent and coherent prioritisation for the commissioning of health and wellbeing services. It provides a framework for making decisions about relative priorities at a strategic and planning/commissioning level and facilitates rational and reasonable decisions about which services are commissioned in accordance with the SY&B Integrated Care System (ICS).

The Policy applies to all commissioning decisions made by SY&B CCGs and should be applied when healthcare interventions can no longer be prioritised on the basis of clinical evidence, outcomes and value for money.

This policy links with our strategic plan and commissioning intentions available at the ICS Plan.

Commissioners will incorporate National Evidence Based Interventions guidance into this document in line with national process.

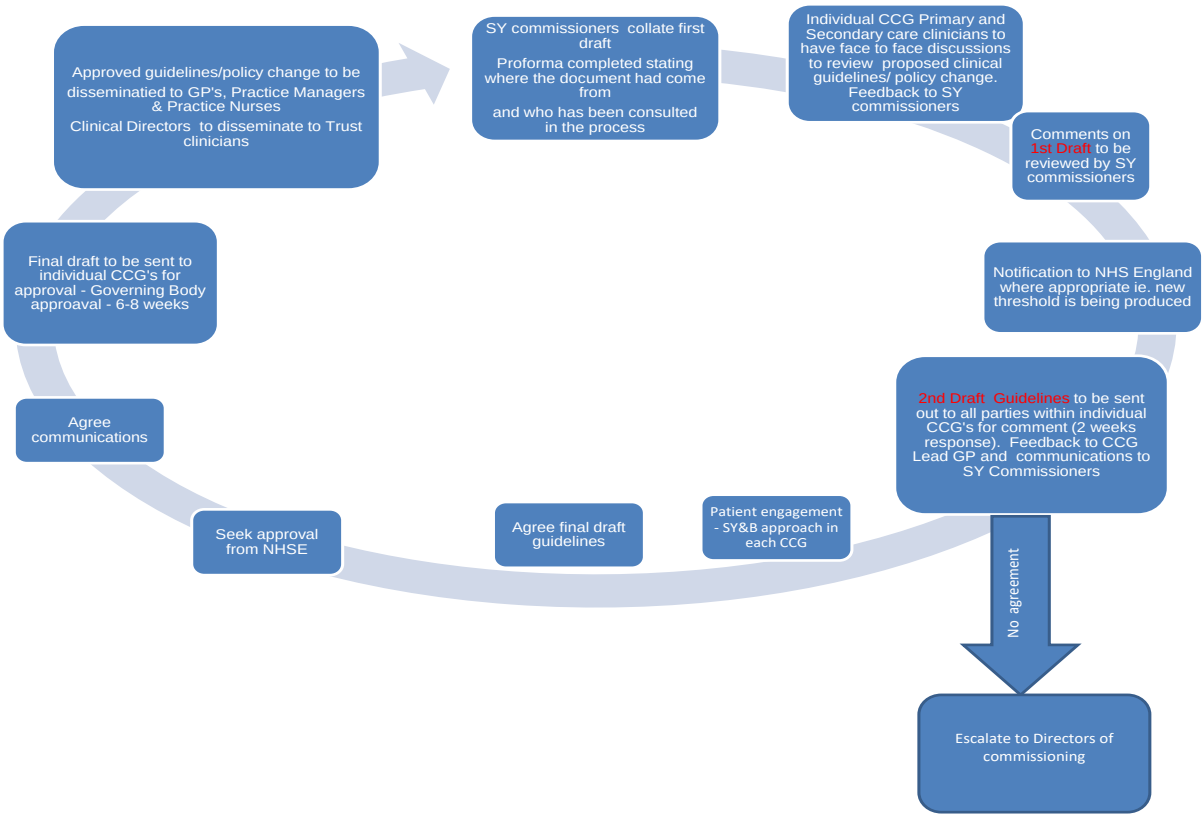
3. Decision Making and Prioritisation Approach

SY&B CCGs are required to make decisions about strategic and operational priorities for annual resource allocation. These may arise from:

- Business cases for investment in services
- Value for money reviews
- Performance monitoring of services or specific treatments where they no longer provide evidenced clinical value, outcomes and best value for money or are a lower priority than services we need to fund within our affordability envelope (including proposal for new Individual Funding Request (IFR) policies)
- Decisions required outside of our planning process on funding outside existing commissioned services and exceptionality for individual cases. This may apply in the following circumstances:
    - A new intervention is made available that is of significant importance
    - A new treatment or service is made available that provides such significant health or financial benefits
    - A proposal is submitted by an external body that provides benefits

SY&B CCGs work together to agree a common approach where decisions are not specific to individual CCGs and their providers. As legal entities, decisions are required by individual CCGs prior to implementation at a SY&B level. Accordingly, the decision making approach within individual CCGs is set out in Figure 1

Figure 1 SY&B process for decision making



4. Priorities for Annual Resource Allocation

SY&B CCGs will prioritise existing resources, reconsider commissioned services that are not considered to be delivering the expected health benefit and consider any new services or business cases to ensure that we are utilising our resources effectively. Local needs and national benchmarking information, where appropriate, will guide CCGs in this prioritisation of expenditure at a local level between commissioning programmes. The following criteria will be used for consideration:

- Alignment with the SY&B Integrated Care System
- Alignment with the CCGs' strategic objectives or national mandatory priorities
- Benefits and outcomes are identified and evidenced/measurable
- Compliance with any legal and clinical frameworks or guidance and procurement processes
- Response to a need that has been assessed
- Clinical effectiveness, outcomes including assessment by NICE or other evidence-based review
- Impact on health inequalities and protected characteristics
- Will improve patient safety and experience
- Accessibility to service users
- Affordability and value for money

5. Service Developments

SY&B commission services in line with NICE Guidance. There is a contractual requirement for providers to treat in line with NICE guidance.

The CCGs will not introduce new drugs/technologies on an ad hoc basis through the mechanism of individual case funding. To do so risks inequity, since the treatment will not be offered openly and equally to all with equal need. There is also the risk that diversion of resources in this way will de-stabilise other areas of health care which have been identified as priorities by the CCGs.

The CCGs expect consideration of new drugs/technologies to take place within the established planning frameworks of the NHS. This will enable clear prioritisation against other calls for funding and the development of implementation plans which will allow access for all patients with equal need.

The CCGs have a default policy of not funding a treatment where no specific policy exists to approve funding for the treatment. If the CCGs or an individual CCG has not previously been asked to fund an intervention that has the potential to affect a number of patients, applications should be made by clinicians for the CCGs/CCG to consider the intervention through its general commissioning policy and not by way of an IFR application.

Interventional Procedure Guidance issued by NICE will be deemed by the CCGs as a Service Development and will not be routinely funded by the CCGs unless agreed in advance.

6. Scope of Document

SY&B Commissioning for Outcomes Policy covers the following:

- National Evidence Based Interventions Phase 1
  - Category 1 Interventions – Procedures not routinely commissioned
  - Category 2 Interventions – Criteria Led
- National Evidence Based Interventions Phase 2
  - Category 1 Interventions – Procedures not routinely commissioned
    Category 2 Interventions – Criteria Led
- Local Evidence Based Interventions
  - Procedures not Routinely Commissioned
  - Criteria Led
- The SY&B Commissioning Guidelines for Plastic Surgery Procedures which have been incorporated into this document
- The Y&H Fertility Policy which has been incorporated into this document

Age Range: This policy applies to both adults and children unless specified otherwise.

This document sets out:

- The procedures covered by this policy
- The referrals process including the use of the IFR process where prior approval is required or there is a case for exceptionality.
  Note: Procedures which are not routinely commissioned require prior approval through the Individual Funding Request Panel (Section 11).
- The interventions and threshold for treatment
- Monitoring arrangements
- Rules around payment
- Referral checklists
- Patient information sheet

7. Review

This policy will be reviewed on an annual basis.

Date of next Review: March 2022

Part 2
Interventions and Process for Referral

8. **National Evidence Based Interventions Phase 1 and Phase 2 and Local Evidence Based Interventions – Clinical responsibilities**

Table 1 below lists the interventions to which the national Evidence Based Interventions Policy Phase 1 and Phase 2 applies. It incorporates procedures not routinely commissioned and procedures criteria led.

Table 1 also incorporates the Local Evidence Based Interventions for procedures not routinely commissioned and procedures criteria led.

Key

Speciality	Speciality of Intervention
Ref No	Indicates Phase 1 (1) or Phase 2 (2) or Local Evidence Based Intervention (LEBI)
Intervention	Intervention description
Category	Indicates source of intervention (Evidence Based Interventions - Phase 1 [EBI1] or Phase 2 [EBI2] or Local Evidence Based Interventions [LEBI])
Process	Indicates if checklist if relevant, recommends message on ICE system or IFR to be considered
Page Number	Policy - Page number of full detail of intervention Checklist - Page Number of checklist for Primary or secondary care if applicable (Secondary care checklists to be adopted if desired)

Table 1

1 = Phase 1 EBI, 2= Phase 2 EBI and LEBI = Local Evidence Based Interventions

SPECIALITY	Ref No*.	Intervention	Category	Referring clinician responsibility	Receiving clinician responsibility	Page Number	
						Policy	Checklist if applicable OR ICE
ANAESTHETICS	2AA	Pre-operative Chest X-ray (before an operation)	EBI 2	Refer to guidance on ICE	Refer to guidance on ICE	25	119
	2BB	Pre-operative ECG - Heart tracing (ECG) before an operation	EBI 2	Refer to guidance on ICE	Refer to guidance on ICE	25	120

SPECIALITY	Ref No*.	Intervention	Category	Referring clinician responsibility	Receiving clinician responsibility	Page Number	
						Policy	Checklist if applicable OR ICE
CARDIOLOGY	2A	Diagnostic coronary (invasive) angiography for low risk, stable chest pain	EBI 2		Complete secondary care checklist	25	111
	2F	Specialised blood tests (troponin) for investigation of chest pain	EBI 2	Refer to guidance on ICE	Refer to guidance on ICE	25	114
	2L	Exercise ECG for screening for coronary heart disease	EBI 2	Not routinely commissioned Referral to IFR panel		25	
	2DD	Lipid Lowering Therapy - Regular blood tests when taking cholesterol lowering tablets	EBI 2	Education and refer to guidance on ICE	Education and refer to guidance on ICE	26	121
DERMATOLOGY	1F and LEBI	Removal of Benign Skin Lesions and Removal of Benign Perianal skin lesions	EBI 1/LEBI	Complete the checklist and attach to referral letter	Check and electronically sign/accept the checklist	26	67 and 83
ENT	1A	Snoring Surgery (in the absence of Obstructive Sleep Apnoea (OSA))	EBI 1	Not routinely commissioned Referral to IFR panel		27	
	1G	Grommets in children	EBI 1	Complete the checklist and attach to referral letter	Complete relevant secondary care section of checklist	27	69
	1H	Tonsillectomy	EBI 1	Prior Approval via IFR (Clinical Letter and Checklist)	Ensure Prior Approval in place prior to listing patient Notification to IFR panel for biopsy or removal of lesion (prior approval not required).	29	69

SPECIALITY	Ref No*.	Intervention	Category	Referring clinician responsibility	Receiving clinician responsibility	Page Number	
						Policy	Checklist if applicable OR ICE
ENT	2C	Surgery for chronic sinusitis	EBI 2	Complete the checklist and attach to referral letter	Complete relevant secondary care section of checklist	32	100/110
	2D	Removal of the adenoids (for glue ear and not OSA) Adenoidectomy	EBI 2		Complete relevant secondary care section of checklist (Requires IFR approval)	32	111
	LEBI	Grommets in Adults	LEBI	Complete the checklist and attach to referral letter	Complete relevant secondary care section of checklist IFR for exceptionality	32	82

SPECIALITY	Ref No*.	Intervention	Category	Referring clinician responsibility	Receiving clinician responsibility	Page Number	
						Policy	Checklist if appliable OR ICE
GENERAL SURGERY	1I	Haemorrhoid Surgery	EBI 1	Complete the checklist	Check and accept checklist. IFR for except	34	72
	2B	Surgical repair of hernias	EBI 2/LEBI	Complete the checklist and attach to referral letter	Check and electronically sign/accept the checklist	35	88
	2M	Upper GI Endoscopy to investigate gut problems	EBI 2		Complete the relevant checklist	37	97
	2N	Appropriate Colonoscopy of the lower intestine	EBI 2	Complete the relevant checklist	Complete the relevant checklist	37	102
	2O	Repeat / Follow up colonoscopy of the lower intestine	EBI 2		Complete the relevant checklist	37	104
	2P	Test of the gallbladder - ERCP in acute gallstone pancreatitis without cholangitis	EBI 2		Refer to guidance on ICE	37	115
	2Q and LEBI	Cholecystectomy - Removal of an inflamed gallbladder	EBI 2/LEBI		Complete secondary care checklist. IFR for exceptionality	38	84
	2R	Appendicectomy without confirmation of appendicitis - Tests to confirm appendicitis	EBI 2		Refer to guidance on ICE	41	115
	LEBI	Ingrown toenail	LEBI	Complete the checklist and attach to referral letter	Check and electronically sign/accept the checklist	41	95

SPECIALITY	Ref No*.	Intervention	Category	Referring clinician responsibility	Receiving clinician responsibility	Page Number	
						Policy	Checklist if appliable OR ICE
GYNAECOLOGY	1J	Hysterectomy for management of heavy menstrual bleeding	EBI 1	Checklist from GP not required	Complete and sign checklist	41	73
	1B	Dilation and curettage (D&C) for heavy menstrual bleeding (HMB) in women	EBI 1	Not routinely commissioned	Referral to IFR panel	42	
HAEMATOLOGY	2EE	Blood transfusions	EBI 2		Refer to guidance on ICE	42	122
OPTHALMOLOGY	1K	Meibomian cyst (Chalazion)	EBI 1	Complete the checklist and attach to referral letter	Check and electronically sign/accept the checklist	43	74
	LEBI	Upper Eyelid Blepharoplasty	LEBI	Complete the checklist and attach to referral letter	Check and electronically sign/accept the checklist	43	86
	LEBI	Cataract Surgery	LEBI	Optometrist completes and signs checklist. Complete relevant secondary care section of checklist and check and electronically sign/accept the checklist. (The checklist must be completed for second eye surgery if required). If a Cataract LES or locally commissioned service is in place: Where a patient has been referred outside of the Cataract LES, the receiving clinician must ensure that the patient meets the threshold.		44	87

SPECIALITY	Ref No*.	Intervention	Category	Referring clinician responsibility	Receiving clinician responsibility	Page Number	
						Policy	Checklist if appliable OR ICE
ORTHOPAEDICS	1C	Knee arthroscopy for patients with osteoarthritis	EBI 1	Not routinely commissioned. If a clinician feels that a patient's circumstances are exceptional and may benefit from any of these treatments then they must be referred to the IFR Panel (see section 11).		47	
	1D	Injection for non-specific low back pain	EBI 1	Not routinely commissioned. If a clinician feels that a patient's circumstances are exceptional and may benefit from any of these treatments then they must be referred to the IFR Panel (see section 11).		47	
	1L	Arthroscopic Subacromial Decompression of the shoulder (ASAD)	EBI 1	Primary care checklist/secondary care checklist *Sheffield CCG - Referrals will be made to the MSK service who will apply the criteria (checklist not required)*		48	75
	1M	Carpal tunnel Syndrome Surgery	EBI 1	Complete the checklist and attach to referral letter	Check and electronically sign/accept the checklist	49	76

SPECIALITY	Ref No*.	Intervention	Category	Referring clinician responsibility	Receiving clinician responsibility	Page Number	
						Policy	Checklist if appliable OR ICE
ORTHOPAEDICS	1N	Common Hand Conditions - Dupuytrens release	EBI 1	Complete the checklist and attach to referral letter	Check and electronically sign/accept the checklist	49	77
	1O	Common Hand conditions - Ganglion	EBI 1	Complete the checklist and attach to referral letter	Check and electronically sign/accept the checklist	50	78
	1P	Common Hand Conditions - Trigger finger	EBI 1	Complete the checklist and attach to referral letter	Check and electronically sign/accept the checklist	50	79
	2E	Knee arthroscopic surgery for meniscal tears	EBI 2		Complete relevant checklist	50	106
	2J	Lumbar Discectomy - Spinal surgery for a slipped disc	EBI 2		Complete relevant checklist	50	113
	2K	Lumbar Radiofrequency facet joint denervation	EBI 2	Not routinely commissioned. If a clinician feels that a patient's circumstances are exceptional and may benefit from any of these treatments then they must be referred to the IFR Panel (see section 11)		50	

SPECIALITY	Ref No*.	Intervention	Category	Referring clinician responsibility	Receiving clinician responsibility	Page Number	
						Policy	Checklist if appliable OR ICE
ORTHOPAEDICS	2S	Low back pain imaging	EBI 2	Refer to guidance on ICE (not routine investigation)		50	115
	2T	Knee MRI when symptoms are suggestive of osteoarthritis	EBI 2	Refer to guidance on ICE	Refer to guidance on ICE	50	116
	2U	Knee MRI for suspected meniscal tears	EBI 2	Complete the checklist and attach to referral letter	Check and electronically sign/accept the checklist	51	101
	2V	Vertebral augmentation (vertebroplasty or Kyphoplasty) for painful osteoporotic vertebral fractures	EBI 2	Not routinely commissioned. If a clinician feels that a patient's circumstances are exceptional and may benefit from any of these treatments then they must be referred to the IFR Panel (see section 11).		52	
	2W	Imaging for shoulder pain	EBI 2	Refer to guidance on ICE		52	117
	2X	MRI scan of the hip for arthritis	EBI 2	Refer to guidance on ICE		52	118
	2Y	Surgery to fuse the bones in the back for back pain - Fusion surgery for mechanical axial low back pain	EBI 2	Not routinely commissioned. If a clinician feels that a patient's circumstances are exceptional and may benefit from any of these treatments then they must be referred to the IFR Panel (see section 11).		52	

SPECIALITY	Ref No*.	Intervention	Category	Referring clinician responsibility	Receiving clinician responsibility	Page Number	
						Policy	Checklist if appliable OR ICE
ORTHOPAEDICS	LEBI	Hallux valgus surgery	LEBI	Complete the checklist and attach to referral letter	Check and electronically sign/accept the checklist	53	90
	LEBI	Total Knee replacement	LEBI	Complete the checklist and attach to referral letter	Check and electronically sign/accept the checklist	55	93
	LEBI	Total Hip Replacement	LEBI	Complete the checklist and attach to referral letter	Check and electronically sign/accept the checklist	55	91
PAEDIATRICS	2Z	Helmet therapy in the treatment of positional plagiocephaly in children*	EBI 2	Not routinely commissioned. If a clinician feels that a patient's circumstances are exceptional and may benefit from any of these treatments then they must be referred to the IFR Panel (see section 11)		58	
PAIN CLINIC	LEBI	Acupuncture for non-specific back pain	LEBI	Not routinely commissioned. If a clinician feels that a patient's circumstances are exceptional and may benefit from any of these treatments then they must be referred to the IFR Panel (see section 11)		58	

SPECIALITY	Ref No*.	Intervention	Category	Referring clinician responsibility	Receiving clinician responsibility	Page Number	
						Policy	Checklist if appliable OR ICE
PLASTICSURGERY (All summarised in appendix 3)	1E and LEBI	Plastic surgery procedures	EBI 1 and LEBI	Prior Approval via IFR (Clinical Letter and Questionnaire)	Ensure Prior Approval in place prior to listing patient	59	
UROLOGY	2G	Surgical removal of kidney stones	EBI 2		Complete appropriate checklist	60	108
	2H	Cystoscopy for men with un-complicated lower urinary tract symptoms	EBI 2	Complete the checklist and attach to referral letter	Check and electronically sign/accept the checklist	60	1107
	2I	Surgical intervention for benign prostatic hyperplasia	EBI 2		Complete appropriate checklist	60	109
	2CC	Prostate- specific antigen (PSA) testing	EBI 2		Refer to guidance on ICE	60	120
	LEBI	Male circumcision	LEBI	Complete the checklist and attach to referral letter	Check and electronically sign/accept the checklist	60	96
	LEBI	Vasectomy under GA	LEBI	Prior Approval via IFR (Clinical Letter and Questionnaire)	Ensure Prior Approval in place prior to listing patient	62	
VASCULAR	1Q	Varicose veins	EBI 1	Complete the checklist and attach to referral letter	Check and electronically sign/accept the checklist	62	80

9 Making a Referral

Where an evidence-based threshold applies, clinicians are required to complete the referral checklist and attach the document to the referral. Referrals without a completed checklist will be returned to the referral source indicating the reason for rejection. The provider will confirm that the electronic checklist is present and that the patient meets the threshold, criteria. The secondary care element of the referral checklist will be completed (where this applies to an intervention) and electronically signed/accepted by the receiving clinician to evidence that the patient meets the criteria. The referral checklist will be included within the patient notes / filed for future compliance audit.

A referral should only proceed to treatment if the patient meets the threshold or specific criteria in the category 2 intervention and a completed and compliant referral checklist is in place.

In some circumstances, GPs, Consultants or NHS clinicians may consider an individual has exceptional clinical circumstances and may benefit from a treatment which is not routinely provided. Requests for such treatments must be made through an Individual Funding Request (IFR) by the clinician. This request will then be considered, approved or rejected by an independent panel. The referral process is illustrated at **Diagram 1.**

Consultant to Consultant referrals for hysterectomy for heavy menstrual bleeding must comply with the Consultant to Consultant Policy. In these circumstances the receiving Consultant must complete a checklist to indicate whether or not the patient meets the Threshold criteria. Any qualifying evidence must also be documented within the patient's medical records.

Table 1 (page 9 -18) show the responsibilities of the clinician for each condition.

The criteria for treatment and referral checklists for each procedure are set out in **Part 3** of this document. Where patients do not meet the criteria for referral they should be advised to return to their GP or other appropriate health care professional should their condition change. Likewise, where patients are on a pathway for elective care, clinical review should be available where necessary should a patient's condition require earlier intervention.

Health Improvement Programmes
NHS Barnsley and Rotherham CCGs have introduced health and wellbeing initiatives that encourages patients who are smokers and/or have a Body Mass Index (BMI) of 30 or over to ensure they are in the best possible health before they go for a routine, non-urgent operation. Patients will receive support to stop smoking and/or lose weight.

Barnsley and Rotherham CCGs do not routinely commission referral to secondary care for routine, non-urgent elective surgery for patients (over 18 years old) who are active smokers or whose BMI is 30 or more (See separate commissioning policy for groups who are exempt)

In Barnsley the programme is called 'Get Fit First' for surgery. In Rotherham the programme is called 'Fitter Better Sooner'.

<u>Get Fit First in Barnsley (For Barnsley CCG patients only)</u>
The Get Fit First Programme is a health and wellbeing initiative introduced by NHS Barnsley Clinical Commissioning Group that encourages patients who are smokers and/or have a Body Mass Index (BMI) of 30 or over to ensure they are in the best possible health before they go for a routine, non-urgent operation. Patients will receive support to stop smoking and/or lose weight.

Barnsley CCG does not routinely commission referral to secondary care for routine, non-urgent elective surgery for patients (over 18 years old) who are active smokers or whose BMI is 30 or more (See separate commissioning policy for groups who are exempt)

- Evidence of smoking abstinence will be required prior to referral for surgery. Patients who stop smoking can be referred after 12 weeks. Patients who do not stop smoking will be referred for surgery after 6 months from initial consultation and advised to abstain from smoking for a minimum of 2 days prior to surgical intervention. This will allow a period of health improvement.
- Patients who do not reduce BMI to ≤30 or make a 10% reduction from their starting weight will be referred for surgery after 6 months from initial consultation (subject to clinical opinion).

Note: Some interventions in this policy include a specific BMI as part of the criteria for referral; Varicose Vein surgery (BMI 30), Specialist Plastics Policies (BMI 18.5 – 27). The completion of 6 months health improvement does not overrule these specific BMI criteria. For Hip / Knee Replacement the previous BMI requirement (35) is replaced with 'Patient meets Get Fit First criteria'.

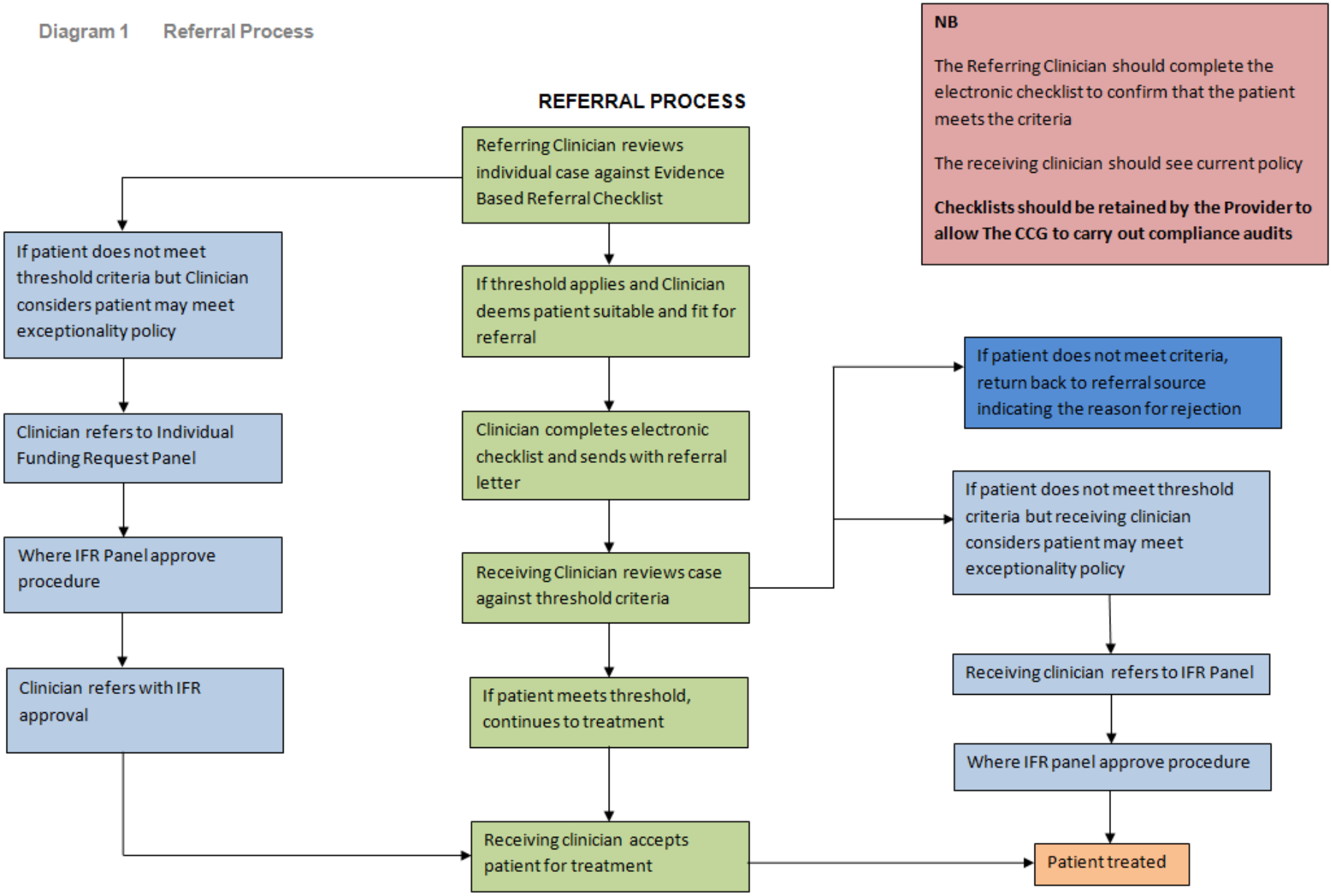
For further information about the initiative visit http://www.barnsleyccg.nhs.uk/patient-help/getfitfirst

Fitter Better Sooner (Rotherham CCG patients only)

- Evidence of smoking abstinence will be required prior to referral for surgery. Patients who stop smoking can be referred after 12 weeks. Patients who do not stop smoking will be referred for surgery after 9 months from initial consultation and advised to abstain from smoking for a minimum of 2 days prior to surgical intervention. This will allow a period of health improvement.
- Patients who do not reduce BMI to ≤30 or make a 10% reduction from their starting weight will be referred for surgery after 9 months from initial consultation (subject to clinical opinion).

Note: Some interventions in this policy include a specific BMI as part of the criteria for referral; Varicose Vein surgery (BMI 30), Specialist Plastics Policies (BMI 18.5 – 27). The completion of 6 months health improvement does not overrule these specific BMI criteria. For Hip / Knee Replacement the previous BMI requirement (35) is replaced with 'Patient meets Fitter Better Sooner criteria'.

Diagram 1 Referral Process



10. Individual Funding Requests (IFR)

If a clinician feels that a patient's circumstances are exceptional and may benefit from any of these treatments, then they must be referred to the IFR Panel.

The criteria for treatment and referral checklists for each intervention are set out in Part 3 of this document.

11. Prior approval for treatment outside of this policy

Table 1 (pages 9 to 18) make clear the requirements of the referring and receiving clinician for evidence based interventions. Clinicians will seek prior approval for treatment where patients are to be treated outside of these policies. Where a clinician believes that a patient might benefit from an intervention but where they do not meet the clinical threshold, the clinician may apply to the IFR Panel to make the case for exceptionality. In these circumstances clinicians will be required to evidence the reasons for exceptionality. Where a procedure has a BMI restriction, patients whose high BMI is due to bulk muscle should be referred to the IFR panel as an exception.

12. Exceptionality

The CCG commissions according to the policy criteria. Requests for individual funding can be made only where exceptional circumstances exist and can be made through the NHS Individual Funding Request (IFR) procedure.

Responsibility for demonstrating exceptionality rests with the referring clinician.

A patient may be considered exceptional to the general standard policy if both the following apply:

- He/she is different to the general population of patients who would normally be refused the healthcare intervention, and
- There are good grounds to believe that the patient is likely to gain significantly more benefit from the intervention than might be expected for the average patient with that particular condition.

In assessing exceptionality, the IFR panel will not consider social, demographic or employment circumstances.

Where a patient has already been established on a health care intervention, for example as part of a clinical trial or following payment for additional private care, this will be considered to neither advantage nor disadvantage the patient. However, response to an intervention will not be considered to be an exceptional factor.

The IFR policy for each CCG is shown in **Appendix 7**.

Where prior approval is required it should be sought from the CCG in advance of the treatment being provided.

All requests should be sent to:

Individual Funding Requests
722 Prince of Wales Road,
Sheffield,
S9 4EU

or sent electronically to: sheccg.sybifr@nhs.net, or by fax to: 0114 3051370 (safe haven) adhering to confidentiality procedures. Only requests by letter will be accepted. A clinical letter with a completed checklist (where relevant) should be sent to the IFR panel outlining why the patient does not meet the criteria and evidence supporting their exceptionality.

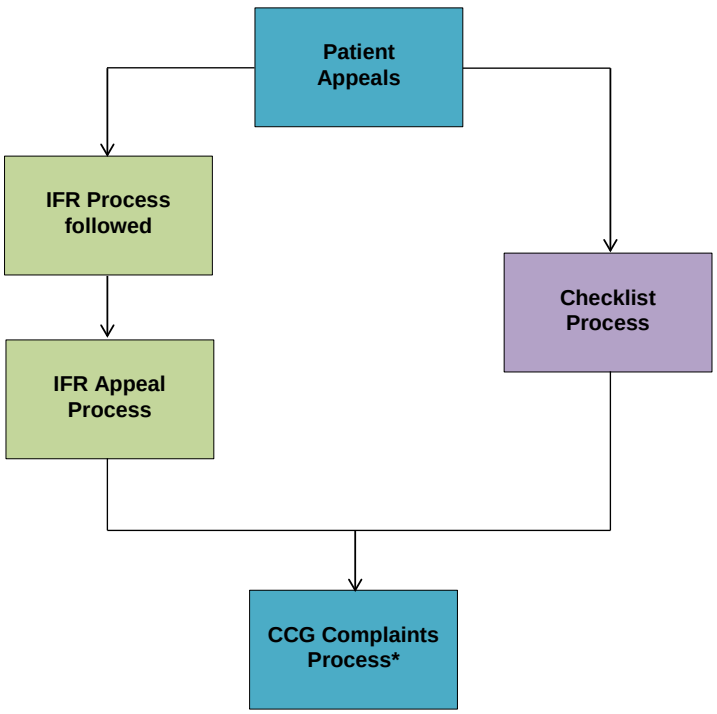
Service Condition 29.26 of the NHS Standard Contract makes clear that failure by the commissioner to respond within the agreed timescale may be taken as approval to treat. The IFR team aims to process requests through the panel within 14 days and request further information from the GP where required.

13. Appeals

SY&B CCGs recognise that there may be times when members of the public are dissatisfied with the decisions. We are committed to undertaking engagement and consultation work that, at a minimum meets national expectations of best practice, and believe that doing so will help ensure our decisions are in the interests of the public of SY&B.

Any patient/carer who feels that a decision is not justified may register a complaint or appeal, as per the below process. Ultimately, the CCGs' decisions may be the subject to legal challenge from individuals or groups.

Figure 2- Patient Appeals Process



***Individual CCG complaints processes are detailed at the following Link**

Part 3
Summary of Commissioning Position and Evidence Base

14. List of Procedures/Interventions including National Local Based Interventions Phase 1 and Phase 2 and Local Based Interventions. (Not routinely commissioned and criteria Led)

Spec	Ref	Intervention	Criteria for treatment	Evidence Base / Local Guidance	Process
Anaesthetics	2AA	**Pre-operative Chest X-ray (before an operation)**	Not routinely commissioned	**National Evidence Based Interventions Policy P.69** EBI_list2_guidance_150321.pdf (aomrc.org.uk)	Refer to message on ICE
	2BB	**Pre-operative ECG - Heart tracing (ECG) before an operation**	Not routinely commissioned	**National Evidence Based Interventions Policy P.70** EBI_list2_guidance_150321.pdf (aomrc.org.uk)	Refer to message on ICE
Cardiology	2A	**Diagnostic coronary (invasive) angiography for low risk, stable chest pain**	National Based Interventions policy	**National Based Interventions policy: P.11** EBI_list2_guidance_150321.pdf (aomrc.org.uk)	Complete secondary care checklist
	2L	**Exercise ECG for screening for coronary heart disease**	Not routinely commissioned	**National Evidence Based Interventions Policy P.32** EBI_list2_guidance_150321.pdf (aomrc.org.uk)	Refer to message on ICE
	2F	**Specialised blood tests (troponin) for investigation of chest pain**	National Based Interventions policy	**National Based Interventions policy: P.21** EBI_list2_guidance_150321.pdf (aomrc.org.uk)	Refer to message on ICE

Spec	Ref	Intervention	Criteria for treatment	Evidence Base / Local Guidance	Process
	2DD	**Lipid Lowering Therapy - Regular blood tests when taking cholesterol lowering tablets**	National Based Interventions policy	National Based Interventions policy: P.75 EBI_list2_guidance_150321.pdf (aomrc.org.uk)	Education and refer to message on ICE
Dermatology	1F	**Removal of Benign Skin Lesions**	National Evidence Based Interventions Policy and Local Based Interventions	For Benign Skin Lesions SY&B commissioners have elected to maintain the existing referral checklist (which is in line with the EBI policy) as the national criteria are very broad and unmanageable via checklist in long-form. To ensure the referral process is manageable the checklist groups the criteria where a lesion might be removed. Any patients that do not meet the threshold criteria can be referred to the IFR panel who will assess patients against the EBI guidance. **National Evidence Based Interventions Policy** https://www.england.nhs.uk/wp-content/uploads/2018/11/ebi-statutory-guidance-v2.pdf	Evidence Based Intervention – refer using checklist. IFR for exceptionality
	LEBI	**Benign Perianal Skin Tags**	Local Evidence Based interventions – criteria led Referral should only be undertaken when one or more of the following criteria have been met:	**For Local Evidence Base and Criteria See Appendix 2** **NHS England.** Interim Clinical Commissioning Policy: Anal Skin Tag Removal https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2013/11/N-SC002.pdf **McKinnell and Gray**, 2010,	Refer using checklist. IFR for exceptionality .

Spec	Ref	Intervention	Criteria for treatment	Evidence Base / Local Guidance	Process
			• There is doubt about the benign nature of the skin lesion • Viral warts in immunocompromised patients where underlying malignancy may be masked. Recommended by GU Med when conservative treatment has failed	QIPP Programme Right Care: Value Improvement Identifying Procedures of Low Value, Public Health Commissioning Network. **NHS Choices** Lumps and swellings http://www.nhs.uk/conditions/lumps-swellings/Pages/Introduction.aspx (accessed January 2017)	
ENT	1A	**Snoring Surgery (in the absence of Obstructive Sleep Apnoea (OSA))**	Cat 1 . Not routinely commissioned	**National Evidence Based Interventions Policy** https://www.england.nhs.uk/wp-content/uploads/2018/11/ebi-statutory-guidance-v2.pdf **2020/21 National Tariff Payment System – a consultation notice**https://improvement.nhs.uk/documents/6257/2021_NTPS_statutory_consultation_notice.pdf (page 132)	exceptionality can be applied for via a clinical letter to the IFR panel.
	1G	**Grommets in children**	The CCG will **only** fund grommet insertion in children (age under 18 for Barnsley/Doncaster/ Bassetlaw/Rotherham or 16 and under for Sheffield) when one or more of the following criteria are met: • Recurrent otitis media – 5 or more recorded episodes in preceding 12 month period	**National Evidence Based Interventions Policy** https://www.england.nhs.uk/wp-content/uploads/2018/11/ebi-statutory-guidance-v2.pdf	Evidence Based Intervention - refer using checklist. IFR for exceptionality

Spec	Ref	Intervention	Criteria for treatment	Evidence Base / Local Guidance	Process
ENT			• Suspected hearing loss at home or at school / nursery • Speech delay, poor educational progress due to hearing loss, following 3 months of watchful waiting • Abnormal appearance of tympanic membrane • Persistent hearing loss for at least 3 months with hearing levels of: 25dBA or worse in both ears on pure tone audiometry **OR** 25dBA or worse or 35dHL or worse on free field audiometry testing **AND** Type B or C2 tympanometry • Suspected underlying sensorineural hearing loss • Atelectasis of the tympanic membrane where development of cholesteatoma or erosion of the ossicles is a risk • OME in the presence of a secondary disability e.g. autistic spectrum disorder, Down Syndrome, cleft palate • Persistent OME (more than 3 months) with fluctuating hearing but significant		

Spec	Ref	Intervention	Criteria for treatment	Evidence Base / Local Guidance	Process
			delay in speech, educational attainment or social skills. This policy applies to all tubes inserted into the tympanic membrane to aid ventilation and pressure equalisation of the middle ear. This includes grommets - myringotomy tubes - and tympanostomy or T tubes. National Evidence Based Interventions policy only applies to glue ear (otitis media with effusion). The CCG will routinely fund additional conditions which are detailed in Appendix 2 provided a checklist is completed to evidence a patient meets the criteria.		
ENT	1H	**Tonsillectomy** **(Significant changes to criteria 2021)**	The CCG will **only** fund tonsillectomy when one or more of the following criteria have been met: **Primary care assessment-** • Recurrent attacks of tonsillitis as defined by: Sore throats are due to acute tonsillitis which is disabling and prevents normal functioning **AND**	SY&B Commissioners noted that referrals for tonsillectomy for recurrent tonsillitis require additional clinical input to assess against national criteria (number of occurrences of sore throats) hence the recommendation to use IFR	Prior Approval via IFR (Clinical Letter and Checklist) Notification via IFR for biopsy or removal of lesion

Spec	Ref	Intervention	Criteria for treatment	Evidence Base / Local Guidance	Process
ENT			7 or more well documented, clinically significant *, adequately treated episodes in the preceding year **OR** • 5 or more such episodes in each of the preceding 2 years **OR** • 3 or more such episodes in each of the preceding 3 years **A Clinically significant episode is characterised by at least three of the following (Centor criteria):* *-Tonsillar exudate* *-Tender anterior cervical lymphadenopathy or lymphadenitis* *-History of fever (over 38'C)* *-Absence of cough* Two or more episodes of quinsy (peritonsillar abscess) • Severe halitosis secondary to tonsillar crypt debris • Failure to thrive (child) secondary to difficulty swallowing caused by enlarged tonsils Primary care clinicians should send a brief referral letter and a copy of the checklist to IFR for prior approval	**Burton MJ, Glasziou PP.** Tonsillectomy or adeno-tonsillectomy versus non-surgical treatment for chronic/recurrent acute tonsillitis. *Cochrane Database of Systematic Reviews* 1999, Issue 3. Art. No.: CD001802. First published online: July 26 1999. Available from: http://www.cochrane.org/reviews/en/ab001802.html (accessed 2019) **Osbourne MS, Clark MPA.** The surgical arrest of post-tonsillectomy haemorrhage: Hospital Episode Statistics 12 years on. Annals RCS. 2018.May (100) 5: 406-408 **Paradise JL, Bluestone CD, Bachman RZ.** Efficacy of tonsillectomy for recurrent throat infection in severely affected children. Results of parallel randomized and non-randomized clinical trials. N England J Med 1984:310(11):674-83 **Rubie I, Haighton C, O'Hara J, Rousseau N, Steen N, Stocken DD, Sullivan F, Vale L, Wilkes S, Wilson J**. The National randomised controlled Trial of Tonsillectomy IN Adults (NATTINA): a clinical and cost-effectiveness study: study protocol for a randomised control trial. Trials. 2015 Jun 6;16:263. https://www.ncbi.nlm.nih.gov/pubmed/26047934 (accessed 2019) **Scottish Intercollegiate Guidelines Network**	The IFR panel will provide clinical oversight on the management of these policies. Refer through IFR for exceptionality.

Spec	Ref	Intervention	Criteria for treatment	Evidence Base / Local Guidance	Process
			Secondary care assessment- • Obstructive sleep disordered breathing causing severe daytime and night time symptoms. Obstructive sleep disordered breathing is defined as: -Grade 3 or 4 tonsils AND -Symptoms persisting for more than three months AND -Night time symptoms- consistent snoring AND consistent wakefulness OR secondary enuresis OR witnessed apnoeas OR restlessness/excessive sweating AND • -Daytime symptoms- impaired school performance OR hyperactivity/aggression OR altered mood OR excessive tiredness Secondary care clinicians should send a clinical letter and copy of the GP referral to IFR for prior approval • Biopsy/removal of lesion on tonsil Secondary Care clinicians should send a clinical letter and copy of the GP referral to IFR for notification and monitoring (prior approval not required).	Management of sore throat and indications for tonsillectomy. A National clinical Guideline. April 2010 https://www.sign.ac.uk/assets/sign117.pdf (accessed 2019) **Safe Delivery Of Paediatric ENT Surgery In The UK: A National Strategy** https://www.entuk.org/sites/default/files/files/Safe%20Delivery%20Paediatric%20ENT.pdf (accessed 2020)	

Spec	Ref	Intervention	Criteria for treatment	Evidence Base / Local Guidance	Process
ENT	2C	**Surgery for chronic sinusitis**	National Based Interventions policy	National Based Interventions policy:P.14 EBI_list2_guidance_150321.pdf (aomrc.org.uk)	Primary Care and secondary care checklist – IFR for exceptionality
ENT	2D	**Removal of the adenoids (for glue ear and not OSA) Adenoidectomy**	National Based Interventions policy	National Based Interventions policy:P.17 EBI_list2_guidance_150321.pdf (aomrc.org.uk)	Secondary Care Management (Require IFR approval)
ENT	LEBI	**Grommets for adults**	**Adults** should meet at least one of the following criteria. • Persistent hearing loss for at least 3 months with hearing levels of 25dB or worse on pure tone audiometry **or** • Recurrent acute otitis media – 5 or more episodes in the preceding 12 month period **or** • Eustachian tube dysfunction causing pain **or** • Atelectasis of the tympanic membrane where development of cholesteatoma or erosion of the ossicles is a risk **or**	ENT UK 2009 OME/Adenoid and Grommet **Perera R.** Autoinflation for hearing loss associated with otitis media with effusion.(Cochrane review). In: Cochrane database of systemic reviews, 2006. Issue Chichester: Wiley Interscience. http://www.cochrane.org/CD006285/ENT_autoinflation-for-hearing-loss-associated-with-otitis-media-with-effusion-glue-ear **Fickelstein Y. et al.** Adult-onset otitis media with effusion. Archives of Otolaryngology -- Head & Neck Surgery, May 1994, vol./is. 120/5(517-27). **Dempster J.H. et al.**	Complete relevant primary/ secondary care section of checklist IFR for exceptionality

Spec	Ref	Intervention	Criteria for treatment	Evidence Base / Local Guidance	Process
ENT			• As a conduit for drug delivery direct to the middle ear **or** • In the case of conditions e.g. nasopharyngeal carcinoma, ethmoidal cancer, maxillectomy, olfactory neuroblastoma, sinonasal cancer, and complications relating to its treatment (including radiotherapy), if judged that the risks outweigh the benefit by the responsible clinician. Part of a more extensive procedure at Consultant's discretion such as tympanoplasty, acute otitis media with facial palsy This policy applies to all tubes inserted into the tympanic membrane to aid ventilation and pressure equalisation of the middle ear. This includes grommets - myringotomy tubes - and tympanostomy or T tubes	The management of otitis media with effusion in adults. Clinical Otolaryngology & Allied Sciences, June 1988, vol./is. 13/3(197-9) **Yung M.W. et al.** Adult-onset otitis media with effusion: results following ventilation tube insertion. Journal of Laryngology & Otology, November 2001, vol./is. 115/11(874-8). **Wei W.I. et al**. The efficacy of myringotomy and ventilation tube insertion in middle-ear effusions in patients with nasopharyngeal carcinoma. Laryngoscope, November 1987, vol./is. 97/11(1295-8) **Ho W.K. et al**. Otorrhea after grommet insertion for middle ear effusion in patients with nasopharyngeal carcinoma. American Journal of Otolaryngology, January 1999, vol./is. 20/1(12-5) **Chen C.Y. et al.** Failure of grommet insertion in post-irradiation otitis media with effusion. Annals of Otology, Rhinology & Laryngology, August 2001, vol./is. 110/8(746-8) **Ho W.K. et al.** Randomized evaluation of the audiologic outcome of ventilation tube insertion for middle ear effusion in	

Spec	Ref	Intervention	Criteria for treatment	Evidence Base / Local Guidance	Process
ENT				patients with nasopharyngeal carcinoma. Journal of Otolaryngology, October 2002, vol./is. 31/5(287-93) **Park J.J. et al.** Meniere's disease and middle ear pressure - vestibular function after transtympanic tube placement. ACTA OTOLARYNGOL, 2009 Dec; 129(12): 1408-13 **Sugaware K. et al.** Insertion of tympanic ventilation tubes as a treating modality for patients with Meniere's disease: a short- and long-term follow-up study in seven cases. Auris, Nasus, Larynx, February 2003, vol./is. 30/1(25-8) **Montandon P. et al.** Prevention of vertigo in Meniere's syndrome by means of transtympanic ventilation tubes. Journal of Oto-Rhino-Laryngology & its Related Specialties, 1988, vol./is. 50/6(377-81)	
General Surgery	1l	**Haemorrhoid surgery**	National Evidence Based Interventions Policy	**National Evidence Based Interventions Policy** https://www.england.nhs.uk/wp-content/uploads/2018/11/ebi-statutory-guidance-v2.pdf	Evidence Based Intervention – refer using primary care checklist. IFR for exceptionality

Spec	Ref	Intervention	Criteria for treatment	Evidence Base / Local Guidance	Process
General Surgery	2B and LEBI	**Surgical Hernia Repair** • **Inguinal** • **Femoral** • **Umbilical** • **Para-umbilical** • **Incisional**	Local Evidence Based interventions – criteria led and National Phase 2 Interventions ***Inguinal:*** Surgical treatment should only be offered when one of the following criteria is met: • Symptomatic i.e. symptoms are such that they interfere with work or activities of daily living **OR** • The hernia is difficult or impossible to reduce, **OR** • Inguino-scrotal hernia, **OR** • The hernia increases in size month on month ***Femoral:*** All suspected femoral hernias should be referred to secondary care due to the increased risk of incarceration/strangulation ***Umbilical/Para-umbilical and midline ventral hernias:*** Surgical treatment should only be offered when one of the following criteria is met: • pain/discomfort interfering with activities of daily living **OR**	**For Local Evidence Base and Criteria See Appendix 2** **National Based Interventions policy** EBI_list2_guidance_150321.pdf (aomrc.org.uk) **National Institute for Health and Care Excellence** (2004) laprascopic surgery for hernia repair. [TA83]. London: National Institute for Health and Care Excellence. https://www.nice.org.uk/guidance/ta83 (Accessed 2016) **Medscape: *Hernias*.** Available from: http://emedicine.medscape.com/article/775630-overview#a0104 (accessed 2016) **McIntosh A. Hutchinson A. Roberts A & Withers, H**. Evidence-based management of groin hernia in primary care—a systematic review. Family Practice, 2000;17(5), 442-447. GP notebook: *Paraumbilical hernia*s. Available from: http://www.gpnotebook.co.uk/simplepage.cfm?ID=-1811546097&linkID=17862&cook=n (accessed 2016) **Friedrich M. Müller Riemenschneider F. Roll S. Kulp W. Vauth C. Greiner W & von der Schulenburg JM**. Health Technology Assessment of laparoscopic compared to conventional surgery with and without mesh for incisional hernia repair regarding safety, efficacy and cost-effectiveness. *GMS health technology assessment*. 2008;*4*.	Refer using checklist. IFR for exceptionality.

Spec	Ref	Intervention	Criteria for treatment	Evidence Base / Local Guidance	Process
General Surgery			• Increase in size month on month **OR** • to avoid incarceration or strangulation of bowel where • hernia is ≥ 2cm ***Incisional:*** Surgical treatment should only be offered the following criteria are met: Pain/discomfort interfering with activities of daily living	**Dabbas.** Frequency of abdominal wall hernias: is classical teaching out of date. JRSM *Short Reports*: 2011;2/5. **Fitzgibbons**. Watchful waiting versus repair of inguial hernia in minimally symptomatic men, a randomised controlled trial. *JAMA*: 2006;295, 285-292 **Purkayastha S. Chow A, Anthanasiou T, Tekkis P P & Darzi A**. Ingunal hernias. *Clinical evidence, 2008;*0412, 1462-3846 **Rosenberg J. Bisgaard T. Kehlet H. Wara P. Asmussen T. Juul P & Bay-Nielsen M.** Danish Hernia Database recommendations for the management of inguinal and femoral hernia in adults. *Dan Med Bull*, 2011;*58*(2), C4243. **Simons M P. Aufenacker T. Bay-Nielsen M. Bouillot J L. Campanelli G. Conze J & Miserez, M**. European Hernia Society guidelines on the treatment of inguinal hernia in adult patients. *Hernia*, 2009;*13*(4),343-403. **Primatesta P & Goldacre MJ.** Inguinal hernia repair: incidence of elective and emergency surgery, readmission and mortality. *International journal of epidemiology*, 1996;*25*(4), 835-839.	

Spec	Ref	Intervention	Criteria for treatment	Evidence Base / Local Guidance	Process
				Patient Care Committee & Society for Surgery of the Alimentary Tract. Surgical repair of incisional hernias. SSAT patient care guidelines. Journal of gastrointestinal surgery: official journal of the Society for Surgery of the Alimentary Tract. 2004;8(3), 369. **The Society for Surgery of the Alimentary Tract**. *Surgical Repair of Groin Hernias. Available from: http://www.ssat.com/cgi-bin/hernia6.cgi* (accessed 2016*)* **National Evidence Based Interventions Policy** https://www.england.nhs.uk/wp-content/uploads/2018/11/ebi-statutory-guidance-v2.pdf	
General Surgery	2M	**Upper GI Endoscopy to investigate gut problems**	National Based Interventions policy	National Based Interventions policy:P.34 EBI_list2_guidance_150321.pdf (aomrc.org.uk)	Primary and secondary care checklist
	2N	**Appropriate Colonoscopy of the lower intestine**	National Based Interventions policy	National Based Interventions policy:P.38 EBI_list2_guidance_150321.pdf (aomrc.org.uk)	Primary and secondary care checklist
	2O	**Repeat / Follow up colonoscopy of the lower intestine**	National Based Interventions policy	National Based Interventions policy:P.38 EBI_list2_guidance_150321.pdf (aomrc.org.uk)	Secondary care checklist required
	2P	**Test of the gallbladder - ERCP in acute gallstone pancreatitis without cholangitis**	National Based Interventions policy	National Based Interventions policy:P.44 EBI_list2_guidance_150321.pdf (aomrc.org.uk)	Checklist not appropriate

Spec	Ref	Intervention	Criteria for treatment	Evidence Base / Local Guidance	Process
	2Q and LEBI	**Cholecystectomy**	National Based Interventions policy Cholecystectomy for patients with moderate or severely symptomatic gallstones will be routinely funded Patients admitted to hospital with acute cholecystitis or mild gallstone pancreatitis should have an index cholecystectomy before discharge. *This guidance may not be applicable in patients with severe acute pancreatitis* Local Evidence Based interventions – criteria led The CCG will **only** support the funding of cholecystectomy **in mild or asymptomatic gallstones if one or more of the following criteria are met:** • High risk of gall bladder cancer, e.g. *gall bladder polyps ≥1cm, porcelain gall bladder, strong family history (parent, child or sibling with gallbladder cancer). (**Annual USS for smaller asymptomatic polyps)* • Transplant recipient (pre or post-transplant).	**For Local Evidence Base and Criteria See Appendix 2** National Based Interventions policy: P.45 EBI_list2_guidance_150321.pdf (aomrc.org.uk) **Sanders G, Kingsnorth AN**. Gallstones. *BMJ*. 2007;335:295-9. **Sakorafas GH, Milingos D, Peros G.** Asymptomatic cholelithiasis: is cholecystectomy really needed? A critical reappraisal 15 years after the introduction of laparoscopic cholecystectomy. *Dig Dis Sci*. 2007;52:1313-25. **Royal College of Surgeons** https://www.rcseng.ac.uk/-/media/files/rcs/library-and-publications/non-journal-publications/gallstones--commissioning-guide.pdf **Behari A and Kapoor VK.** Asymptomatic Gallstones (AsGS) – To Treat or Not to? *Indian J Surg*. 2012;74: 4–12. **Tsirline VB, Keilani ZM, El Djouzi S *et al*.** How frequently and when do patients undergo cholecystectomy after bariatric surgery? *Surg Obes Relat Dis* 2013;1550-7289(13)00335-3. **Taylor J, Leitman IM, Horowitz M**. Is routine cholecystectomy necessary at the time of Roux-en-Y gastric bypass? *Obes Surg*. 2006;16:759-61.	Refer using secondary care checklist/ IFR for exceptionality .

Spec	Ref	Intervention	Criteria for treatment	Evidence Base / Local Guidance	Process
			• Diagnosis of chronic haemolytic syndrome by a secondary care specialist. • Increased risk of complications from gallstones, e.g. presence of stones in the common bile duct, stones smaller than 3mm with a patent cystic duct, presence of multiple stones. • Acalculus cholecystitis diagnosed by a secondary care specialist. **Exclusion Criteria:** The CCG **will not** support the funding of cholecystectomy for patients in the following scenarios: • Patients with gallstones who experience one episode of mild abdominal pain only which can safely be managed with oral analgesia in primary care/community setting. Such patients should be advised to follow a low fat diet and only require referral if: - they have further episodes, **OR**	**Caruana JA, McCabe MN, Smith AD *et al*.** Incidence of symptomatic gallstones after gastric bypass: is prophylactic treatment really necessary? *Surg Obes Relat Dis*. 2005;1(6):564-7; discussion 567-8.	

Spec	Ref	Intervention	Criteria for treatment	Evidence Base / Local Guidance	Process
			- their pain is not controlled by oral analgesia **OR** - is associated with other symptoms, i.e. vomiting • Asymptomatic gallstones in patients with diabetes mellitus. • Asymptomatic gallstones in patients undergoing bariatric surgery, unless intra-operatively the gall bladder is found to be abnormal or the presence of calculi are very apparent. In such cases it is worth considering concurrent cholecystectomy. • All patients with asymptomatic gallstones who do not meet any of the above criteria. Barnsley and Rotherham CCG patients who are asymptomatic will not be funded for cholecystectomy. Patients will be funded after one episode of mild pain		

Spec	Ref	Intervention	Criteria for treatment	Evidence Base / Local Guidance	Process
General Surgery	2R	**Appendicectomy without confirmation of appendicitis - tests to confirm appendicitis**	National Based Interventions policy	National Based Interventions policy: P.47 EBI_list2_guidance_150321.pdf (aomrc.org.uk)	Message on ICE
	LEBI	**Ingrown toe nail in secondary care**	Local Evidence Based interventions – criteria led Referral to secondary care should only be undertaken when: • the patient is in clinical need of surgical removal of ingrown toe nail, has been seen by a community podiatrist and has a documented allergic reaction to local anaesthetic preventing treatment in the community and a general anaesthetic will be needed. OR • People of all ages with infection and/or recurrent inflammation due to ingrown toenail AND who have high medical risk*. *Medical risk is determined by the referring clinician	For Local Evidence Base and Criteria See Appendix 2 Eekhof JAH, Van Wijk B, Knuistingh Neven A, van der Wouden JC. Interventions for ingrowing toenails. Cochrane Database of Systematic Reviews 2012, Issue 4. Art. No.: CD001541. DOI: 10.1002/14651858.CD001541.pub3 NICE (2016). Clinical Assessment Service: foot and ankle pathway | QP Case Study | Local practice | NICE. [online] Available at: https://www.nice.org.uk/savingsandproductivityandlocalpracticeresource?ci=http%3a%2f%2farms.evidence.nhs.uk%2fresources%2fQIPP%2f959489%2fattachment%3fniceorg%3dtrue	Refer using checklist. IFR for exceptionality For Sheffield CCG refer to community podiatry service who will determine if referral to secondary care is required.
Gynaecology	1J	**Hysterectomy for heavy menstrual bleeding**	National Evidence Based Interventions Policy	**National Evidence Based Interventions Policy** https://www.england.nhs.uk/wp-content/uploads/2018/11/ebi-statutory-guidance-v2.pdf Patient choice regarding opting out of conservative treatment only applies to levonorgestrel intrauterine system or LNG-IUS and not to the whole pathway. If	Evidence Based Intervention – refer using checklist. IFR for exceptionality

Spec	Ref	Intervention	Criteria for treatment	Evidence Base / Local Guidance	Process
				a patient declines any element then approval from IFR is required. Please note that dilatation and curettage (D&C) is NOT routinely commissioned to either diagnose or treat heavy menstrual bleeding, in line with the Evidence Based Interventions policy – see reference 1B.	
	1B	**Dilation and curettage (D&C) for heavy menstrual bleeding (HMB) in women**	Cat 1 . Not routinely commissioned	**National Evidence Based Interventions Policy** https://www.england.nhs.uk/wp-content/uploads/2018/11/ebi-statutory-guidance-v2.pdf **2020/21 National Tariff Payment System – a consultation notice**https://improvement.nhs.uk/documents/6257/2021_NTPS_statutory_consultation_notice.pdf (page 132)	exceptionality can be applied for via a clinical letter to the IFR panel.
Haematology	2EE	**Blood Transfusion**	National Evidence Based Interventions Policy	**National Evidence Based Interventions Policy P.26** EBI_list2_guidance_150321.pdf (aomrc.org.uk)	Refer to message on ICE secondary care

Spec	Ref	Intervention	Criteria for treatment	Evidence Base / Local Guidance	Process
Ophthalmology		**Meibomian cyst (Chalazia) removal**	National Evidence Based Interventions Policy	**National Evidence Based Interventions Policy** https://www.england.nhs.uk/wp-content/uploads/2018/11/ebi-statutory-guidance-v2.pdf	Evidence Based Intervention – refer using checklist. IFR for exceptionality
	LEBI	**Blepharoplasty**	Local Evidence Based interventions – criteria led. Referral should only be made for the following indication: • To relieve symptoms of blepharospasm or significant dermatitis on the upper eyelid caused by redundant tissue. **OR** • Following skin grafting for eyelid reconstruction **OR** • Following surgery for ptosis For all other individuals, the following criteria apply: • Documented patient complaints of interference with vision or visual field related activities such as difficulty reading or driving due to upper eye lid skin drooping, looking	**For Local Evidence Base and Criteria See Appendix 2** **Minhas A, Ronoh J., Badrinath P., 2008.** "Upper Eyelid Blepharoplasty for the Treatment of Functional Problems: A Brief to the Suffolk PCT Clinical Priorities Group". Suffolk PCT. **Hacker H.D. and Hollsten D.A, 1992.** "Investigation of automated perimetry in the evaluation of patients for upper lid blepharoplasty". Ophthalmic, Plastic & Reconstructive Surgery 8 (4) pp. 250-255. **Purewal B.K. and Bosniak S., 2005.** "Theories of upper eyelid blepharoplasty". Ophthalmology Clinics of North America 18 (2) pp 271-278. **American Academy of Ophthalmology, 1995.** "Functional Indications for Upper and Lower Eyelid Blepharoplasty". Ophthalmic Procedures Assessment American Journal of Ophthalmology 102 (4) pp. 693-695.	Refer using checklist. IFR for exceptionality .

Spec	Ref	Intervention	Criteria for treatment	Evidence Base / Local Guidance	Process
			through the eyelids or seeing the upper eye lid skin **AND** • There is redundant skin overhanging the upper eye lid margin and resting on the eyelashes when gazing straight ahead **AND** Evidence from visual field testing that eyelids impinge on visual fields reducing field to 120° laterally and/or 20° or less superiorly	**Kosmin A.S., Wishart P.K., Birch M.K.,** 1997. "Apparent glaucomatous visual field defects caused by dermatochalasis". Eye 11 pp. 682-686	
	LEBI	**Cataract Surgery**	Local Evidence Based interventions – criteria led All requests for the surgical removal of cataract(s) will **only** be supported by the CCG when the following applies: The total assessment score is 7 or above as per the cataract assessment and referral form Second eye surgery will be considered on the same basis as first eye surgery ***Exceptions*** Exceptions are applicable to first or second eye.	**For Local Evidence Base and Criteria See Appendix 2** **NICE Guidance** Cataracts in adults: management (NG77) https://www.nice.org.uk/guidance/ng77 NICE February 2014. Eye conditions pathway http://pathways.nice.org.uk/pathways/eye-conditions NICE guidance IPG 264. June 2008. https://www.nice.org.uk/guidance/ipg264 NICE guidance IPG 209.February 2007. http://guidance.nice.org.uk/IPG209 **Department of Health**. National Eye Care Plan (2004)	Refer using checklist. IFR for exceptionality

Spec	Ref	Intervention	Criteria for treatment	Evidence Base / Local Guidance	Process
			The only exceptions to the above referral criteria are as follows: • Anisometropia (a large refractive difference between the two eyes, on average about dioptres) which would result in poor binocular vision or disabling diplopia which may increase falls. • Angle closure glaucoma including creeping angle closure and phacomorphic glaucoma • Diabetic and other retinopathies including retinal vein occlusion and age related macular degeneration where the cataract is becoming dense enough to potentially hinder management. • Oculoplastics disorders where fellow eye requires closure as part of eye lid reconstruction or where further surgery on the ipsilateral eye will increase the risks of cataract surgery • Corneal disease where early cataract removal would reduce the	**The Royal College of Ophthalmologists**: Cataract Surgery guidelines (2004) **NHS Executive** Action on Cataracts; Good Practice Guidance (2000). **Evans JR, Fletcher AE, Wormald RP, Ng ES. Stirling S.** Prevalence of visual impairment in people aged 75 years and older in Britain: Results from the MRC trial of assessment and management of older people in the community. *Br J Ophthalmol* 2002; 86: 795-800	

Spec	Ref	Intervention	Criteria for treatment	Evidence Base / Local Guidance	Process
			chance of losing corneal clarity (e.g. Fuch's corneal dystrophy or after keratoplasty) • Corneal or conjunctival disease where delays might increase the risk of complications (e.g. cicatrising conjunctivitis) • Other glaucoma's (including open-angle glaucoma), inflammatory eye disease or medical retina disease where allowing a cataract to develop would hamper clinical decision making or investigations such as OCT, visual fields or fundus fluorescein angiography • Neuro-ophthalmological conditions where cataract hampers monitoring of disease (e.g. visual field changes) • Post Vitrectomy cataracts which hinder the retinal view or result in a rapidly progressing myopia.		

Spec	Ref	Intervention	Criteria for treatment	Evidence Base / Local Guidance	Process
			• Cataracts progress fairly rapidly following vitrectomy and are age dependent. Patients over the age of 50, especially those over 60 can have a rapid increase in the density of a cataract.		
Orthopaedics	1C	**Knee arthroscopy for patients with osteoarthritis**	Cat 1 . Not routinely commissioned	**National Evidence Based Interventions Policy** https://www.england.nhs.uk/wp-content/uploads/2018/11/ebi-statutory-guidance-v2.pdf **2020/21 National Tariff Payment System – a consultation notice**https://improvement.nhs.uk/documents/6257/2021_NTPS_statutory_consultation_notice.pdf (page 132)	exceptionality can be applied for via a clinical letter to the IFR panel.
	1D	**Injection for non-specific low back pain**	Cat 1 . Not routinely commissioned	**National Evidence Based Interventions Policy** https://www.england.nhs.uk/wp-content/uploads/2018/11/ebi-statutory-guidance-v2.pdf **2020/21 National Tariff Payment System – a consultation notice**https://improvement.nhs.uk/documents/6257/2021_NTPS_statutory_consultation_notice.pdf (page 132)	exceptionality can be applied for via a clinical letter to the IFR panel.

Spec	Ref	Intervention	Criteria for treatment	Evidence Base / Local Guidance	Process
Orthopaedics	1L	**Arthroscopic shoulder decompression for sub-acromial shoulder pain**	**See Appendix 2 for additional local guidance** The CCG will **only** fund Arthroscopic shoulder decompression for sub-acromial shoulder pain as a standalone procedure when the following criteria are all met: • Patient has had symptoms for at least 3 months from the start of treatment **AND** • Symptoms are intrusive and debilitating (for example waking several times a night, pain when putting on a coat) **AND**	**British Elbow & Shoulder Society (BESS), British Orthopaedic Association (BOA), Royal College of Surgeons for England (RCSEng)** Commissioning Guide: Subacromial Shoulder Pain https://www.boa.ac.uk/wp-content/uploads/2014/08/Subacromial-Shoulder-Commissioning-Guide_final.pdf **Evidence Based Interventions** https://www.england.nhs.uk/wp-content/uploads/2018/11/ebi-statutory-guidance-v2.pdf Commissioners have elected to follow the existing local policy for Arthroscopic shoulder decompression for sub-acromial shoulder pain.	Evidence Based Intervention – refer using checklist. IFR for exceptionality

Spec	Ref	Intervention	Criteria for treatment	Evidence Base / Local Guidance	Process
Orthopaedics			• Patient has been compliant with conservative intervention (education, rest, NSAIDs, simple analgesia, appropriate physiotherapy) for at least 6 weeks **AND** • Patient has initially responded positively to a steroid injection but symptoms have returned despite compliance with conservative management **AND** • Referral is at least 8 weeks following steroid injection **AND** Patient confirms they wish to have surgery	Although the national policy mentions that non-operative management is effective, the existing SY&B policy is clearer on the clinical criteria for conservative treatments.	
	1M	**Carpal tunnel release**	National Evidence Based Interventions Policy	**National Evidence Based Interventions Policy** https://www.england.nhs.uk/wp-content/uploads/2018/11/ebi-statutory-guidance-v2.pdf	Evidence Based Intervention – refer using checklist. IFR for exceptionality
	1N	**Dupuytren's surgery**	National Evidence Based Interventions Policy	**National Evidence Based Interventions Policy** https://www.england.nhs.uk/wp-content/uploads/2018/11/ebi-statutory-guidance-v2.pdf	Evidence Based Intervention – refer using checklist. IFR for exceptionality

Spec	Ref	Intervention	Criteria for treatment	Evidence Base / Local Guidance	Process
	1O	**Ganglion surgery**	National Evidence Based Interventions Policy	**National Evidence Based Interventions Policy** https://www.england.nhs.uk/wp-content/uploads/2018/11/ebi-statutory-guidance-v2.pdf	Evidence Based Intervention – refer using checklist. IFR for exceptionality
	1P	**Trigger finger release**	National Evidence Based Interventions Policy	**National Evidence Based Interventions Policy** https://www.england.nhs.uk/wp-content/uploads/2018/11/ebi-statutory-guidance-v2.pdf **Cost of Immediate Surgery Versus Non-operative Treatment for Trigger Finger in Diabetic Patients** https://www.ncbi.nlm.nih.gov/pubmed/27671766	Evidence Based Intervention – refer using checklist. IFR for exceptionality
Orthopaedics	2E	**Knee arthroscopy for meniscal tears**	National evidence based interventions	National Based Interventions policy: P.55 EBI_list2_guidance_150321.pdf (aomrc.org.uk)	Secondary care checklist
	2J	**Lumbar Discectomy - Spinal surgery for a slipped disc**		**National Evidence Based Interventions Policy P.29** EBI_list2_guidance_150321.pdf (aomrc.org.uk)	Secondary Care checklist
	2K	**Lumbar Radiofrequency facet joint denervation**	National Based Interventions policy	National Evidence Based Interventions Policy P.31 EBI_list2_guidance_150321.pdf (aomrc.org.uk)	Secondary Care checklist

Spec	Ref	Intervention	Criteria for treatment	Evidence Base / Local Guidance	Process
Orthopaedics	2S	**Low back pain imaging**	Not routinely commissioned	**National Evidence Based Interventions Policy. P. 50** **EBI_list2_guidance_150321.pdf (aomrc.org.uk)** **For further information please see the following NICE guidance:** **— Low back pain and sciatica in over 16s: assessment and management (November 2016)** **https://www.nice.org.uk/guidance/ng59** **— Low back pain and sciatica in over 16s: assessment and management (November 2016) - Quality statement 2: Referrals for imaging** **https://www.nice.org.uk/guidance/qs155/chapter/Quality-statement-2-Referralsfor-imaging** **— National Pathway of Care for Low Back and Radicular Pain** **https://www.nice.org.uk/guidance/ng59/resources/endorsed-resource-nationalpathway-of-care-for-low-back-and-radicular-pain-4486348909.**	ICE (not routine investigation) – not routinely commissioned
	2T	**Knee MRI when symptoms are**	National Based Interventions policy	**National Evidence Based Interventions Policy P.53** EBI_list2_guidance_150321.pdf (aomrc.org.uk)	Refer to message on ICE

Spec	Ref	Intervention	Criteria for treatment	Evidence Base / Local Guidance	Process
		suggestive of osteoarthritis			
	2U	**Knee MRI for suspected meniscal tears**	National Based Interventions policy	**National Evidence Based Interventions Policy P.18** EBI_list2_guidance_150321.pdf (aomrc.org.uk)	Secondary care checklist
Orthopaedics	2V	**Vertebral augmentation (vertebroplasty or Kyphoplasty) for painful osteoporotic vertebral fractures**	National Based Interventions policy	**National Evidence Based Interventions Policy P.57** EBI_list2_guidance_150321.pdf (aomrc.org.uk)	Secondary Care checklist
	2W	**Imaging for shoulder pain**	National Based Interventions policy	National Evidence Based Interventions Policy P. 60 EBI_list2_guidance_150321.pdf (aomrc.org.uk)	Refer to message on ICE
	2X	**MRI scan of the hip for arthritis**	National Based Interventions policy	National Evidence Based Interventions Policy P. 63 EBI_list2_guidance_150321.pdf (aomrc.org.uk)	Refer to message on ICE and IFR
	2Y	**Surgery to fuse the bones in the back for back pain - Fusion surgery for mechanical axial low back pain**	Cat 1 Not routinely commissioned	National Evidence Based Interventions Policy P.65 EBI_list2_guidance_150321.pdf (aomrc.org.uk)	exceptionality can be applied for via a clinical letter to the IFR panel

	LEBI	**Hallux Valgus**	Local Evidence Based interventions – criteria led This procedure is **not** funded for cosmetic reasons or for asymptomatic or mild symptomatic hallux valgus. • Surgery for hallux valgus will be funded if the following criteria are met and evidenced in clinic letters: • ulcer development over the site of the bunion or the sole of the foot **OR** • evidence of severe deformity (over or under riding toes) **OR** • Significant and persistent pain when walking **AND** conservative measures tried for at least six months (e.g. bunion pads / insoles / altered footwear) have failed to provide do not provide symptomatic relief in sensible shoes **OR** • Physical examination and X-ray show degenerative changes in the 1st metatarsophalangeal joint, increased intermetatarsal angle and/or valgus deformity >15 degrees.	**For Local Evidence Base and Criteria See Appendix 2** **NICE** http://pathways.nice.org.uk/pathways/musculoskeletal-conditions (accessed 2016) **National Institute of Health.** Consensus development program. Dec 2003 https://consensus.nih.gov/2003/2003totalkneereplacement117html.htm (accessed 2016) The musculoskeletal services framework – A joint responsibility: doing it differently. **Department of Health**. 2006. http://webarchive.nationalarchives.gov.uk/20130107105354/http:/www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4138412.pdf **Namba, R., Paxton, L., Fithian, D., and Stone, M.** Obesity and perioperative morbidity in total hip and total knee arthroplasty patients. J Arthroplasty 20(7) Supplement 3 (2005), 46-50. **Hawkeswood MD, J.,Reebye MD, R.** Evidence-based guidelines for the nonpharmacological treatment of osteoarthritis of the hip and knee. Issue: BCMJ, Vol. 52, No. 8, October 2010, page(s) 399-403 Articles. **College of General Practitioners.** 'Guideline for the non-surgical management of hip and knee osteoarthritis. July 2009.InterQualR. Total Joint Replacement Hip Procedures criteria. 2013.	Refer using checklist. IFR for exceptionality.

Spec	Ref	Intervention	Criteria for treatment	Evidence Base / Local Guidance	Process
				NICE. TA44 Metal on Metal Hip Resurfacing. 04 January 2013. https://www.nice.org.uk/guidance/TA2/documents/appendix-b-proposal-paper-presented-to-the-institutes-guidance-executive2 **NHS England.** Interim Clinical Commissioning Policy: Hip Resurfacing. November 2013 https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2013/11/N-SC019.pdf **Kandala NB, Connock M, Pulikottil-Jacob R, Sutcliffe P, Crowther MJ, Grove A,Mistry H Clarke A.** Setting benchmark revision rates for total hip replacement: analysis of registry evidence. BMJ 2015;350:h756 doi: 10.1136/bmj.h756 (Published 9 March 2015)	

Spec	Ref	Intervention	Criteria for treatment	Evidence Base / Local Guidance	Process
Orthopaedics	LEBI	**Hip/Knee Replacement for osteoarthritis**	Local Evidence Based interventions – criteria led Patient's clinical condition must be clearly documented during a clinical encounter prior to surgical decision and documentation must include dates and description of measures: (If more than one joint replacement is being considered **EACH** surgery requires evaluation against the criteria set forth on its own merits. Of particular note if a patient has completed a joint replacement and another joint replacement is being considered, a complete re-evaluation of their condition for functional limitations and pain will be required. Patients **DO NOT** require referral back to the GP for re referral) The CCG will **only** fund hip/knee replacement for osteoarthritis when conservative measures have failed (listed below) or its successor **AND** the following criteria have been met: • Referral to the Hip or Knee Pathway **AND** • Patient has a BMI of less than 35** (Patients with BMI>35 should be referred for weight management interventions for a minimum of 6 months. If the patient fails to lose weight to a BMI less than 35 then may consider referral through the IFR process **AND** • Intense to severe persistent pain (defined in table one provided in the checklist and documentation to support is required) which leads to severe functional limitations (defined in table two provided in the checklist and documentation to support is required), ***OR*** • Moderate to severe functional limitation (defined in table two and documentation to support is required) affecting the patients quality of life despite 6 months of conservative measures* including referral to the local hip pathway or its successor.		

Spec	Ref	Intervention	Criteria for treatment	Evidence Base / Local Guidance	Process
Orthopaedics			***Exceptions include:*** • Patients whose pain is so severe and/or mobility is compromised that they are in immediate danger of losing their independence and that joint replacement would relieve this. • Patients in whom the destruction of their joint is of such severity that delaying surgical correction would increase the technical difficulties of the procedure. • Rapid onset of severe hip pain ****Conservative measures:*** • Patient education such as elimination of damaging influence on hips/knees, activity modification (avoid impact and excessive exercise), good shock-absorbing shoes and lifestyle adjustment. Documentation of this is required. **AND** • Physiotherapy **AND** • Oral NSAIDS a minimum of 3 weeks and paracetamol based analgesics. Documentation of dates and medication types is required. ****** Not applicable to Barnsley patients due to Get Fit First Programme.		

Spec	Ref	Intervention	Criteria for treatment	Evidence Base / Local Guidance	Process
			The requirement for "Patient has a BMI of less than 35" is replaced with "Patient meets Get Fit First criteria" i.e. • Patient has a BMI of less than 30 *OR* • Patient has engaged with Get Fit First health improvement and reached target weight (lost 10% from starting weight) *OR* • If the patients completes Get Fit First health improvement but fails to achieve necessary weight loss then referral is at the discretion of the clinicians involved, however further weight will likely be advised and he surgeon may not operate due to increased risk. ** BMI not applicable to Sheffield patients <u>** Not applicable to Rotherham Patients due to the Fitter Better Sooner programme</u> • Evidence of smoking abstinence will be required prior to referral for surgery. Patients who stop smoking can be referred after 12 weeks. Patients who do not stop smoking will be referred for surgery after 9 months from initial consultation and advised to abstain from smoking for a minimum of 2 days prior to surgical intervention. This will allow a period of health improvement. • Patients who do not reduce BMI to ≤30 or make a 10% reduction from their starting weight will be referred for surgery after 9 months from initial consultation (subject to clinical opinion). <u>Note:</u> For Hip / Knee Replacement the previous BMI requirement (35) is replaced with 'Patient meets Fitter Better Sooner criteria'		

Spec	Ref	Intervention	Criteria for treatment	Evidence Base / Local Guidance	Process
Paediatrics	2Z	**Helmet therapy in the treatment of positional plagiocephaly in children**	Cat 1 Not routinely commissioned	**National Evidence Based Interventions Policy P.66** EBI_list2_guidance_150321.pdf (aomrc.org.uk)	If a clinician feels that a patient's circumstances are exceptional and may benefit from any of these treatments then they must be referred to the IFR Panel (see section 11).
Pain Clinic	LEBI	**Acupuncture**	Not Routinely Commissioned except for chronic tension type headaches and migraine	NICE Guideline NG59 https://www.nice.org.uk/guidance/ng59 NICE CKS – Migraine https://cks.nice.org.uk/migraine CG 150 Headaches in over 12s – Diagnosis and Management https://www.nice.org.uk/guidance/cg150/chapter/recommendations	Refer through IFR for exceptionality

Plastics	1E and LEBI	**Breast reduction / asymmetry and Gynaecomastia**	See 'Breast Reduction' and 'Gynaecomastia' section of Specialist Plastics Policy Summarised in Appendix 3	SY&B Commissioners have elected to follow the existing local Specialist Plastics Policy for these interventions. <u>Breast Reduction</u> Referrals for breast reduction under the national criteria would require the clinician to accurately assess the weight of breast tissue to be removed [500gms or 4 cup sizes]. Additional clinical input is required hence the recommendation to use IFR. The local policy requires a minimum G cup which has been professionally measured to ensure equity. For cases that are borderline medical photographs are requested. <u>Asymmetrical Breasts</u> For asymmetrical breasts the Evidence Based Interventions guidance states a difference of 150-200g is required whereas the local policy stipulates a difference of two cup sizes with a professional measurement. <u>Gynaecomastia</u> The national Evidence Based Interventions guidance states that surgery to correct gynaecomastia will only be commissioned for men with a history of prostate cancer. SY&B Commissioners have elected to follow the existing local Specialist Plastics policy for gynaecomastia which provides more comprehensive guidance on where this corrective intervention may be funded.	Prior Approval via IFR. Clinical Letter and questionnaire The IFR panel will provide clinical oversight on the management of these policies. Refer through IFR for exceptionality.

Spec	Ref	Intervention	Criteria for treatment	Evidence Base / Local Guidance	Process
Urology	2G	**Surgical removal of kidney stones**	National Based Interventions policy	**National Evidence Based Interventions Policy P.23** EBI_list2_guidance_150321.pdf (aomrc.org.uk)	Secondary Care checklist
	2H	**Cystoscopy for men with un-complicated lower urinary tract symptoms**	National Based Interventions policy	**National Evidence Based Interventions Policy P.25** EBI_list2_guidance_150321.pdf (aomrc.org.uk)	Primary Care checklist
	2I	**Surgical intervention for benign prostatic hyperplasia**	National Based Interventions policy	**National Evidence Based Interventions Policy P.26** EBI_list2_guidance_150321.pdf (aomrc.org.uk)	Secondary Care checklist
	2CC	**Prostate- specific antigen (PSA) testing**	National Based Interventions policy	**National Evidence Based Interventions Policy P.72** EBI_list2_guidance_150321.pdf (aomrc.org.uk)	Refer to message on ICE
	LEBI	**Male Circumcision**	Local Evidence Based interventions – criteria led Circumcision will **only** be commissioned for the following indications as confirmed by an appropriate clinician: • Phimosis (inability to retract the foreskin due to a narrow prepucial ring) • Recurrent paraphimosis (inability to pull forward a retracted foreskin)	**For Local Evidence Base and Criteria See Appendix 2** **NHS Choices.** Circumcision in adults: http://www.nhs.uk/conditions/Circumcision/Pages/Introduction.aspx (Accessed 16 January 2017) **Royal College of Surgeons**. Commissioning guide: Foreskin conditions. 2013. Available from: http://www.rcseng.ac.uk/healthcare-bodies/docs/published-guides/foreskin-conditions	Refer using checklist. IFR for exceptionality .

Spec	Ref	Intervention	Criteria for treatment	Evidence Base / Local Guidance	Process
			• Balanitis Xerotica Obliterans (chronic inflammation leading to a rigid fibrous foreskin) • Balanoposthitis (recurrent bacterial infection of the prepuce) • Recurrent febrile urinary tract infections due to an anatomical abnormality as confirmed by a secondary care Consultant e.g. Urologist, Paediatrician	**Moreno G, Corbalán J, Peñaloza B, Pantoja T**. Topical corticosteroids for treating phimosis in boys. Cochrane Database of Systematic Reviews 2014, Issue 9. Art. No.: CD008973. DOI: 10.1002/14651858.CD008973.pub2 **Liu, Yang, Chen et al**. Is steroids therapy effective in treating phimosis? A meta-analysis. Int Urol Nephrol. 2016 Mar; 48(3):335-42. doi: 10.1007/s11255-015-1184-9 **Zhu, Jia, Dai et al.** Relationship between circumcision and human papillomavirus infection: a systemic review and meta-analysis. Asian J Androl. 2016 March. http://www.ajandrology.com/article.asp?issn=1008-682X;year=2017;volume=19;issue=1;spage=125;epage=131;aulast=Zhu **Singh-Grewal D,Macdessi J, Craig J.** Circumcision for the prevention of urinary tract infection in boys: a systematic review of randomised trials and observational studies. Arch Dis Child. 2005 Aug;90(8):853-8 **Bailey RC, Moses S, Parker CB, Agot K, Maclean I, Krieger JN, et al.** Male circumcision for HIV prevention in young men in Kisumu, Kenya: a randomised controlled trial. The Lancet. 2007;369 (9562): 643–56	

Spec	Ref	Intervention	Criteria for treatment	Evidence Base / Local Guidance	Process
	LEBI	**Vasectomy under General Anaesthetic**	Not Routinely Commissioned Needle phobia is no longer an exception for this procedure	**NHS Choices** https://www.nhs.uk/conditions/contraception/vasectomy-male-sterilisation/	Refer to local service in community. Refer through IFR for exceptionality
Vascular	1Q	**Varicose vein surgery**	National Evidence Based Interventions Policy In addition the SYB Policy requires patients to have a BMI of 30 or less. (The BMI criteria will not apply for Sheffield patients). Note: If a patients BMI remains above 30, completion of Get Fit First 6 month health improvement does not negate this criterion for Barnsley patients. For Rotherham patient the Fitter Better Sooner applies. Patients who do not reduce BMI to ≤30 or make a 10% reduction from their starting weight will be referred for surgery after 9 months from initial consultation (subject to clinical opinion).	**National Evidence Based Interventions Policy** https://www.england.nhs.uk/wp-content/uploads/2018/11/ebi-statutory-guidance-v2.pdf **National Institute for Health and Care Excellence** (July 2013) Varicose veins: diagnosis and management [CG 168] London: National Institute for Health and Care Excellence. https://www.nice.org.uk/guidance/cg168/evidence/full-guideline-pdf-191485261 NICE clinical guidance 168 notes that a raised BMI is identified as factor associated with increased risk of progression of varicose veins and notes that the surgical outcome with increased BMI is worse (there is a higher risk of reoccurrence).	Evidence Based Intervention – refer using checklist. IFR for exceptionality Sheffield CCG excluded from the BMI requirement for this procedure.

15. Plastics and Fertility Procedures

15.1 Fertility

Speciality	Procedure	Commissioning Position	Evidence Base	Process
Obstetrics & Gynaecology	Reversal of Female Sterilisation	**Not Routinely Commissioned**	**National supporting evidence** NHS England Interim Commissioning Policy https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2013/11/N-SC028.pdf **Faculty of Sexual and Reproductive Healthcare (FSRH)** Clinical Guidance- Male and Female Sterilisation - Summary of Recommendations Clinical Effectiveness Unit September 2014 **http://www.fsrh.org/pdfs/MaleFemaleSterilisationSummary.pdf**	Refer through IFR for exceptionality
Obstetrics & Gynaecology	In-vitro fertilisation (IVF)/ Assisted conception	IVF is commissioned in line with the Y&H Fertility policy	Y&H Access to Infertility Treatment Policy Link for Rotherham - Access to Infertility Treatment (rotherhamccg.nhs.uk) Link for Sheffield Link for Barnsley Link for Doncasterhttps://www.doncasterccg.nhs.uk/wp-content/uploads/2020/07/Access-to-infertility-treatment-V11.1-July-2020.pdf Link for Bassetlaw	Policy applied in secondary care. Referral through IFR for exceptionality
Urology	Reversal of Male Sterilisation	**Not Routinely Commissioned** Reversal of sterilisation is not routinely commissioned. Informed consent for sterilisation requires that patients have understood the irreversible nature of the procedure. The clinician may still submit an application to sheccg.sybifr@nhs.net (safehaven) if exceptionality can be demonstrated.	**National supporting evidence** NHS England Interim Commissioning Policy https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2013/11/N-SC028.pdf **Faculty of Sexual and Reproductive Healthcare (FSRH)** Clinical Guidance- Male and Female Sterilisation - Summary of Recommendations Clinical Effectiveness Unit September 2014 **http://www.fsrh.org/pdfs/MaleFemaleSterilisationSummary.pdf**	Refer through IFR for exceptionality

15.2 Specialist Plastic Surgery Procedures

Speciality	Procedure	Commissioning Position	Process
Plastic and Cosmetic surgery	1. Abdominoplasty	**Not Routinely Commissioned** **See Appendix 3 for information on when cases may be considered on an exceptional basis and evidence base.**	Refer through IFR for exceptionality
	2. Breast Surgery 2.1 Breast Augmentation 2.2 Breast Reduction 2.3 Breast Asymmetry 2.4 Breast Reduction for gynaecomastia 2.5 Breast lift mastopexy 2.6 Correction of nipple inversion		
	3.Hair 3.1 Hair removal 3.2 Correction of male pattern baldness 3.3 Hair transplantation		
	4. Acne scarring		
	5. Buttock, thigh and arm lift surgery		
	6. Congenital vascular abnormalities		
	7. Correction of Prominent Ears		
	8. Facelift, browlift & Botulinum toxin		
	9. Labioplasty, Vaginoplasty and Hymen Reconstruction		
	10. Liposuction		
	11. Rhinoplasty		
	12. Rhinophyma		
	13. Surgical scars		
	14. Thread vein/ Telangiectasia		
	15. Tattoo removal		
	16. Surgical Repair of Torn Ear Lobes		

16. Monitoring and payment

Zero payment or Category 1 Interventions without IFRs

These procedures are not routinely commissioned. Only activity that is approved by IFR will be paid for. Any activity that does not meet this threshold will be reimbursed at £0 (zero tariff) to reflect changes to the NHS Standard Contract and National Tariff Payment System from 1 April 2019.

Category 2 Interventions and Local Evidence Based Interventions

These interventions are only commissioned when specific criteria are met. CCGs will audit adherence to Evidence Based Interventions. Where there is no evidence that the patient meets the criteria for treatment, CCGs will not pay for the patient's treatment. Service Condition 29.22 of the NHS Standard Contract makes clear that the commissioner is under no obligation to pay for activity which has been undertaken by the provider in contravention of agreed prior approval schemes.

CCGs will monitor activity and finance levels on a monthly basis through Contract Performance Meetings. A baseline will be established and activity monitored against the procedure and diagnostic codes listed in Appendix 5

Part 4
Appendices

Appendix 1 - Evidence Based Threshold Checklists

Patient Name: Address: Date of Birth: NHS Number Consultant/Service to whom referral will be made:

Please send this form with the referral letter.

Removal of Benign Skin Lesions

Instructions for use:
Please refer to policy for full details.
Primary Care clinicians need to complete the checklist and submit with referral via eRS / Secondary Care complete the checklist and file for future compliance audit.

The CCG will only fund management of benign skin lesions when **one or more** of the following criteria are met*:

Where it is safe to do so, every attempt should be made to manage benign skin lesions in primary care/community setting *provided removal would not be purely cosmetic.*	Delete as appropriate	
Diagnostic uncertainty exists and there is suspicion of malignancy ***(please refer as appropriate).***	Yes	No
The lesion is painful or impairs function and warrants removal, but it would be unsafe to do so in primary care/community setting, for example because of large size (>10mm), location (e.g. face or breast) or bleeding risk. ***Removal would not be purely cosmetic.***	Yes	No
Viral warts in immunosuppressed patients.	Yes	No
Patient scores >20 in Dermatology Life Quality Index** ***administered during a consultation with the GP or other healthcare professional.***	Yes	No

** If clinician considers need for referral/treatment on clinical grounds outside of these criteria, please refer to the individual funding requests policy for further information. If patient meets the above criteria then prior approval is not required.*

***See* http://www.dermatology.org.uk/quality/dlqi/quality-dlqi.html *for information on the use of the Dermatology Life Quality Index.*

This policy does not apply to treatment of benign skin lesions in the perianal area.

Patient Name: Address: Date of Birth: NHS Number Consultant/Service to whom referral will be made:

Please send this form with the referral letter.

Grommets for Otitis Media with Effusion in Children

Instructions for use:
Please refer to policy for full details.
Primary Care clinicians need to complete the checklist and submit with referral via eRS / Secondary Care complete the checklist and file for future compliance audit.

The CCG will only fund Grommets for Otitis Media with Effusion in children (when the following criteria are met:

In ordinary circumstances*, referral should not be considered unless the patient meets one or more of the following criteria when presenting in a Primary Care setting:	**Delete as appropriate**	
Recurrent acute otitis media - 5 or more recorded episodes in the preceding 12 month period.	Yes	No
Suspected hearing loss at home or at school / nursery,	Yes	No
Speech delay, poor educational progress due to the hearing loss, following 3 months of watchful waiting	Yes	No
Abnormal appearance of tympanic membrane	Yes	No
In ordinary circumstances*, procedure should not be considered unless the patient meets one or more of the following criteria when presenting in a Secondary Care setting:	**Delete as appropriate**	
Persistent hearing loss for at least three months (in any setting) with hearing levels of:25dBA or worse in both ears on pure tone audiometry or • 25dBA or worse or 35dHL or worse on free field audiometry testing and • Type B or C2 tympanometry	Yes	No
Suspected underlying sensorineural hearing loss	Yes	No
Atelectasis of the tympanic membrane where development of cholesteatoma or erosion of the ossicles is a risk.	Yes	No
OME in the presence of a secondary disability e.g. autistic spectrum disorder, Down's Syndrome, cleft palate.	Yes	No
Persistent OME (more than three months) with fluctuating hearing but significant delay in speech, educational attainment or social skills.	Yes	No

** If clinician considers need for referral/treatment on clinical grounds outside of these criteria, please refer to the CCG's Individual funding request policy for further information. If patient meets the above criteria then prior approval is not required.*

As the presence of a second disability such as Down's syndrome or cleft palate can predispose children to OME in such children it is left to the clinician's discretion how far this policy will apply.

Tonsillectomy

INFORMATION TO ACCOMPANY AN INDIVIDUAL FUNDING REQUEST (IFR) FOR TONSILLECTOMY (CHILDREN & ADULTS)

Instructions for Use
Please send this form to the IFR panel.
PLEASE ATTACH A BRIEF REFERRAL LETTER IN SUPPORT OF YOUR REQUEST

Patient Details	
PATIENT NAME	
DATE OF BIRTH	
NHS NUMBER	
ADDRESS	
REFERRING GP	

ADDITIONAL INFORMATION: A six month period of watchful waiting is recommended prior to referral for tonsillectomy in order to establish a pattern of symptoms.

	Delete as appropriate	
Sore throats are due to acute tonsillitis	Yes	No
Episodes of sore throat are disabling and prevent normal functioning as evidence by three of the Centor criteria (tonsillar exudates, tender anterior cervical lymph nodes, history of fever [over 38], and absence of cough).	Yes	No

Please supply ALL dates of disabling episodes of tonsillitis when your patients has been seen AND treated over the past 3 years:

	Delete as appropriate	
Two or more documented episodes of quinsy (peri-tonsillar abscess)	Yes	No
Severe halitosis secondary to tonsillar crypt debris	Yes	No
A child with failure to thrive due to difficulty swallowing secondary to tonsillar hypertrophy	Yes	No

THE COMMISSIONING CRITERIA ARE DETAILED OVERLEAF

GP Signature	
Date	

Criteria for Commissioning Tonsillectomy (Children and Adults)

The CCG will **only** fund tonsillectomy when one or more of the following criteria have been met:

- Recurrent attacks of tonsillitis as defined by:
  - Sore throats are due to acute tonsillitis which is disabling and prevents normal functioning

  AND
  - 7 or more well documented, clinically significant*, adequately treated episodes in the preceding year **OR** 5 or more such episodes in each of the preceding 2 years **OR**
    3 or more such episodes in each of the preceding 3 years

**A clinically significant episode is characterised by at least three of the following (Centor criteria):*

-Tonsillar exudate

-Tender anterior cervical lymphadenopathy or lymphadenitis

-History of fever (over 38'C)

-Absence of cough

- Two or more episodes of quinsy (peri-tonsillar abscess)
- Severe halitosis secondary to tonsillar crypt debris
- Failure to thrive (child) secondary to difficulty swallowing caused by enlarged tonsils
- Obstructive sleep disordered breathing causing severe daytime and night time symptoms

Obstructive sleep disordered breathing is defined as:

-Grade 3 or 4 tonsils AND
-Symptoms persisting for more than three months AND
-Night time symptoms- consistent snoring AND consistent wakefulness OR secondary enuresis OR witnessed apnoeas OR restlessness/excessive sweating AND
-Daytime symptoms- impaired school performance OR hyperactivity/aggression OR altered mood OR excessive tiredness

- Biopsy/removal of lesion on tonsil- notification only, prior approval not required.

National Supporting Evidence

Scottish Intercollegiate Guidelines Network
Management of sore throat and indications for tonsillectomy. A National clinical Guideline. April 2010
https://www.sign.ac.uk/assets/sign117.pdf

Evidence Based Interventions: Guidance for CCGs
https://www.england.nhs.uk/wp-content/uploads/2018/11/ebi-statutory-guidance-v2.pdf

Individual Funding Requests (IFR) should be sent to:

Alison Ball
Head of Individual Funding Requests
722 Prince of Wales Road
Sheffield S9 4EU
Safehaven Fax: 0114 3051370
Safehaven Email: sheccg.sybifr@nhs.net

Patient Name: Address: Date of Birth: NHS Number Consultant/Service to whom referral will be made:

Please send this form with the referral letter.

Haemorrhoidectomy

Instructions for use:
Please refer to policy for full details.
Primary Care clinicians need to complete the checklist and submit with referral via eRS / Secondary Care complete the checklist and file for future compliance audit.

The CCG will only fund haemorrhoidectomy when the following criteria are met:

In ordinary circumstances, referral should not be considered unless the patient meets **one or more** of the following criteria.*	**Delete as appropriate**	
Recurrent third or fourth degree combined external/internal haemorrhoids with persistent pain or bleeding **OR**	Yes	No
Irreducible and large haemorrhoids with frequently reoccurring, persistent pain or bleeding **OR**	Yes	No
Failed conservative treatment (including non-operative interventions: rubber band ligation, injection sclerotherapy, infrared coagulation/photocoagulation, bipolar diathermy and direct-current electrotherapy.)	Yes	No

**If clinician considers need for referral/treatment on clinical grounds outside of these criteria, please refer to the CCG's Individual Funding Request policy for further information. . If patient meets the above criteria then prior approval is not required.*

Patient Name: Address: Date of Birth: NHS Number Consultant/Service to whom referral will be made:

Please send this form with the referral letter.

Hysterectomy for Management of Heavy Menstrual Bleeding

Instructions for use:
To Secondary Care Clinician: Please refer to the policy for full details, and ensure there is evidence that the criteria selected are met. Complete the checklist and file for future compliance audit.

The CCG will only fund Hysterectomy when the following criteria are met:
Dilation and Curettage (D&C) is **not** routinely commissioned to either diagnose or treat heavy menstrual bleeding in line with Evidence Based Interventions Policy. Patients **WILL NOT** receive a D&C:

- As a diagnostic tool **ALONE** for heavy menstrual bleeding, **or**
- As a therapeutic treatment for heavy menstrual bleeding.

Patients **WILL** receive hysterectomy in the investigation and management of heavy menstrual bleeding only when the following criteria are met respectively for each procedure:

Please note that if a patient declines any element an application for exceptional funding must be made to the IFR team

Hysterectomy for HMB will only be funded if ALL the following criteria are met:	**Delete as appropriate**	
A levonorgestrel intrauterine system (e.g. Mirena) has been trialled for *at least 6 months* (unless declined or contraindicated) and has not successfully relieved symptoms **AND**	Yes	No
A trial of *at least 3 months each* of two other pharmaceutical treatment options has not effectively relieved symptoms (or is contraindicated, or not tolerated). These treatment options include: • NSAIDs Tranexamic acid • Combined oral contraceptive pill • Oral and injected progestogens **AND**	Yes	No
Surgical treatments such as endometrial ablation, thermal balloon ablation, microwave endometrial ablation or uterine artery embolisation (UAE) have either been ineffective or are not appropriate, or are contraindicated	Yes	No

If patient meets the above criteria then prior approval is not required. Please note that if a patient declines any element IFR must apply.

If clinician considers need for referral/treatment on clinical grounds outside of these criteria, please refer to the Individual funding request policy for further information.

Patient Name: Address: Date of Birth: NHS Number Consultant/Service to whom referral will be made:

Please send this form with the referral letter.

Meibomian cyst (Chalazion)

Instructions for use:
Please refer to policy for full details.
Primary Care clinicians need to complete the checklist and submit with referral via eRS / Secondary Care complete the checklist and file for future compliance audit.

The CCG will only fund surgical treatment of chalazia when when the following criteria are met:

In ordinary circumstances, referral should not be considered unless the patient meets **two or more** of the following criteria*	**Delete as appropriate**	
Conservative treatment has been tried for at least 3 months **AND**	Yes	No
Interferes with vision **OR**	Yes	No
Interferes with the protection of the eye due to altered lid closure or anatomy **OR**		
Is a source of infection requiring medical attention at least twice within the last six months **OR**	Yes	No
Is a source of infection causing an abscess requiring drainage	Yes	No

** If the patient does not fulfil these criteria but the clinician feels there are exceptional circumstances please refer to the Individual funding request policy for further information. If patient meets the above criteria then prior approval is not required.*

A meibomian cyst/chalazion that keeps coming back should be biopsied to rule out malignancy. Use the appropriate referral route for suspected malignancy in this case.

Patient Name: Address: Date of Birth: NHS Number Consultant/Service to whom referral will be made:

Please send this form with the referral letter.

Arthroscopic Subacromial Decompression of the Shoulder (ASAD)

Instructions for use:
Please refer to policy for full details.
Primary Care clinicians need to complete the checklist and submit with referral via eRS / Secondary Care complete the checklist and file for future compliance audit.

The CCG will only fund ASAD as a standalone procedure when the following criteria are met:

In ordinary circumstances, referral should not be considered unless the patient meets **ALL** of the following criteria.*	**Delete as appropriate**	
Patient has had symptoms for at least 3 months from the start of treatment **AND**	Yes	No
Symptoms are intrusive and debilitating (for example waking several times a night, pain when putting on a coat) **AND**	Yes	No
Patient has been compliant with conservative intervention (education, rest, NSAIDs, simple analgesia, appropriate physiotherapy) for at least 6 weeks **AND**	Yes	No
Patient has initially responded positively to a steroid injection but symptoms have returned despite compliance with conservative management **AND**	Yes	No
Referral is at least 8 weeks following steroid injection **AND**	Yes	No
Patient confirms they wish to have surgery	Yes	No

**If clinician considers need for referral/treatment on clinical grounds outside of these criteria, please refer to the CCG Individual Funding Request policy for further information. If patient meets the above criteria then prior approval is not required.*

Patient Name: Address: Date of Birth: NHS Number Consultant/Service to whom referral will be made:

Please send this form with the referral letter.

Carpal Tunnel Syndrome Surgery.

Instructions for use:
Please refer to policy for full details.
Primary Care clinicians need to complete the checklist and submit with referral via eRS / Secondary Care complete the checklist and file for future compliance audit.

The CCG will only fund Carpal Tunnel Surgery when the following criteria are met:

In ordinary circumstances, referral should not be considered unless the patient meets **one or more** of the following criteria.*	Delete as appropriate	
Severe symptoms at presentation (including sensory blunting, muscle wasting, weakness on thenar abduction or symptoms that significantly interfere with daily activities)**	Yes	No
If there is no improvement in mild-moderate symptoms after 3 months conservative management which includes nocturnal splinting used for at least 8 weeks (documentation of dates and type(s) of conservative measures is required)	Yes	No

** If clinician considers need for referral/treatment on clinical grounds outside of these criteria, please refer to the individual funding requests policy for further information. If patient meets the above criteria then prior approval is not required.*

**This criterion includes all individuals whose symptoms are severe where six months conservative management would be detrimental to the management of the condition. Evidence should be provided to demonstrate severity of symptoms.

Patient Name: Address: Date of Birth: NHS Number Consultant/Service to whom referral will be made:

Please send this form with the referral letter.

Common Hand Conditions – Dupuytren's Disease

Instructions for use:
Please refer to policy for full details.
Primary Care clinicians need to complete the checklist and submit with referral via eRS / Secondary Care complete the checklist and file for future compliance audit.

The CCG will only fund correction of Dupuytren's disease when the following criteria are met:

In ordinary circumstances, referral should not be considered unless the patient meets one of the following criteria.*	Delete as appropriate	
20 degrees or more fixed flexion at the metacarpophalangeal (MCPJ) joint **OR	Yes	No
** 20 degrees or more fixed flexion at the proximal interphalangeal (PIPJ) joint **OR**	Yes	No
Severe thumb contractures which interfere with function	Yes	No

** If clinician considers need for referral/treatment on clinical grounds outside of these criteria, please refer to the Individual funding request policy for further information. If patient meets the above criteria then prior approval is not required. ** Inability to flatten fingers or palm on table*

Patient Name: Address: Date of Birth: NHS Number Consultant/Service to whom referral will be made:

Please send this form with the referral letter.

Common Hand Conditions – Ganglions

Instructions for use:
Please refer to policy for full details.
Primary Care clinicians need to complete the checklist and submit with referral via eRS / Secondary Care complete the checklist and file for future compliance audit.

The CCG will only fund correction of Ganglion(s) when the following criteria are met:

In ordinary circumstances, referral should not be considered unless the patient meets **one** of the following criteria.*	Delete as appropriate	
Painful seed ganglia** that persist or recur after puncture/aspiration **OR**	Yes	No
Mucoid cysts that are disturbing nail growth or have a tendency to discharge (risk of septic arthritis in distal inter-phalangeal joint) **OR**	Yes	No
Wrist ganglia associated with neurological deficit, restricted hand function or severe pain	Yes	No
If the diagnosis is in doubt	Yes	No

**If clinician considers need for referral/treatment on clinical grounds outside of these criteria, please refer to The Individual funding request policy for further information. If patient meets the above criteria then prior approval is not required.*

*** A seed ganglia is a fluid filled swelling that appears at the base of the finger on the palm side.*

Patient Name: Address: Date of Birth: NHS Number Consultant/Service to whom referral will be made:

Please send this form with the referral letter.

Common Hand Conditions – Trigger Finger

Instructions for use:
Please refer to policy for full details.
Primary Care clinicians need to complete the checklist and submit with referral via eRS / Secondary Care complete the checklist and file for future compliance audit.

The CCG will only fund Trigger finger correction when the following criteria are met:

In ordinary circumstances, referral should not be considered unless the patient meets the following criteria:*	Delete as appropriate	
Failure to respond to up to two steroid injections** (one in the case of patients with diabetes mellitus) or splinting of the finger for 3-12 weeks (does not apply if the patient has had 2 previous trigger digits unsuccessfully treated with non-operative methods) **AND**	Yes	No
Loss of complete active flexion	Yes	No

*** Where injection of trigger finger is not available in primary care, please refer to MSK for this treatment*

** If clinician considers need for referral/treatment on clinical grounds outside of these criteria, please refer to the Individual funding request policy for further information. If patient meets the above criteria then prior approval is not required.*

Patient Name: Address: Date of Birth: NHS Number Consultant/Service to whom referral will be made:

Please send this form with the referral letter.

Varicose Vein Surgery

Instructions for use:
Please refer to policy for full details.
Primary Care clinicians need to complete the checklist and submit with referral via eRS / Secondary Care complete the checklist and file for future compliance audit.

Treatment of varicose veins in secondary care is considered a low priority treatment and will only be funded by the CCG if the criteria below have been met. Treatment will NOT be funded for cosmetic reasons or in pregnancy.

Patients can be considered for surgery if they meet the following criteria:	Delete as appropriate	
Patient's BMI is 30[#] or less **AND**	Yes	No
Intractable ulceration secondary to venous stasis **OR**	Yes	No
Bleeding varicose vein or if the patient is at high risk of re-bleeding. (i.e. there has been more than one episode of minor haemorrhage or one episode of significant haemorrhage from a ruptured superficial varicosity) **OR**	Yes	No
Significant and or progressive lower limb skin changes such as Varicose eczema, or lipodermatosclerosis with moderate to severe oedema proven to be caused by chronic venous insufficiency (itching is insufficient for referral) **OR**	Yes	No
Thrombophlebitis associated with severe and persistent pain requiring analgesia and affecting activities of daily living and or instrumental activities of daily living* **OR**	Yes	No
If the patient is severely symptomatic affecting activities of daily living and or instrumental activities of daily living. - **ALL** below must apply: • Symptoms must be caused by varicosity and cannot be attributed to any other comorbidities or other disease affecting the lower limb. • There must be a documented unsuccessful six month trial of conservative management.** • Evidence that symptoms are affecting activities of daily living and/or Instrumental activities of daily living.	Yes	No

[#]This criteria does not apply to Sheffield CCG patients.
After completion of the Get Fit First health improvement period, Barnsley patients must achieve a BMI below 30 in order to qualify for treatment.
After completion of the Fitter Better Sooner health improvement period, Rotherham patients must achieve a BMI below 30 in order to qualify for treatment.

*Activities of daily living include: functional mobility, eating, bathing and personal care. They can be measured using the Barthel activities of daily living index. Instrumental activities of daily living include more complex tasks such as care of others, community mobility, health management and meal preparation.
** Conservative management should include advice on walking and exercise, avoidance of activities that exacerbate symptoms, leg elevation whenever sitting and weight loss and compression stockings if appropriate.

If clinician considers need for referral/treatment on clinical grounds outside of these criteria, please refer to CCG's Individual funding request policy for further information. If patient meets the above criteria then prior approval is not required.

Patient Name: Address: Date of Birth: NHS Number Consultant/Service to whom referral will be made:

Please send this form with the referral letter.

Grommets in Adults

Instructions for use:
Please refer to policy for full details.
Primary Care clinicians need to complete the checklist and submit with referral via eRS / Secondary Care complete the checklist and file for future compliance audit.

The CCG will only fund Grommets for Adults when the following criteria are met:

In ordinary circumstances, referral should not be considered unless the patient meets one or more of the following criteria.*	**Delete as appropriate**	
Persistent hearing loss for at least 3 months with hearing levels of 25dB or worse on pure tone audiometry **OR**	Yes	No
Recurrent acute otitis media – 5 or more episodes in the preceding 12 month period **or**	Yes	No
Eustachian tube dysfunction causing pain **OR**	Yes	No
Atelectasis of the tympanic membrane where development of cholesteatoma or erosion of the ossicles is a risk **OR**	Yes	No
As a conduit for drug delivery direct to the middle ear **OR**	Yes	No
In the case of conditions e.g. nasopharyngeal carcinoma, ethmoidal cancer, maxillectomy, olfactory neuroblastoma, sinonasal cancer, and complications relating to its treatment (including radiotherapy), if judged that the risks outweigh the benefit by the responsible clinician **or**	Yes	No
Part of a more extensive procedure at Consultant's discretion such as tympanoplasty, acute otitis media with facial palsy	Yes	No

** If clinician considers need for referral/treatment on clinical grounds outside of these criteria, please refer to the Individual funding request policy for further information. If patient meets the above criteria then prior approval is not required.*

Patient Name: Address: Date of Birth: NHS Number Consultant/Service to whom referral will be made:

Please send this form with the referral letter.

Treatment of benign perianal skin lesions in secondary care

Instructions for use:
Please refer to policy for full details.
Primary Care clinicians need to complete the checklist and submit with referral via eRS / Secondary Care complete the checklist and file for future compliance audit.

The CCG will only fund surgical treatment of benign skin lesions when the following criteria are met:

In ordinary circumstances, referral should not be considered unless the patient meets **one or more** of the following criteria.*	**Delete as appropriate**	
There is clinical uncertainty about the benign nature of the skin lesion	Yes	No
Viral warts in immunocompromised patients where underlying malignancy may be masked	Yes	No
Recommended by GU Med when conservative treatment has failed	Yes	No

**If clinician considers need for referral/treatment on clinical grounds outside of these criteria, please refer to the Individual Funding Request policy for further information. If patient meets the above criteria then prior approval is not required.*

Patient Name: Address: Date of Birth: NHS Number Consultant/Service to whom referral will be made:

Management of Gall bladder disease including **mild and asymptomatic/incidental gallstones

Instructions for use:
Please refer to policy for full details.
Secondary Care to complete the checklist and file for future compliance audit.

The CCG will **only** provide funding for cholecystectomy in **mild (see policy) or asymptomatic gallstones if **one or more** of the following criteria are met:	**Delete as appropriate**	
*High risk of gall bladder cancer, e.g. gall bladder polyps ≥1cm, porcelain gall bladder, strong family history (parent, child or sibling with gallbladder cancer).	Yes	No
Transplant recipient (pre or post-transplant).	Yes	No
Diagnosis of chronic haemolytic syndrome by a secondary care specialist.	Yes	No
Increased risk of complications from gallstones, e.g. presence of stones in the common bile ductstones smaller than 3mm with a patent cystic duct, presence of multiple stones.	Yes	No
Acalculus cholecystitis diagnosed by a secondary care specialist.	Yes	No

* *(Annual USS for smaller asymptomatic polyps)*

**Barnsley and Rotherham CCG patients who are asymptomatic will not be funded for cholecystectomy. Patients will be funded after one episode of mild pain'

The CCG will continue to fund cholecystectomy for patients with moderate to severely symptomatic gallstones, and for acute cholecystitis or mild gallstone pancreatitis

Patient has moderate or severely symptomatic gallstones and agrees to surgery	Yes	No
*For a patient admitted to hospital with acute cholecystitis or mild gallstone pancreatitis, was index laparoscopic cholecystectomy performed within that admission?		

*This guidance may not be applicable in patients with severe acute pancreatitis

If clinician considers need for referral/treatment on clinical grounds outside of these criteria, please refer to the Individual Funding Request policy for further information.

If patient meets the above criteria then prior approval is not required.

Patient Name: Address: Date of Birth: NHS Number Consultant/Service to whom referral will be made:

Please send this form with the referral letter.

Surgical Repair of Hernias

Instructions for use:
Please refer to policy for full details. (This policy only applies to patients aged over 16 years). Primary Care clinicians need to complete the checklist and submit with referral via eRS / Secondary Care complete the checklist and file for future compliance audit.

PATIENTS WITH DIVARICATION OF THE RECTI SHOULD NOT BE REFERRED FOR SURGICAL OPINION

Suspected groin hernias in women should be urgent referrals (adults over 19 years)

The CCG will only fund ***inguinal*** hernia surgery when the following criteria are met:

In ordinary circumstances, referral/treatment should not be considered unless the patient meets **one or more** of the following criteria.*	**Delete as appropriate**	
Symptomatic hernias i.e. those which limit work or activities of daily living **OR**	Yes	No
Hernias that are difficult or impossible to reduce **OR**	Yes	No
Inguino-scrotal hernias **OR**	Yes	No
An increase in the size of the hernia month on month (please use your clinical discretion when referring/surgical repair of these patients)	Yes	No

**If clinician considers need for referral/treatment on clinical grounds outside of these criteria, please refer to the Individual funding request policy for further information. If patient meets the above criteria then prior approval is not required.*

Please note that for asymptomatic or minimally symptomatic inguinal hernias, the CCG advocates a watchful waiting approach (informed consent regarding the potential risks of developing hernia complications e.g. incarceration, strangulation, or bowel obstruction). Patients should also be advised regarding weight loss as appropriate.

The CCG will only fund ***umbilical, para umbilical and midline ventral*** hernia surgery when the following criteria are met:

In ordinary circumstances, referral/treatment should not be considered unless the patient meets **one or more** of the following criteria.*	**Delete as appropriate**	
Pain or discomfort interfering with activities of daily living **OR**	Yes	No
An increase in the size of the hernia month on month **OR**	Yes	No
To avoid strangulation and incarceration of bowel where hernia is ≥ 2cm	Yes	No

The CCG will only fund ***Incisional*** hernia surgery when the following criteria are met:

Pain or discomfort interfering with activities of daily living	Yes	No

All suspected femoral hernias must be referred to secondary care due to the increased risk of incarceration/ strangulation	Yes	No

Patient Name: Address: Date of Birth: NHS Number Consultant/Service to whom referral will be made:

Please send this form with the referral letter.

Upper Eyelid Blepharoplasty

Instructions for use:
Please refer to policy for full details.
Primary Care clinicians need to complete the checklist and submit with referral via eRS / Secondary Care complete the checklist and file for future compliance audit.

The CCG will only fund blepharoplasty when the following criteria are met:

In ordinary circumstances, referral should not be considered unless the patient meets **one or more** of the following criteria*	**Delete as appropriate**	
Does the patient complain of symptoms of blepharospasm or significant dermatitis on the upper eyelid caused by redundant tissue?	Yes	No
Did the patient develop symptoms following skin grafting for eyelid reconstruction?	Yes	No
Did the patient develop symptoms following surgery for ptosis?	Yes	No

** If the patient does not fulfil these criteria but the clinician feels there are exceptional circumstances please refer to the Individual funding request policy for further information. If patient meets the above criteria then prior approval is not required.*

If the above criteria are not met, does the patient meet ALL of the following exceptions:–

Is there documentation that the patient complains of interference with vision or visual field related activities such as difficulty reading or driving due to upper eye lid skin drooping, looking through the eyelids or seeing the upper eye lid skin **AND**	Yes	No
Is there redundant skin overhanging the upper eye lid margin and resting on the eyelashes when gazing straight ahead **AND**	Yes	No
Evidence from visual field testing that eyelids impinge on visual fields reducing field to 120° laterally and/or 20° or less superiorly	Yes	No

Patient Name: Address: Date of Birth: NHS Number Consultant/Service to whom referral will be made:

Please send this form with the referral letter.

Cataract Surgery

Instructions for use:

First Eye Surgery: **Please complete Part 1 and 2.**
Second Eye Surgery: Please complete Part 1 and 3.
Where a patient has been referred outside of the Cataract LES or locally commissioned service, the receiving clinician must ensure that the patient meets the Clinical Threshold. (Complete the checklist and file for future compliance audit).

The CCG will only fund Cataract Surgery, when the following criteria are met:

Part 1 - Assessment

VA Scores* VA 6/6 = 0 VA 6/9 = 1 VA 6/12 = 2 VA 6/18 = 7		**SPH**	**CYL**	**AXS**	**VA**	**Dominant Eye**	**Score**	
	R							**VA Score**
	L							

Lifestyle Questions to ask patient*	**Not at all**	**Slightly**	**Moderately**	**Very Much**
Is the patient's quality of life affected by vision difficulties (*e.g. car driving, watching TV, doing hobbies, etc?)*				
Is the patient's social functioning affected by vision difficulties (*e.g. crossing roads, recognising people, recognising coins etc?)*				

*These questions are designed to elicit the information from pts as to the effect on their lifestyle. The clinician will use the responses to weight the scoring below

Circle Score	**Yes**	**No**
Any difficulties for patient with mobility *(including aspect of travel, e.g. driving, using public transport)*?	2	0
Is the patient affected by glare in sunlight or night (*car headlights)*?	2	0
Is the patient's vision affecting their ability to carry out daily tasks?	2	0

Part 2 - First Eye Cataract Surgery

FIRST EYE TOTAL ASSESSMENT SCORE (*VA AND LIFESTYLE SCORE)*

NB: ***THE PATIENT MUST HAVE A TOTAL ASSESSMENT SCORE OF 7 TO MEET THE THRESHOLD FOR FIRST EYE SURGERY OR THE PATIENT MEETS ONE THE EXCEPTIONS (PLEASE DOCUMENT IN PART 4)***

The patient meets the Clinical Threshold for first eye cataract surgery	**Yes**	**No**

Part 3 - Second Eye Cataract Surgery

Complete Part 1 for Second Eye

SECOND EYE TOTAL ASSESSMENT SCORE (VA AND LIFESTYLE SCORE)

NB: ***THE PATIENT MUST HAVE A TOTAL ASSESSMENT SCORE OF 7 TO MEET THE THRESHOLD FOR SECOND EYE SURGERY OR THE PATIENT MEETS ONE THE EXCEPTIONS (PLEASE DOCUMENT IN PART 4)***

The patient meets the Clinical Threshold for second eye cataract surgery.	**Yes**	**No**

Part 4 - Exceptions

Exceptions are applicable to first or second eye.

The only exceptions to the referral criteria are as follows:	Delete as appropriate	
Anisometropia (a large refractive difference between the two eyes, on average about 3 dioptres), which would result in poor binocular vision or disabling diplopia which may increase the risk of falls.	Yes	No
Angle closure glaucoma including creeping angle closure and phacomorphic glaucoma	Yes	No
Diabetic and other retinopathies including retinal vein occlusion and age related macular degeneration where the cataract is becoming dense enough to potentially hinder management.	Yes	No
Oculoplastics disorders where fellow eye requires closure as part of eye lid reconstruction or where further surgery on the ipsilateral eye will increase the risks of cataract surgery	Yes	No
Corneal disease where early cataract removal would reduce the chance of losing corneal clarity (e.g. Fuch's corneal dystrophy or after keratoplasty)	Yes	No
Corneal or conjunctival disease where delays might increase the risk of complications (e.g. cicatrising conjunctivitis)	Yes	No
Other glaucoma's (including open-angle glaucoma), inflammatory eye disease or medical retina disease where allowing a cataract to develop would hamper clinical decision making or investigations such as OCT, visual fields or fundus fluorescein angiography	Yes	No
Neuro-ophthalmological conditions where cataract hampers monitoring of disease (e.g. visual field changes)	Yes	No
Post vitrectomy cataracts which hinder the retinal view or result in a rapidly progressing myopia.	Yes	No

If clinician considers need for referral/treatment on clinical grounds outside of these criteria, please refer to the CCG's Individual funding request policy for further information. If patient meets the above criteria then prior approval is not required.

*Snellen / Logmar Conversion Chart:

Snellen	Logmar
6/6	0.0
6/9	0.10 – 0.20
6/12	0.20 – 0.30
6/18	0.40 – 0.50
6/24	0.50 – 0.70
6/36	0.70 – 0.90
6/60	1.00

Patient Name: Address: Date of Birth: NHS Number Consultant/Service to whom referral will be made:

Please send this form with the referral letter.

Hallux Valgus Surgery

Instructions for use:

Please refer to policy for full details.

Primary Care clinicians need to complete the checklist and submit with referral via eRS / Secondary Care complete the checklist and file for future compliance audit.

The CCG will only fund hallux valgus surgery when the following criteria are met:

This procedure is **not** funded for cosmetic reasons or for asymptomatic or mild symptomatic hallux valgus.

In ordinary circumstances, referral should not be considered unless the patient meets **one** of the following criteria.*	**Delete as appropriate**	
Ulcer development over the site of the bunion or the sole of the foot **OR**	Yes	No
Evidence of severe deformity (over or under riding toes) **OR**	Yes	No
Significant and persistent pain when walking **AND** conservative measures (e.g. bunion pads / insoles / altered footwear) have failed to provider symptomatic relief in sensible shoes **OR**	Yes	No
Physical examination and X-ray show degenerative changes in the 1st metatarsophalangeal joint, increased intermetatarsal angle and/or valgus deformity >15 degrees	Yes	No

**If clinician considers need for referral/treatment on clinical grounds outside of these criteria, please refer to the Individual Funding Request policy for further information. If patient meets the above criteria then prior approval is not required.*

Patient Name: Address: Date of Birth: NHS Number Consultant/Service to whom referral will be made:

Please send this form with the referral letter.

Hip Replacement

Instructions for use:
Please refer to policy for full details.
Primary Care clinicians need to complete the checklist and submit with referral via eRS / Secondary Care complete the checklist and file for future compliance audit

The CCG will **only** fund hip replacement for osteoarthritis if the following criteria have been met:	**Delete as appropriate**	
Referral to the Hip Pathway **AND**	Yes	No
Patient has a BMI of less than 35. (Patients with BMI>35 should be referred for weight management interventions for a minimum of 6 months. If the BMI remains over 35 then an IFR referral could be considered**.) **AND EITHER**	Yes	No
Intense to severe persistent pain (defined in table one and documentation to support is required) which leads to severe functional limitations (defined in table two and documentation to support is required), **OR**	Yes	No
Moderate to severe functional limitation (defined in table two and documentation to support is required) affecting the patients quality of life despite 6 months of conservative measures*	Yes	No

If clinician considers need for referral/treatment on clinical grounds outside of these criteria, please refer to The CCG's Individual funding request policy for further information. If patient meets the above criteria then prior approval is not required.

*Conservative measures = oral NSAIDs, physiotherapy or referral to the Hip Referral Pathway, and paracetamol based analgesics and patient education (e.g. activity / lifestyle modification). Documentation of dates and types of conservative measures required to be included with this form.

** Not applicable to Barnsley patients due to Get Fit First Programme
** Not applicable to Rotherham patients die to Fitter Better Sooner Programme

Table 1: Classification of pain level

Pain level	
Slight	Sporadic pain.(May be daily but comes and goes 25% or less of the day) Pain when climbing/descending stairs. Allows daily activities to be carried out (those requiring great physical activity may be limited). (Able to bathe, dress, cook, and maintain house) Medication, aspirin, paracetamol or NSAIDs to control pain with no/few side effects

Moderate	Occasional pain.(May be daily and occurs 50-75% of the day) Pain when walking on level surfaces (half an hour, or standing). Some limitation of daily activities.(Occasionally has difficulty with self-care and home maintenance) Medication, aspirin, paracetamol or NSAIDs to control with no/few side effects.
Intense / Severe	Pain of almost continuous nature.(Occurs 75-100% of the day) Pain when walking short distances on level surfaces (>20ft) or standing for less than half an hour or pain when resting Daily activities significantly limited. (unable to maintain home, cook, bathe or dress without difficulty or assistance) Continuous use of NSAIDs or narcotics for treatment to take effect or no response Requires the use of support systems (walking stick, crutches).

Table 2: Functional Limitations

Minor	Functional capacity adequate to conduct normal activities and self-care Walking capacity of more than one hour No aids needed
Moderate	Functional capacity adequate to perform only a few of the normal activities and self-care Walking capacity of between half and one hour Aids such as a cane are needed occasionally
Severe	Largely or wholly incapacitated Walking capacity of less than half hour Cannot move around without aids such as a cane, a walker or a wheelchair. Help of a carer is required.

If the above criteria are not met, does the patient meet the following exceptions:–

Patients whose pain is so severe and/or mobility is compromised that they are in immediate danger of losing their independence and that joint replacement would relieve this. (Refer through IFR)	Yes	No
Patients whom the destruction of their joint is of such severity that delaying surgical correction would increase the technical difficulties of the procedure.(Refer through IFR)	Yes	No
Rapid onset of severe hip pain	Yes	No

Patients with co-morbidities should be optimised prior to referral for possible surgery

Diabetes	Hypertension	Anaemia	Sleep Apnoea
HbA1c ≤ 70 nmol/ml	**BP ≤ 160/100 Aim for 140/85 non Diabetic Aim for 140/80 Diabetic**	**Hb > 13 in men Hb > 12 in women**	**Referred for Sleep Studies with STOP BANG Score ≥ 5**

Patient Name: Address: Date of Birth: NHS Number Consultant/Service to whom referral will be made:

Please send this form with the referral letter.

Knee replacement

Instructions for use:
Please refer to policy for full details.
Primary Care clinicians need to complete the checklist and submit with referral via eRS / Secondary Care complete the checklist and file for future compliance audit.

**Fitter better sooner programme applies for Rotherham patients. See page 20 of CFO policy

The CCG will only fund knee replacement for osteoarthritis when the following criteria have been met	**Delete as appropriate**	
Referral has been made to the Knee Pathway **AND**	Yes	No
Patient has a BMI of less than 35** (Patients with BMI>35 should be referred for weight management interventions for a minimum of 6 months. If the BMI remains over 35 then an IFR referral could be considered**.) **AND**	Yes	No
Osteoarthritis of the knee causes persistent, severe pain as defined in table 1 **AND**	Yes	No
Pain from osteoarthritis of the knee leads to severe loss of functional ability and reduction in quality of life as defined in table 2 **AND**	Yes	No
Symptoms have not adequately responded to 6 months of conservative measures* OR conservative measures are contraindicated. Documentation of dates and types of measures is required.	Yes	No

If clinician considers need for referral/treatment on clinical grounds outside of these criteria, please refer to the Individual funding request policy for further details. If patient meets the above criteria then prior approval is not required.

* Conservative measures =, oral NSAIDs, physiotherapy or referral to the Knee Referral Pathway and paracetamol based analgesics, intra-articular corticosteroid injections and patient education (e.g. activity / lifestyle modification). See policy for further details.
** Not applicable to Barnsley patients due to Get Fit First Programme
** Not applicable to Rotherham patients due to Fitter Better Sooner Programme

Table 1: Classification of pain level

Pain level	
Slight	Sporadic pain.(May be daily but comes and goes 25% or less of the day) Pain when climbing/descending stairs. Allows daily activities to be carried out (those requiring great physical activity may be limited). (Able to bathe, dress, cook, and maintain house) Medication, aspirin, paracetamol or NSAIDs to control pain with no/few side effects

Moderate	Occasional pain.(May be daily and occurs 50-75% of the day) Pain when walking on level surfaces (half an hour, or standing). Some limitation of daily activities.(Occasionally has difficulty with self-care and home maintenance) Medication, aspirin, paracetamol or NSAIDs to control with no/few side effects.
Intense / Severe	Pain of almost continuous nature.(Occurs 75-100% of the day) Pain when walking short distances on level surfaces (>20ft) or standing for less than half an hour or pain when resting Daily activities significantly limited. (unable to maintain home, cook, bathe or dress without difficulty or assistance) Continuous use of NSAIDs or narcotics for treatment to take effect or no response Requires the use of support systems (walking stick, crutches).

Table 2: Functional Limitations

Minor	Functional capacity adequate to conduct normal activities and self-care Walking capacity of more than one hour No aids needed
Moderate	Functional capacity adequate to perform only a few of the normal activities and self-care Walking capacity of between half and one hour Aids such as a cane are needed occasionally
Severe	Largely or wholly incapacitated Walking capacity of less than half hour Cannot move around without aids such as a cane, a walker or a wheelchair. Help of a carer is required.

If the above criteria are not met, does the patient meet the following exceptions:–

Patients whose pain is so severe and/or mobility is compromised that they are in immediate danger of losing their independence and that joint replacement would relieve this. (Refer through IFR)	Yes	No
Patients whom the destruction of their joint is of such severity that delaying surgical correction would increase the technical difficulties of the procedure. (Refer through IFR)	Yes	No

Patients with co-morbidities should be optimised prior to referral for possible surgery

Diabetes	Hypertension	Anaemia	Sleep Apnoea
HbA1c ≤ 70 nmol/ml	**BP ≤ 160/100 Aim for 140/85 non Diabetic Aim for 140/80 Diabetic**	**Hb > 13 in men Hb > 12 in women**	**Referred for Sleep Studies with STOP BANG Score ≥ 5**

Patient Name: Address: Date of Birth: NHS Number Consultant/Service to whom referral will be made:

Please send this form with the referral letter.

Surgery for Ingrown Toenails

Instructions for use:
Please refer to policy for full details.
Primary Care clinicians need to complete the checklist and submit with referral via eRS / Secondary Care complete the checklist and file for future compliance audit.

The CCG will only fund surgery for ingrown when the following criteria are met:

*In ordinary circumstances**, referral should not be considered unless the patient meets **one** of the following criteria.*	**Delete as appropriate**	
Patient has been seen by a community podiatrist and has a documented allergic reaction to local anaesthetic preventing treatment in the community and a general anaesthetic will be needed.	Yes	No
Patient has infection and/or recurrent inflammation due to ingrown toenail **AND** has high medical risk*.	Yes	No

**Medical risk is determined by the referring clinician - including, but not limited to, vascular disease, neurological disease or diabetes which are categorised as having high medical need due to the risk of neuropathic complications.*

***If clinician considers need for referral/treatment on clinical grounds outside of these criteria, please refer to the Individual Funding Request policy for further information. If patient meets the above criteria then prior approval is not required.*

Patient Name: Address: Date of Birth: NHS Number Consultant/Service to whom referral will be made:

Please send this form with the referral letter.

Male Circumcision

Instructions for use:
Please refer to policy for full details.
Primary Care clinicians need to complete the checklist and submit with referral via eRS /
Secondary Care complete the checklist and file for future compliance audit.

The CCG will only fund male circumcision when the following criteria are met:

In ordinary circumstances, referral should not be considered unless the patient meets **one or more** of the following criteria.*	**Delete as appropriate**	
Phimosis (inability to retract the foreskin due to a narrow prepucial ring) or recurrent paraphimosis (inability to pull forward a retracted foreskin)	Yes	No
Balanitis Xerotica Obliterans (chronic inflammation leading to a rigid fibrous foreskin)	Yes	No
Balanoposthitis (recurrent bacterial infection of the prepuce).	Yes	No
Recurrent febrile urinary tract infections due to an anatomical abnormality as confirmed by a secondary care Consultant e.g. Urologist, Paediatrician	Yes	No

**If clinician considers need for referral/treatment on clinical grounds outside of these criteria, please refer to the Individual Funding Request policy for further information. If patient meets the above criteria then prior approval is not required.*

This policy does not apply to:

- Penile malignancy. Use the 2ww cancer referral pathway
- Traumatic injury where the foreskin cannot be salvaged

Patient Name: Address: Date of Birth: NHS Number Consultant/Service to whom referral will be made:

Please send this form with the referral letter.

Upper GI Endoscopy

Instructions for use:
Please refer to policy for full details.
Primary Care clinicians need to complete the checklist and submit with referral via eRS

Secondary Care complete the checklist below and file for future compliance audit.

The CCG will only fund upper GI Endoscopy when the following criteria are met*:

For the investigation of symptoms clinicians should consider endoscopy:

- Any age with gastro-oesophageal symptoms that are nonresponsive to treatment or unexplained
- With suspected GORD who are thinking about surgery
- With H pylori that has not responded to second- line eradication
- Eradication can be confirmed with a urea breath test.

Upper Endoscopy should only be performed if the patient meets one of the following criteria:	**Delete as appropriate**	
Urgent: (Within two weeks) Any dysphagia (difficulty in swallowing), to prioritise urgent assessment of dysphagia please refer to the Edinburgh Dysphagia Score **OR**	Yes	No
Aged 55 and over with weight loss and any of the following: — Upper abdominal pain — Reflux — Dyspepsia (4 weeks of upper abdominal pain or discomfort — Heartburn — Nausea or vomiting	Yes	No
Those aged 55 or over who have one or more of the following: — Treatment resistant dyspepsia (as above), upper abdominal pain with low haemoglobin level (blood level) **OR** — Raised platelet count with any of the following: nausea, vomiting, weight loss, reflux, dyspepsia, upper abdominal pain **OR** — Nausea and vomiting with any of the following: weight loss, reflux, dyspepsia, upper abdominal pain.	Yes	No
For the assessment of Upper GI bleeding: — For patients with haematemesis, calculate Glasgow Blatchford Score at presentation and any high-risk patients should be referred — Endoscopy should be performed for unstable patients with severe acute upper gastrointestinal bleeding immediately after resuscitation	Yes	No

— Endoscopy should be performed within 24 hours of admission for all other patients with upper gastrointestinal bleeding.		
For the investigation of symptoms: — Clinicians should consider endoscopy: — Any age with gastro-oesophageal symptoms that are nonresponsive to treatment or unexplained — With suspected GORD who are thinking about surgery — With H pylori that has not responded to second- line eradication • Eradication can be confirmed with a urea breath test.	Yes	No
For the management of specific cases		
For H pylori and associated peptic ulcer: Eradication can be confirmed with a urea breath test, however if peptic ulcer is present repeat endoscopy should be considered 6-8 weeks after beginning treatment for H pylori and the associated peptic ulcer	Yes	No
For Barrett's oesophagus: • The non-endoscopic test called Cytosponge can be used (where available) to identify those who have developed Barrett's oesophagus as a complication of long-term reflux and thus require long term surveillance for cancer risk • Consider endoscopy to diagnose Barrett's Oesophagus if the person has GORD (endoscopically determined oesphagitis or endoscopy – negative reflux disease) • Consider endoscopy surveillance if person is diagnosed with Barrett's Oesophagus.	Yes	No
For coeliac disease: Patients aged 55 and under with suspected coeliac disease and anti-TTG >10x reference range should be treated for coeliac disease on the basis of positive serology and without endoscopy or biopsy.	Yes	No
Surveillance endoscopy: • Surveillance endoscopy should only be offered in patients fit enough for subsequent endoscopic or surgical intervention, should neoplasia be found. Many of this patient group are elderly and/or have significant comorbidities. Senior clinician input is required before embarking on long term endoscopic surveillance • Patients diagnosed with extensive gastric atrophy (GA) or gastric intestinal metaplasia, (GIM) (defined as affecting the antrum and the body) should have endoscopy surveillance every three years • Patients diagnosed with GA or GIM just in the antrum with additional risk factors- such as strong family history of gastric cancer of persistent Hpylori infection, should undergo endoscopy every three years.	Yes	No
Screening endoscopy can be considered in: • European guidelines (2015) for patients with genetic risk factors / family history of gastric cancer recommend genetics referral first	Yes	No

before embarking on long term screening. Screening is not appropriate for all patients and should be performed in keeping with European expert guidelines • Patients where screening is appropriate, for individuals aged 50 and over, with multiple risk factors for gastric cancer (e.g. H. Pylori infection, family history of gastric cancer - particularly in first degree relative -, pernicious anaemia, male, smokers).		
Post excision of adenoma: • Following complete endoscopic excision of adenomas, gastroscopy should be performed at 12 months and then annually thereafter when appropriate.	Yes	No

** If clinician considers need for referral/treatment on clinical grounds outside of these criteria, please refer to the individual funding requests policy for further information. If patient meets the above criteria then prior approval is not required.*

Endoscopy should be offered only as recommended in guidance from NICE and the British Society for Gastroenterology which are incorporated in the guidance.
NICE guideline on coeliac disease: recognition, assessment and management | The British Society of Gastroenterology (bsg.org.uk)

*Glasgow-Blatchford Bleeding Score (GBS) - MDCalc

Patient Name: Address: Date of Birth: NHS Number Consultant/Service to whom referral will be made:

Please send this form with the referral letter.

Surgical intervention for chronic rhinosinusitis

Instructions for use:
Please refer to policy for full details.
Primary Care clinicians need to complete the checklist and submit with referral via eRS

Evidence Based Interventions Phase II policy confirms that referral to secondary care will only be funded when the following criteria are met:

	Delete as appropriate	
In ordinary circumstances, referral should not be considered unless the following criteria are met*		
A clinical diagnosis of chronic rhinosinusitis has been made in primary care and patient still has moderate/ severe symptoms after a 3-month trial of intranasal steroids and nasal saline irrigation	Yes	No
In the case of chronic rhinosinusitis with nasal polyps there has been no improvement in symptoms 4 weeks after a trial of 5-10 days of oral steroids (0.5mg/kg to a max of 60 mg)	Yes	No
Patient has nasal symptoms with an unclear diagnosis in primary care	Yes	No

**If clinician considers need for referral/treatment on clinical grounds outside of these criteria, please refer to the CCG's Individual Funding Request policy for further information*

Any patient with unilateral symptoms or clinical findings, orbital, or neurological features should be referred urgently / via 2-week wait depending on local pathways

Patient Name: Address: Date of Birth: NHS Number Consultant/Service to whom referral will be made:

Please send this form with the referral letter.

Knee MRI for suspected meniscal tears

Please refer to National Guidance for full details, complete the checklist and file for future compliance audit.

Evidence Based Interventions Phase II policy confirms this investigation will only be funded when the following criteria are met:

The majority of patients who initially present in primary care with knee symptoms, no red flags and no history of acute knee injury or a locked knee do not need an MRI investigation and can be treated with non-operative supportive measures.

In ordinary circumstances, referral for MRI for meniscal tears should only be considered if the patient has the one of the following:*	**Delete as appropriate**	
• clear history of a significant acute knee injury and mechanical symptoms	Yes	No
• locked knee	Yes	No
• persistent mechanical knee symptoms of more than three months duration	Yes	No

**If clinician considers need for intervention on clinical grounds outside of these criteria, please refer to the Individual funding request policy for further information. If patient meets the above criteria then prior approval is not required.*

Appropriate Colonoscopy in the management of hereditary colectoral cancer

Please refer to National Guidance for full details, complete the checklist and file for future compliance audit.

Evidence Based Interventions Phase II policy confirms this investigation/procedures will only be funded when the following criteria are met:

Colonoscopy should only be offered to at risk people identified through risk stratification Colonoscopy should not be used as first-line investigation in all patients. Colonoscopy is an invasive procedure which carries a small risk of serious complications, for example intestinal perforation. Colonoscopy should be offered only as recommended by British Society for Gastroenterology which is incorporated in this guidance. Risk stratification is instead recommended to identify at-risk patients, and non-invasive tests and other procedures such as a Faecal Immunochemical Test (FIT test) should be used as a first-line investigation where appropriate.

The relevant BSG colonoscopy surveillance guidelines should be followed.

British Society of Gastroenterology surveillance guidelines for colonoscopy in the management of hereditary colorectal cancer: https://www.bsg.org.uk/resource/guidelines-for-the-management-of-hereditary-colorectal-cancer.html.

	Yes	No
Family history of CRC		
For individuals with moderate familial CRC risk:		
• Offer one-off colonoscopy at age 55 years		
• Subsequent colonoscopic surveillance should be performed as determined by post-polypectomy surveillance guidelines.		
For individuals with high familial CRC risk (a cluster of 3x FDRs with CRC across >1 generation):		
• Offer colonoscopy every 5 years from age 40 years to age 75 years.		
Lynch Syndrome (LS) and Lynch-like Syndrome		
For individuals with LS that are *MLH1* and *MSH2* mutation carriers:		
• Offer colonoscopic surveillance every 2 years from age 25 years to age 75 years.		
• For individuals with LS that are *MSH6* and *PMS2* mutation carriers:		
• Offer colonoscopic surveillance every 2 years from age 35 years to age 75 years.		
For individuals with Lynch-like Syndrome with deficient MMR tumours without hypermethylation/BRAF pathogenic variant and no pathogenic constitutional pathogenic variant in MMR genes (and their unaffected FDRs), and no evidence of biallelic somatic MMR gene inactivation:		
• Offer colonoscopic surveillance every 2 years from age 25 years to age 75 years.		
Early Onset CRC (EOCRC)		
For individuals diagnosed with CRC under age 50 years, where hereditary CRC symptoms have been excluded:		
• Offer standard post-CRC colonoscopy surveillance after 3 years		
• Then continue colonoscopic surveillance every 5 years until eligible for national screening.		
Serrated Polyposis Syndrome (SPS)		
For individuals with SPS:		
• Offer colonoscopic surveillance every year from diagnosis once the colon has been cleared of all lesions >5mm in size		

• If no polyps ≥ 10mm in size are identified at subsequent surveillance examinations, the interval can be extended to every 2 years.		
For first degree relatives of patients with SPS:		
• Offer an index colonoscopic screening examination at age 40 or ten years prior to the diagnosis of the index case		
• Offer a surveillance colonoscopy every 5 years until age 75 years, unless polyp burden indicates an examination is required earlier according to post-polypectomy surveillance guidelines.		
Multiple Colorectal Adenoma (MCRA)		
For individuals with MCRA (defined as having 10 or more metachronous adenomas):		
• Offer annual colonoscopic surveillance from diagnosis to age 75 years after the colon has been cleared of all lesions >5mm in size — If no polyps 10mm or greater in size are identified at subsequent surveillance examinations, the interval can be extended to 2 yearly.		
Familial Adenomatous Polyposis (FAP)		
For individuals confirmed to have FAP on predictive genetic testing:		
• Offer colonoscopic surveillance from 12-14 years		
• Then offer surveillance colonoscopy every 1-3 years, personalised according to colonic phenotype.		
For individuals who have a first degree relative with a clinical diagnosis of FAP (i.e. “at risk”) and in whom a *APC* mutation has not been identified:		
• Offer colorectal surveillance from 12-14 years		
• Then offer every 5 years until either a clinical diagnosis is made and they are managed as FAP or the national screening age is reached.		
MUTYH-associated Polyposis (MAP)		
For individuals with MAP:		
• Offer colorectal surveillance from 18-20 years, and if surgery is not undertaken, repeat annually.		
For monoallelic MUTYH pathogenic variant carriers:		
• The risk of colorectal cancer is not sufficiently different to population risk to meet thresholds for screening and routine colonoscopy is not recommended.		
Peutz-Jeghers Syndrome (PJS)		
For asymptomatic individuals with PSJ:		
• Offer colorectal surveillance from 8 years		
• If baseline colonoscopy is normal, deferred until 18 years, however if polyps are found at baseline examination, repeat every 3 years.		
For symptomatic patients, investigate earlier.		
Juvenile Polyposis Syndrome (JPS)		
For asymptomatic individuals with JPS:		
• Offer colorectal surveillance from 15 years		
• Then offer a surveillance colonoscopy every 1-3 years, personalised according to colorectal phenotype.		
For symptomatic patients, investigate earlier.		
For some patients with multiple risk factors for CRC, for example those with Lynch Syndrome and inflammatory bowel disease/multiple polyps, more frequent colonoscopy may be indicated. This needs to be guided by clinicians but with a clear scientific rationale linked to risk management.		

**If clinician considers need for colonoscopy on clinical grounds outside of these criteria, please refer to the CCG’s Individual Funding Request policy for further information.*

Repeat Colonoscopy of the lower intestine

Please refer to National Guidance for full details, complete the checklist and file for future compliance audit.

Evidence Based Interventions Phase II policy confirms this investigation/procedures will only be funded when the following criteria are met:

Surveillance colonoscopy is not always recommended following surgical resection of colorectal lesions. Surveillance colonoscopy should be offered only as recommended by the British Society for Gastroenterology which is incorporated in this guidance. Instead, risk stratification is recommended to identify patients who require follow up colonoscopy.

The relevant BSG colonoscopy surveillance guidelines should be followed

Follow the British Society of Gastroenterology surveillance guidelines for post-polypectomy and post-colorectal cancer resection:
https://www.bsg.org.uk/resource/bsg-acpgbi-phe-post-polypectomy-and-post-colorectalcancer-resection-surveillance-guidelines.html

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Risk Surveillance Criteria for Colonoscopy	Yes	No
Either of the following put individuals at high-risk for future colorectal cancer following polypectomy: — 2 or more premalignant polyps including at least one advanced colorectal polyp (defined as a serrated polyp of at least 10mm in size **OR** containing any grade of dysplasia, or an adenoma of at least 10mm in size or containing high-grade dysplasia); **OR** — 5 or more premalignant polyps.	**Yes**	**No**
Surveillance colonoscopy after polypectomy **For individuals at high-risk and under the age of 75 and whose life expectancy is greater than 10 years:** — Offer one-off surveillance colonoscopy at 3 years.	Yes	No
For individuals with no high-risk findings: — No colonoscopic surveillance should be undertaken — Individuals should be strongly encouraged to participate in their national bowl screening programme when invited. **For individuals not at high-risk who are more than 10 years younger than the national bowel screening programme lower age-limit, consider for surveillance colonoscopy after 5 or 10 years, individual to age and other risk factors.**	Yes	No
Surveillance colonoscopy after potentially curative CRC resection:	Yes	No

— Offer a clearance colonoscopy within a year after initial surgical resection — Then offer a surveillance colonoscopy after a further 3 years — Further surveillance colonoscopy to be determined in accordance with the post-polypectomy high-risk criteria.		
Surveillance after pathologically en bloc R0 EMR or ESD of LNPCPs or early polyp cancers: — No site-checks are required — Offer surveillance colonoscopy after 3 years — Further surveillance colonoscopy to be determined in accordance with the post-polypectomy high-risk criteria.	Yes	No
Surveillance after piecemeal EMR or ESD of LNPCPs (large nonpedunculated colorectal polyps of at least 20mm in size): — Site-checks at 2-6 months and 18 months from the original resection. Once no recurrence is confirmed, patients should undergo post-polypectomy surveillance after 3 years — Further surveillance colonoscopy to be determined in accordance with the post-polypectomy high-risk criteria.	Yes	No
Surveillance where histological completeness of excision cannot be determined in patients with: (i) a non-pedunculated polyps of 10-19mm in size, or (ii) an adenoma containing high-grade dysplasia, or (iii) a serrated polyp containing any dysplasia: — Site-check should be considered within 2-6 months — Further surveillance colonoscopy to be determined in accordance with the post-polypectomy high-risk criteria	Yes	No
Ongoing colonoscopic surveillance: — To be determined by the findings at each surveillance procedure, using the high-risk criteria to stratify risk — Where there are no high-risk findings, colonoscopic surveillance should cease but individuals should be encouraged to participate in the national bowel screening programme when invited.	**Yes**	**No**

**If clinician considers need for referral/treatment on clinical grounds outside of these criteria, please refer to the CCG's Individual Funding Request policy for further information.*

Arthroscopic surgery for meniscal tears

Please refer to National Guidance for full details, complete the checklist and file for future compliance audit.

Evidence Based Interventions Phase 2 policy confirms this investigation/procedure will only be funded when the following criteria are met:

The vast majority of patients with a meniscal tear should be initially treated non-operatively and should not have arthroscopic meniscectomy as a first line treatment. Non-operative treatment is highly effective with patient education using verbal and written materials, physiotherapy and weight loss interventions. Exercise should comprise both local muscle strengthening and general aerobic fitness. Paracetamol and topical NSAIDs should be first line pharmacological pain management strategies. Many patients treated this way will improve and do not require surgery.

	Delete as appropriate	
In ordinary circumstances, arthroscopic meniscal surgery should only be offered as a first line treatment when the following criteria apply:*		
The patient has a locked knee	Yes	No
The patient has a bucket handle tear of the meniscus is present	Yes	No
Patient has had an acute injury and an MRI scan reveals a potentially repairable meniscus tear	Yes	No
Patients considering arthroscopic knee surgery should go through a shared decision-making process	Yes	No

**If clinician considers need for surgical intervention on clinical grounds outside of these criteria, please refer to the CCG's Individual Funding Request policy for further information.*

Cystoscopy for men with uncomplicated lower urinary tract symptoms

Please refer to National Guidance for full details, complete the checklist and file for future compliance audit.

Evidence Based Interventions Phase II policy confirms this investigation/procedure will only be funded when the following criteria are met:

Assessment of men with LUTS should focus initially on a thorough history and examination, complemented by use of a frequency – volume chart, urine dipstick analysis and International Prostate Symptom Score where appropriate. This assessment may be initiated in primary care settings.

Specialist assessment should also incorporate a measurement of flow rate and post void residual volume.

In the context of male lower urinary tract symptoms (LUTS), cystoscopy may offer indirect evidence regarding an underlying cause (commonly prostatic enlargement, for example).

This guidance applies to male adults aged 19 years and over.

	Delete as appropriate	
In ordinary circumstances, cystoscopy should only be offered to men with LUTS in the presence of the following features from their history:*		
Recurrent infection	Yes	No
Sterile pyuria	Yes	No
Haematuria	Yes	No
Profound symptoms	Yes	No
Pain	Yes	No
Additional information may also inform clinical decision making around the use of cystoscopy in men with LUTS. Such factors might include but not limited to		
Smoking history	Yes	No
Travel or occupational history suggesting high risk of malignancy	Yes	No
Previous surgery	Yes	No

**If clinician considers need for referral/treatment on clinical grounds outside of these criteria, please refer to the CCG's Individual Funding Request policy for further information.*

Surgical removal of kidney stones

Please refer to NICE NG118 (recommendation 1.5) for full details on the assessment and management of renal and ureteric stones:
https://www. nice.org.uk/guidance/ng118/chapter/Recommendations.

Evidence Based Interventions Phase II policy confirms this investigation will only be funded when the following criteria are met:

Adult renal stones

Size		Yes	No
< 5mm	If asymptomatic, was watchful waiting considered?		
5-10mm	Was watchful waiting considered?		
	Was shockwave lithotripsy(SWL) first line treatment?		
10-20mm	Was SWL first line treatment		
	Was ureteroscopy (URS) second line treatment if SWL contraindicated/ineffective?		
> 20mm	(including staghorn) was percutaneous nephrolithotomy (PCNL) performed?		

Adult ureteric stones

Size		Yes	No
<5mm	If asymptomatic was watchful waiting (with medical therapy e.g. Alpha blocker for use with distal stones) considered?		
5-10mm	Was SWL first-line treatment?		
10-20mm	Was SWL considered?		
10-20mm	Was URS first line treatment? Y/N		

Surgical intervention for benign prostatic hyperplasia

Please refer to National Guidance for full details, complete the checklist and file for future compliance audit.

Evidence Based Interventions Phase II policy confirms this procedure will only be funded when the following criteria are met:

	Delete as appropriate	
In ordinary circumstances,surgical intervention should not be considered unless the following criteria are met*		
Surgery should only be offered to men with severe voiding symptoms	Yes	No
Conservative management options and drug treatment have been unsuccessful	Yes	No
History of urinary tract infections, bladder stones or urinary retention, or bothersome and persistent LUTS alongside high or unchanged International Prostate Symptom Scores	Yes	No
If surgical intervention is considered patient has been counselled thoroughly regarding alternatives to and outcomes from surgery. *(Complications of the intervention vary and include discomfort, bleeding, and rarely urinary incontinence).*	Yes	No

**If clinician considers need for surgical intervention on clinical grounds outside of these criteria, please refer to the CCG's Individual Funding Request policy for further information.*

Surgical intervention for chronic rhinosinusitis

Please refer to National Guidance for full details, complete the checklist in secondary care and file for future compliance audit.

Evidence Based Interventions Phase II policy confirms this procedure will only be funded when the following criteria are met:

There are a number of medical conditions whereby endoscopic sinus surgery may be required outside of the criteria listed in the box below and in these cases they should not be subjected to the criteria and continue to be routinely funded: These conditions are as follows:

- Any suspected or confirmed neoplasia
- Emergency presentations with complications of sinusitis (e.g. orbital abscess, subdural or intracranial abscess)
- Patients with immunodeficiency
- Fungal Sinusitis
- Patients with conditions such as Primary Ciliary Dyskinesia, Cystic Fibrosis or NSAID-Eosinophilic Respiratory Disease (NSAID-ERD, Samter's Triad, Aspirin Sensitivity, Asthma, CRS)
- Treatment with topical and / or oral steroids contra-indicated.
- As part of surgical access or dissection to treat non-sinus disease (e.g. pituitary surgery, orbital decompression for eye disease, nasolacrimal surgery if possible, by nasal endoscopy and/or a CT sinus scan.

	Delete as appropriate	
Patients can be considered for endoscopic sinus surgery when the following criteria are met:		
A diagnosis of CRS has been confirmed from clinical history and nasal endoscopy and / or CT scan AND	Yes	No
Disease-specific symptom patient reported outcome measure confirms moderate to severe symptoms e.g. Sinonasal Outcome Test (SNOT-22) after trial of appropriate medical therapy (including counselling on technique and compliance) as outlined in RCS/ENT-UK commissioning guidance 'Recommended secondary care pathway'. AND	Yes	No
Pre-operative CT sinus scan has been performed and confirms presence of CRS. Note: a CT sinus scan does not necessarily need to be repeated if performed sooner in the patient's pathway. AND	Yes	No
Patient and clinician have undertaken appropriate shared decision making consultation regarding undergoing surgery including discussion of risks and benefits of surgical intervention. OR	Yes	No
In patients with recurrent acute sinusitis, nasal examination is likely to be relatively normal. Ideally, the diagnosis should be confirmed during an acute attack	Yes	No

**If clinician considers need for clinical intervention on clinical grounds outside of these criteria, please refer to the CCG's Individual Funding Request policy for further information.*

Removal of adenoids in glue ear

Please refer to National Guidance for full details, complete the checklist and file for future compliance audit.

Evidence Based Interventions Phase II policy confirms this procedure will only be funded when the following criteria are met:

Adjuvant adenoidectomy should not be routinely performed in children undergoing grommet insertion for the treatment of otitis media with effusion.

The following checklist should be completed and referral to IFR panel made in all cases.

	Delete as appropriate	
Adjuvant adenoidectomy for the treatment of glue ear should only be offered when one or more of the following clinical criteria are met:		
• The child has persistent and / or frequent nasal obstruction which is contributed to by adenoidal hypertrophy	Yes	No
• The child is undergoing surgery for re-insertion of grommets due to recurrence of previously surgically treated otitis media with effusion	Yes	No
• The child is undergoing grommet surgery for treatment of recurrent acute otitis media	Yes	No

This guidance only refers to children undergoing adenoidectomy for the treatment of glue ear and should not be applied to other conditions where adenoidectomy should continue to be routinely funded. These include:

- As part of treatment for obstructive sleep apnoea or sleep disordered breathing in children (e.g. as part of adenotonsillectomy)
- As part of the treatment of chronic rhinosinusitis in children
- For persistent nasal obstruction in children and adults with adenoidal hypertrophy
- In preparation for speech surgery in conjunction with the cleft surgery team

**All requests for this treatment should be referred to the CCG's Individual Funding Request panel and should be accompanied by a clinical letter and a copy of the GP referral.*

Diagnostic coronary angiography for low risk, stable chest pain

Please refer to National Guidance for full details, complete the checklist and file for future compliance audit.

Evidence Based Interventions Phase II policy confirms this investigation will only be funded when the following criteria are met:

NICE guidelines recommend that where a diagnosis of chest pain cannot, by clinical assessment alone, exclude stable angina, 64-slice CT coronary angiography should be offered as first-line. Invasive coronary angiography should only be offered to patients with significant findings on CT coronary angiogram or with inconclusive further imaging.

When results of non-invasive functional imaging are inconclusive and patients are assessed as having low risk, stable cardiac pain, invasive coronary angiography (cardiac catheterisation) should be offered only as third-line investigation. Patients who have chest pain that is not an Acute Coronary Syndrome (ACS), but there is concern that it is due to an ischemic cause (stable angina) should, in the first instance, be offered a CT Coronary angiography (64 slice or above).

Invasive coronary angiography should be offered to patients who meet one of the following criteria:	**Delete as appropriate**	
There have been significant findings on the patients CT coronary angiogram ie ≥ 70% diameter stenosis of at least one major epicardial artery segment or ≥ 50% diameter stenosis in the left main coronary artery.	Yes	No
There has been inconclusive CT coronary angiography AND inconclusive functional imaging for myocardial ischemia in the following forms	Yes	No
— Stress echocardiography; or	Yes	No
— First-pass contrast-enhanced magnetic resonance (MR) stress perfusion; or	Yes	No
— MR imaging for stress-induced wall motion abnormalities; or	Yes	No
— Fractional flow reserve CT (FFR-CT); or	Yes	No
— Myocardial perfusion scintigraphy with single photon emission computed tomography (MPS with SPECT).	Yes	No

**If clinician considers need for procedure on clinical grounds outside of these criteria, please refer to the CCG's Individual Funding Request policy for further information.*

Lumbar discectomy

Please refer to National Guidance for full details, complete the checklist and file for future compliance audit.

Evidence Based Interventions Phase II policy confirms this procedure will only be funded when the following criteria are met:

Discectomy may be offered to patients with compressive nerve root signs and symptoms lasting > 3 months despite best efforts with non-operative management. (previously 6 weeks)

In ordinary circumstances, the surgeon should not consider discectomy unless the patient meets the following criteria.*	**Delete as appropriate**	
Patient has experienced compressive nerve root signs and symptoms lasting three months or more (except in severe cases) despite best efforts with non-operative management.	Yes	No

**If clinician considers need for surgical intervention on clinical grounds outside of these criteria, please refer to the CCG's Individual Funding Request policy for further information.*

***Please note: This guideline is not intended to cover patients who demonstrate a deterioration in neurological function (e.g. objective weakness, sexual dysfunction, cauda equina syndrome). These patients require an urgent referral to an acute spinal centre for further evaluation and imaging, as non-operative treatment may lead to irreversible harm*.**

Appendix 2 – Procedures with information on ICE
Procedures not requiring checklist, but information should be put on ICE

Table 2 below lists the procedures to which the national Evidence Based Interventions Phase 2 guidance applies. These interventions do not require a checklist but may require information to be placed on ICE.

Table 2

Procedure	Guidance for ICE
2F **Troponin test**	National Based Interventions policy: P.21 EBI_list2_guidance_050121.pdf (aomrc.org.uk) Troponin testing should be used to diagnose acute myocardial infarction, in suspected myocarditis and the monitoring of chemotherapy related myocardial damage. Troponin testing should only be used in cases where a clinical diagnosis of acute coronary syndrome is suspected or for prognostic purposes when pulmonary embolism is confirmed. High-sensitivity troponin measurements should not be considered in isolation but interpreted alongside the clinical presentation, the time from onset of symptoms, the 12-lead resting ECG, pre-test probability of NSTEMI, the possibility of chronically elevated troponin levels in some people and that 99th percentile thresholds for troponin I and T may differ between sexes. If ACS is not suspected, high-sensitivity troponin test should not be used. For people at low risk of myocardial infarction only perform a second high sensitivity troponin test if the first troponin test at presentation is positive. Diagnosis of myocardial infarction is the detection of a rise and/or fall of cardiac troponin with at least one value above the 99th percentile of the upper reference limit and at least one of the following: — symptoms suggesting myocardial ischaemia — new / presumed new significant ST-segment-T wave (ST-T) changes or new left bundle branch block (LBBB) — development of pathological Q waves on the ECG — imaging evidence of new loss of viable myocardium or new regional wall motion abnormality — identification of an intracoronary thrombus by angiography. The appropriate use of high-sensitivity troponin testing should reduce the need for further investigation, result in shorter stays in hospital and overall result in cost-savings (if used in an early rule out clinical protocol).

	According to this recommendation, if acute coronary syndrome is suspected in a primary care setting, a referral should be made for prompt investigation and treatment.
2P **ERCP in acute gallstone pancreatitis without cholangitis**	National Based Interventions policy: P.44 EBI_list2_guidance_050121.pdf (aomrc.org.uk) Early endoscopic retrograde cholangiopancreatography (ERCP) for acute gallstone pancreatitis without cholangitis is not recommended. Early ERCP in the treatment of acute gallstone pancreatitis, should only be performed if there is evidence of cholangitis or ongoing obstruction of the biliary tree. Early ERCP refers to ERCP being performed on the same admission, ideally within 24 hours.
2R **Appendicectomy without confirmation of appendicitis**	National Based Interventions policy: P.48 EBI_list2_guidance_050121.pdf (aomrc.org.uk) Consider imaging of patients with the suspicion of acute appendicitis in a defined clinical pathway. Where patients present with a high clinical suspicion of appendicitis, then imaging may not be necessary. If there is clinical doubt then imaging can reduce the negative appendicectomy rate. Most patients should have an ultrasound as the first-line investigation. If the diagnosis remains equivocal, a contrast-enhanced CT (CECT, preferably low dose) can be performed to give a definitive diagnosis prior to the patient returning to the surgical unit for a decision on management. A pathway like this is dependent on the availability of an adequately skilled Radiologist (Consultant or Registrar) or Sonographer to perform the ultrasound assessment in a timely fashion. If this is not possible discretion should be used to proceed directly to limited dose CECT of the abdomen and pelvis.
2S **Imaging for lower back pain**	National Based Interventions policy: P.50 EBI_list2_guidance_050121.pdf (aomrc.org.uk) Do not routinely offer imaging in a non-specialist setting for people with low back pain with or without sciatica in the absence of red flags, or suspected

	serious underlying pathology following medical history and examination. Imaging in low back pain should be offered if serious underlying pathology is suspected. Serious underlying pathology includes but is not limited to: cancer, infection, trauma, spinal cord injury (full or partial loss of sensation and/or movement of part(s) of the body) or inflammatory disease. Further information can be accessed at the relevant NICE guideline for these conditions. Patients presenting with low back pain and sciatica should be reviewed in accordance with the low back pain and sciatica guidance (https://www. nice.org.uk/guidance/ng59). Patients presenting with low back pain without sciatica should be reviewed and if none of the above serious underlying pathology are suspected, primary care management typically includes reassurance, advice on continuation of activity with modification, weightloss, analgesia, manual therapy and reviewing patients who are high risk of 51 Academy of Medical Royal Colleges EBI - List 2 Guidance developing chronic pain (i.e. STaRT Back). NICE guidelines recommend using a risk assessment and stratification tool, (e.g. STaRT Back), and following a pathway such as the National Back and Radicular Pain Pathway, to inform shared decision making and create a management plan. Consider a combined physical and psychological programme for management of sub-acute and chronic low back pain (greater than 3 to 6 months duration) e.g. Back Skills Training (BeST). Consider referral to a specialist centre for further assessment and management if required. Imaging within specialist centres is indicated only if the result will change management.
2T Knee MRI when symptoms are suggestive of osteoarthritis	National Based Interventions policy: P.53 EBI_list2_guidance_050121.pdf (aomrc.org.uk) In primary care, where clinical assessment is suggestive of knee osteoarthritis, imaging is not usually necessary. Weight bearing radiographs are the first line of investigation In secondary care the first-line investigation of potential knee Osteoarthritis is weight bearing plain radiography.

	If the patient has a pattern of disease that allows surgical treatment to be adequately planned with plain radiographs, then MRI is not required. However, there are a number of situations where MRI of the osteoarthritic knee can be useful: — Patients who have severe symptoms but relatively mild OA on standard X-rays. In this situation the MRI offers more detail and can show much more advanced OA or Osteonecrosis within the knee — In working up a patient for possible HTO or partial knee replacement an MRI can be a very useful investigation focusing on the state of the anterior cruciate ligament and state of the retained compartments. In summary an MRI scan can be a useful investigation in the contemporary surgical management of osteoarthritis, giving critical information on the pattern of disease and state of the soft tissues. However, requesting an MRI scan when it is not indicated potentially prolongs further waiting times for patients, can cause unnecessary anxiety while waiting for specialist consultation and can delay MRI scans for appropriate patients.
2W **Imaging for shoulder pain**	National Based Interventions policy: P.60 EBI_list2_guidance_050121.pdf (aomrc.org.uk) For patients who initially present with shoulder pain in primary or intermediate care, the first line of radiological investigation should be a plain x-ray. X-rays diagnose most routine shoulder problems such as osteoarthritis, calcium deposits, rotator cuff arthropathy, impingement, fractures and primary and secondary tumours. If following an x-ray and clinical assessment, the diagnosis is still in doubt then a referral to the secondary care shoulder service is indicated where further specialist assessment and appropriate investigations including USS, CT scans and MRI scans can be arranged. The British Elbow and Shoulder Society (BESS) have produced treatment and referral guidelines for routine shoulder conditions (https://bess.ac.uk/patient-care-pathways-andguidelines/).

	If shoulder RED FLAGS are present, an urgent referral to secondary care should be arranged for further investigation and management: — Any history or suspicion of malignancy — Any mass or swelling — Suggestions of infection, e.g. red skin, fever or systemically unwell — Trauma, pain and weakness — Trauma, epileptic fit or electric shock leading to loss of rotation and abnormal shape. Injections for shoulder pain are often indicated as a first line of treatment. The common areas injected are the subacromial space, the glenohumeral joint and the acromioclavicular joint. The most common injection is a subacromial injection. Guided injections (usually utilising ultrasound) are more expensive than unguided injections. Evidence now indicates there is no additional benefit from a guided subacromial injection over an unguided landmark injection and so these are no longer recommended in primary, intermediate and Secondary care during routine management of patients with subacromial shoulder pain. The use of other guided injections for glenohumeral joint and acromioclavicular joint problems should only be offered under the guidance of a secondary care shoulder service responsible for definitive treatment of these patients.
X **MRI scan for hip for osteoarthritis**	National Based Interventions policy: P.63 EBI_list2_guidance_050121.pdf (aomrc.org.uk) Do not request a hip MRI when the clinical presentation (history and examination) and X-rays demonstrate typical features of OA. MRI scans rarely add useful information to guide diagnosis or treatment. Requesting MRI scans further prolongs waiting times for patients. Importantly it can cause unnecessary anxiety while waiting for specialist consultation and can delay MRI scans for patients with diagnoses other than OA of the hip. The diagnosis of hip OA can be effectively made based upon the patient's history and physical examination. NICE recommends diagnosing osteoarthritis clinically without investigations in patients who: — Are 45 or over AND — Have activity-related joint pain AND — Have either no morning joint-related stiffness or morning stiffness that

	lasts no longer than 30 minutes. It is important to exclude other diagnoses, especially when red flags are present. If imaging is necessary, the first-line investigation should be plain x-ray. An MRI or urgent onward referral may be warranted in some circumstances. These include: — Suggestions of infection, e.g. pyrexia, swollen and red joint, significant irritability, other risk factors of septic arthritis — Trauma — History or family history of an inflammatory arthropathy — Mechanical, impingement type symptoms — Prolonged and morning stiffness — History of cancer or corresponding risk factors — Suspected Osteonecrosis / Avascular necrosis of the hip — Suspected transient osteoporosis — Suspected periarticular soft tissue pathology e.g. abductor tendinopathy Important differential diagnoses include inflammatory arthritis (for example, rheumatoid arthritis), femoro-acetabular impingement, septic arthritis and malignancy (bone pain).
2AA **Pre-op chest x ray**	National Based Interventions policy: P.69 EBI_list2_guidance_050121.pdf (aomrc.org.uk) Pre-operative chest radiographs should only be routinely performed when one or more of the following criteria apply: • Patients undergoing cardiac or thoracic surgery • Patients undergoing organ transplantation or live organ donation • The request of the anaesthetist in the following: - Those with suspected or established cardio-respiratory disease, who have not had a chest radiograph in the previous 12 months, and who are likely to go to critical care after surgery. - Those with a recent history of chest trauma - Patients with a significant smoking history who have not had a chest radiograph in the previous 12 months Those with malignancy and possible lung metastases

	- Those undergoing a major abdominal operation, who are at high risk of respiratory complications.
2BB **Pre op ECG**	National Based Interventions policy: P.70 EBI_list2_guidance_050121.pdf (aomrc.org.uk) Pre-operative electrocardiograms should not be routinely performed in low-risk, non-cardiac, adult elective surgical patients. Pre-operative electrocardiograms may be appropriately performed when the following criteria apply: - Patients with an American Society of Anaesthesiologists (ASA) physical classification* status of 3 or greater and no ECG results available for review in the last 12 months. - Patients with a history of cardiovascular or renal disease, or diabetes. - Patients with any history of potential cardiac symptoms (e.g. cardiac chest pain, palpitations, unexplained syncope or breathlessness) or a new murmur, that has not previously been investigated. - Patients over the age of 65 attending for major surgery. *ASA Physical Status Classification System | American Society of Anesthesiologists (ASA) (asahq.org)
2CC **Prostate-specific antigen (PSA) test**	National Based Interventions policy: P.72 EBI_list2_guidance_050121.pdf (aomrc.org.uk) Where PSA testing is clinically indicated (see below), or requested by the man aged 50 and over, he should have a careful discussion about the potential risks and benefits of PSA testing which allows for shared decision making before a PSA test. Various tools are available to assist with shared decision making. PSA testing should be considered in asymptomatic men over age 40 who are at higher risk of prostate cancer due if they are Black and/or have a family history of prostate cancer. PSA testing should be considered when clinically indicated (ideally after counselling on the potential risks and benefits of testing) in men when there is clinical suspicion of prostate cancer, which may include the following symptoms: — Lower urinary tract symptoms (LUTS), such nocturia, urinary frequency, hesitancy, reduced flow, urgency or retention. — Erectile dysfunction. — Visible haematuria. — Unexplained symptoms that could be due to advanced prostate cancer

	(for example lower back pain, bone pain, weight loss). PSA testing for prostate cancer is not recommended in asymptomatic men (unless they are at high risk of prostate cancer i.e. Black and/or family history) is not recommended. This is because the benefits have not been shown to clearly outweigh the harms. In particular, there is concern about the high risk of false positive results. Where PSA test results are mildly raised above the age specific range for an individual patient, it may be appropriate to repeat the test within two to three months to monitor the trend. *Note: PSA testing for prostate cancer should be avoided if the man has:* *— An active or recent urinary infection (PSA may remain raised for many* *months).* *— Had a prostate biopsy in the previous 6 weeks* *both of which are likely to raise PSA and give a false positive result.*
2DD **Liver function, Creatinine kinase** **Lipid level tests – (Lipid lowering therapy)**	National Based Interventions policy: P.75 EBI_list2_guidance_050121.pdf (aomrc.org.uk) **Creatine Kinase Testing** — Creatine kinase should not be routinely monitored in asymptomatic people who are taking lipid modification therapy — Creatine kinase measurement is indicated: — Prior to lipid modification therapy initiation in patients who have experienced generalised, unexplained muscle pains or weakness (whether or not associated with previous lipid-monitoring therapy) — If a patient develops muscle pains or weakness whilst on lipid modification therapy. **Liver Function Testing** — Baseline liver function should be measured before starting lipid modification therapy — Liver function should be measured within 3 months of starting treatment and at 12 months, but not again unless clinically indicated — Routine monitoring of liver function tests in asymptomatic people is not indicated after 12 months of initiating lipid lowering therapy — ALT can be used as a measure of liver function. **Lipid Testing** — Measure full lipid profile by taking at least one lipid sample before starting lipid modification therapy. This should include measurement of

	total cholesterol, HDL cholesterol, non-HDL cholesterol and triglyceride concentrations. A fasting sample is not needed. — Total cholesterol, HDL cholesterol and non-HDL cholesterol should be measured in all people who have been started on high-intensity statin treatment (both primary and secondary prevention, including atorvastatin 20 mg for primary prevention) at 3 months of treatment and aim for a greater than 40% reduction in non-HDL cholesterol. — Consider an annual non-fasting blood test for non-HDL cholesterol to inform discussion at annual medication reviews.
2EE **Blood Transfusion**	National Based Interventions policy: P.78 EBI_list2_guidance_050121.pdf (aomrc.org.uk) Do not give RBC transfusions to patients with B12, folate or iron deficiency anaemia unless there is haemodynamic instability. If haemodynamic instability is present, treat this with transfusion of appropriate blood components (do not delay emergency transfusions). Where, however, severe acute anaemia (Hb <70g/litre) exists that is symptomatic and prevents rehabilitation or mobilisation, those patients may benefit from a single unit of blood. For adult patients (or equivalent based on body weight for children or adults with low body weight) needing RBC transfusion, suggest restrictive thresholds and giving a single unit at a time except in case of exceptions below. Restrictive RBC transfusion thresholds are for patients who need RBC transfusions and who do not: — Have major haemorrhage or — Have acute coronary syndrome or — Need regular blood transfusions for chronic anaemia. 79 Academy of Medical Royal Colleges EBI - List 2 Guidance While transfusions are given to replace deficient red blood cells, they will not correct the underlying cause of the anaemia. RBC transfusions will only provide temporary improvement. It is important to investigate why patients are anaemic and treat the cause as well as the symptoms. Note: Consider whether a dramatic fall in haemoglobin could be due to a severe haemolytic episode and not associated with any of the 3 exceptions. This would also be a possible indication to transfuse more than one unit at a time. When using a restrictive RBC transfusion threshold,

	consider a threshold of 70 g/litre and a haemoglobin concentration target of 70–90 g/litre after transfusion. For patients with acute coronary syndrome, a RBC transfusion threshold of 80 g/litre should be considered and a haemoglobin concentration target of 80–100 g/litre after transfusion. For patients requiring regular transfusion for chronic anaemia, NICE advise defining thresholds and haemoglobin concentration targets for each individual.

Appendix 3 – Commissioning Guidelines for Specialist Plastic Surgery Procedures

BACKGROUND AND INTRODUCTION

This policy sets out the criteria for access to NHS funded cosmetic specialist plastic surgery procedures.

Cosmetic surgery is any surgery carried out to enhance outward appearance. It is carried out on people with abnormal appearance from a range of clinical or congenital conditions or syndromes or as a result of surgery or injury. It can also be carried out to enhance appearance or to correct changes due to ageing or obesity.

In any health care system there are limits set on what is available and on what people can expect.

Clinical Commissioning Groups are required to achieve financial balance. They have a complex task in balancing this with individuals' rights to health care. It is the purpose of the criteria set out in this document to make the limits on cosmetic specialist plastic surgery procedures fair, clear and explicit.

Referrals within the NHS for the revision of treatments originally performed outside the NHS will not normally be permitted.

Referrals should where possible be made to the practitioner who carried out the original procedure.

This policy will be reviewed by the review date or in the light of any new guidance or clinical evidence, whichever is the earliest.

These guidelines cover a group of surgical procedures with cosmetic indications.

It is important to note that a substantial proportion of specialist plastic surgery is carried out by a number of specialities other than Plastic Surgery e.g. ENT Surgery, Ophthalmology, Maxillofacial Surgery, General Surgery and Dermatology. This policy only concerns procedures carried out in hospitals.

Severity of the condition, effectiveness of intervention requested, cost and cost effectiveness should all be taken into consideration in the decision making process.

Commissioning approval is required for NHS funding through the Individual Funding Request process prior to referral to the specialist clinician.

If funding is approval, the decision whether or not to go through with a particular procedure rests with the clinician and the patient in relation to the appropriateness of the procedure, its likelihood of success and risks of failure.

GENERAL GUIDELINES

1. Patients requiring reconstruction surgery to restore normal or near normal appearance or function following cancer treatment or post trauma do not fall within this policy.

2. For cosmetic procedures an NHS referral is inappropriate if the patient falls within the normal morphological range.

3. Patients should not be referred unless they are fit for surgery.

4. Patients should not be referred to the specialist service until approval has been obtained from the CCG through the IFR process and a copy of the approval should be appended to the referral.

5. Inevitably some patients may not fit the guidelines. If the referring clinician feels that a case merits funding on an exceptional basis they should discuss the case with the IFR team or submit an IFR with evidence of exceptionality to be considered by the panel.

6. Patients who have been operated on privately will not normally be eligible for NHS treatment for complications or secondary procedures. However there may be unusual or severe complications or circumstances that require transfer of a patient to the NHS for appropriate management.

7. Body Mass Index(BMI) is referred to as per SIGN[1] guidance :

Less than 18.5	Underweight
18.5 -24.9	Normal BMI
25.0 - 29.9	Overweight
30.0 - 39.9	Obese
40 or above	extremely obese

The BMI should be measured and recorded by the NHS.

8. Plastic surgery procedures will only normally be considered in patients with a BMI in the range of 18.5 to 27 unless weight is not relevant to the proposed surgery. Completion of Get First 6 month health improvement does not overrule this criteria for Barnsley patients.

9. Plastic surgery procedures will not be funded to alleviate psychological problems alone.

10. All decisions will be taken in the context of the overall financial position of the CCG.

11. Photographic evidence may be requested to facilitate thorough consideration of a case.

[1] SIGN (1996) Integrated Prevention and Management of Overweight and Obesity, Edinburgh

PROCEDURE SPECIFIC GUIDANCE

Speciality	Procedure	Commissioning Position & Exceptionality Information
Plastic and Cosmetic surgery	**1. Abdominoplasty/ apronectomy (tummy tuck)**	**Abdominoplasty will not be routinely commissioned by the NHS for cosmetic reasons.** Abdominoplasty may rarely be considered on an exceptional basis, for example where the patient: • has lost a significant amount of weight (moved down two levels of the BMI SIGN guidance) and has a stable BMI, which would normally be below 27 for a minimum of 2 years, and • is experiencing severe difficulties with daily living, for example ambulatory or urological restrictions. Other factors may be considered: • recurrent severe infection or ulceration beneath the skin fold despite appropriate conservative treatment • significant abdominal wall deformity due to surgical scarring or trauma • problems associated with poorly fitting stoma bags
Plastic and Cosmetic surgery	**2. Breast Surgery**	
	2.1 Breast Augmentation	**Breast augmentation will not be routinely commissioned by the NHS for cosmetic reasons, for example for enhancement of small breasts, for tuberous breasts or for breast tissue involution (including post-partum changes).** Breast augmentation may rarely be considered on an exceptional basis, for example where the patient: • has a complete absence of breast tissue either unilaterally or bilaterally or • has suffered trauma to the breast during or after development and • has a BMI within the range 18.5 - 27 and • has completed puberty as surgery is not routinely commissioned for individuals who are below 19 years of age Patients who have received feminising hormones for an adequate length of time as part of a recognised treatment programme for gender dysphoria will only be considered when they meet the above criteria. Revision surgery will only be commissioned for implant rupture, or for other physical symptoms, for example capsule contracture associated with pain, and not for aesthetic indications. Implant replacement will only be considered if the original procedure was performed by the NHS.

Speciality	Procedure	Commissioning Position & Exceptionality Information
Plastic and Cosmetic surgery	**2.2 Breast Reduction**	**Breast reduction will not routinely be commissioned by the NHS for cosmetic reasons.** Breast reduction may rarely be considered on an exceptional basis, for example where the patient: • has a breast measurement of cup size G or larger and • has a BMI in the range 18.5 - 27 or and • is 19 years of age or over and • has significant musculo-skeletal pain causing functional impairment which in the opinion of the referrer is likely to be corrected or significantly improved by surgery and • has tried and failed with all other advice and support, including a professional bra fitting and assessment by a physiotherapist where relevant **National Evidence Base** • Evidence Based Interventions https://www.england.nhs.uk/wp-content/uploads/2018/11/ebi-statutory-guidance-v2.pdf • NHS Website https://www.nhs.uk/conditions/breast-reduction-on-the-nhs/ • The British Association of Plastic, Aesthetic and Reconstructive Surgeons http://www.bapras.org.uk/docs/default-source/commissioning-and-policy/information-for-commissioners-of-plastic-surgery-services.pdf?sfvrsn=2
Plastic and Cosmetic surgery	**2.3 Breast Asymmetry**	**Surgery to correct breast asymmetry will not routinely be commissioned by the NHS for cosmetic reasons.** Surgery may rarely be considered on an exceptional basis, for example where the patient: • has a difference of at least 2 cup sizes and • has a BMI in the range 18.5-27 and • has tried and failed with all other advice and treatment, including a professional bra fitting and • has completed puberty - surgery is not normally commissioned below the age of 19 years **National Evidence Base** • Evidence Based Interventions https://www.england.nhs.uk/wp-content/uploads/2018/11/ebi-statutory-guidance-v2.pdf

Speciality	Procedure	Commissioning Position & Exceptionality Information
Plastic and Cosmetic surgery	**2.4 Breast Reduction for gynaecomastia (male)**	**Surgery to correct gynaecomastia will not routinely be commissioned by the NHS for cosmetic reasons.** Surgery may be considered on an exceptional basis, for example where the patient: • has more than 100g of sub areolar gland and ductal tissue (not fat) and • has a BMI in the range 18.5 - 27 or and • has been screened prior to referral to exclude endocrine and drug related causes (if drugs have been a factor then a period of one year since last use should have elapsed) and • has completed puberty - surgery is not routinely commissioned below the age of 19 years and • has been monitored for at least 1 year to allow for natural resolution if aged 25 or younger **National Evidence Base** • Evidence Based Interventions https://www.england.nhs.uk/wp-content/uploads/2018/11/ebi-statutory-guidance-v2.pdf • The British Association of Plastic, Aesthetic and Reconstructive Surgeons http://www.bapras.org.uk/docs/default-source/commissioning-and-policy/information-for-commissioners-of-plastic-surgery-services.pdf?sfvrsn=2
Plastic and Cosmetic surgery	**2.5 Breast lift mastopexy**	**Mastopexy will not be routinely commissioned by the NHS for cosmetic reasons.** For example post lactation or age related ptosis but may be included as part of the treatment to correct breast asymmetry.
Plastic and Cosmetic surgery	**2.6 Correction of Nipple inversion**	**Surgical correction of benign nipple inversion will not be routinely commissioned by the NHS for cosmetic reasons.**
Plastic and Cosmetic surgery	**3. Hair**	
	3.1 Hair removal	**Hair removal will not be routinely commissioned by the NHS for cosmetic reasons.** Hair removal may be considered on an exceptional basis, for example where the patient: • has had reconstructive surgery resulting in abnormally located hair bearing skin or • has a pilonidal sinus resistant to conventional treatment in order to reduce recurrence risk
Plastic and Cosmetic Surgery	**3.2 Correction of Male Pattern Baldness**	**Treatments to correct male pattern baldness will not be routinely commissioned by the NHS for cosmetic reasons.**

Speciality	Procedure	Commissioning Position & Exceptionality Information
Plastic and Cosmetic surgery	**3.3 Hair transplantation**	**Hair transplantation will not be routinely commissioned by the NHS for cosmetic reasons, regardless of gender.** Hair transplantation may be considered on an exceptional basis, for example when reconstruction of the eyebrow is needed following cancer or trauma.
Plastic and Cosmetic surgery	**4. Acne scarring**	**Procedures to treat facial acne scarring will not be routinely commissioned by the NHS.** Cases may be considered on an exceptional basis, for example when the patient has very severe facial scarring unresponsive to conventional medical treatments.
Plastic and Cosmetic surgery	**5. Buttock, thigh and Arm lift surgery**	**Not Routinely Commissioned** **Surgery to remove excess skin from the buttock, thighs and arms will not be routinely commissioned by the NHS for cosmetic reasons.** Cases may be considered on an exceptional basis, for example where the patient: • has an underlying skin condition, for example cutis laxa or • has lost a considerable amount of weight resulting in severe mechanical problems affecting activities of daily living and • has a normal BMI in the range18.5 - 27 for a minimum of 2 years
Plastic and Cosmetic surgery	**6. Congenital vascular abnormalities**	**Procedures for congenital vascular abnormalities will not be routinely commissioned by the NHS for cosmetic reasons.** Cases may be considered on an exceptional basis for lesions of considerable size on exposed areas only
Plastic and Cosmetic surgery	**7. Correction of Prominent Ears (Pinnaplasty)**	**Surgical correction of prominent ears will not be routinely commissioned by the NHS for cosmetic reasons.** Cases may be considered on an exceptional basis, for example where the patient: • is aged 5-19 at the time of referral and the child (not the parents alone) expresses concern and • has very significant ear deformity or asymmetry **National Evidence Base** • NHS England Interim Commissioning Policy for Pinnaplasty/Otoplasty November 2013: https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2013/11/N-SC027.pdf

Speciality	Procedure	Commissioning Position & Exceptionality Information
Plastic and Cosmetic surgery	**8. Facelift**	**Facelift procedures, Botulinum toxin and dermal fillers will not be routinely commissioned by the NHS for cosmetic reasons** Cases may be considered on an exceptional basis, for example in the presence of an anatomical abnormality or a pathological feature which significantly affects appearance.
Plastic and Cosmetic surgery	**9. Lapiaplasty, Vaginoplasty and Hymen Reconsturction**	**Not Routinely Commissioned - Refer through IFR for exceptionality**
Plastic and Cosmetic surgery	**10. Liposuction**	**Liposuction will not be routinely commissioned by the NHS simply to correct the distribution of fat or for cosmetic reasons.** Cases may be considered on an exceptional basis, for example where the patient has significant lipodystrophy**.**
Plastic and Cosmetic surgery	**11. Rhinoplasty**	**Rhinoplasty will not be routinely commissioned by the NHS for cosmetic reasons.** Cases may be considered on an exceptional basis, for example in the presence of severe functional problems. Post traumatic airway obstruction or septal deviation does not need funding approval**.**
Plastic and Cosmetic surgery	**12. Rhinophyma**	**Surgical/laser treatment of rhinophyma will not be routinely commissioned by the NHS for cosmetic reasons.** Cases may be considered on an individual basis, for example where the patient has functional problems and where conventional medical treatments have been ineffective.
Plastic and Cosmetic surgery	**13. Surgical Scars**	**Revision surgery for scars will not be routinely commissioned by the NHS for cosmetic reasons.** Cases may be considered on an exceptional basis, for example where the patient: • has significant deformity, severe functional problems, or needs surgery to restore normal function or • has a scar resulting in significant facial disfigurement.
Plastic and Cosmetic surgery	**14. Thread veins/telangectasia**	**Not Routinely Commissioned - Refer through IFR for exceptionality**

Speciality	Procedure	Commissioning Position & Exceptionality Information
Plastic and Cosmetic surgery	**15. Tattoo removal**	**Tattoo removal will not be routinely commissioned by the NHS.** Cases may be considered on an exceptional basis, for example where the patient: • has suffered a significant allergic reaction to the dye and medical treatments have failed • has been given a tattoo against their will (rape tattoo) **National Evidence Base** • NHS England Interim Commissioning Policy for Tattoo Removal November 2013: https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2013/11/N-SC032.pdf
Plastic and Cosmetic surgery	**16. Surgical Repair of Torn Earlobes**	**Surgical repair of torn ear lobes or holes resulting from gauge piercing will not be commissioned by the NHS for cosmetic reasons.**

Appendix 4 - Patient Information Sheet

Evidence Based Interventions

Patient Information Leaflet to accompany the South Yorkshire and Bassetlaw Commissioning for Outcomes Policy (Updated January 2019)

Background

During 2018, doctors, nurses and managers across the NHS, both locally in South Yorkshire and across the country, have been working hard to make sure that the interventions (treatments and operations) offered to all patients are the best ones available and that money is not spent on treatments that might not be effective.

The result is the Commissioning for Outcomes Policy (CFO), which came into effect from April 1st 2019. The policy has been agreed by all of the South Yorkshire and Bassetlaw Clinical Commissioning Groups (CCGs), which means that access to healthcare will be fair and equal for all patients in our region.

The policy is based upon the latest national guidance provided by the National Institute for Health and Care Excellence (NICE) and this has shown that some treatments or operations that have until now been routinely recommended might in fact not be the best option for some patients.

The aim of the policy is to make sure that the doctors and nurses involved in your care can offer you the most up to date treatments, based on the latest research and to ensure that NHS funds are spent on the things that will bring the greatest health benefits.

Your GP, hospital consultant or nurse specialist will discuss the different treatment options with you. Some operations or treatments will only be recommended for some patients and your doctor will assess whether or not you meet the clinical conditions or criteria.

If you meet the criteria then this will be the best treatment option for you and the procedure will be arranged.

If you don't meet the criteria then you will be offered the most effective treatment for your particular condition.

If you don't qualify for the treatment, but your doctor or nurse thinks that there are exceptional clinical circumstances in your case then they may submit an Individual Funding Request (IFR) to an independent panel for consideration.

Details about the IFR process and the guidance that is followed can be found by contacting your local CCG, please see the links below.

The table below shows all the interventions/procedures that are included within this Commissioning for Outcomes Policy

Speciality	Intervention
ANAESTHETICS	Pre-operative Chest X-ray (before an operation)
	Pre-operative ECG - Heart tracing (ECG) before an operation
CARDIOLOGY	Diagnostic coronary (invasive) angiography for low risk, stable chest pain
	Specialised blood tests (troponin) for investigation of chest pain
	Lipid Lowering Therapy - Regular blood tests when taking cholesterol lowering tablets
	Exercise ECG for screening for coronary heart disease
ENT	Grommets in children
	Grommets in Adults
	Snoring Surgery (in the absence of Obstructive Sleep Apnoea (OSA))
	Tonsillectomy
	Surgery for chronic sinusitis
	Removal of the adenoids (for glue ear and not OSA) Adenoidectomy
GENERAL SURGERY	Haemorrhoid surgery
	Varicose veins
	Removal of Benign Perianal skin lesions
	Cholecystectomy - Removal of an inflamed gallbladder
	Surgery for minimally symptomatic inguinal hernia
	Ingrown toenail
	Upper GI Endoscopy to investigate gut problems
	Appropriate Colonoscopy of the lower intestine
	Repeat / Follow up colonoscopy of the lower intestine
	Test of the gallbladder - ERCP in acute gallstone pancreatitis without cholangitis
	Appendicectomy without confirmation of appendicitis - Tests to confirm appendicitis
GYNAECOLOGY	Hysterectomy for management of heavy menstrual bleeding
	Dilation and curettage (D&C) for heavy menstrual bleeding (HMB) in women
HAEMATOLOGY	Blood transfusions
OPTHALMOLOGY	Cataract Surgery
	Meibomian cyst (Chalazion)
	Upper Eyelid Blepharaplasty
ORTHOPAEDICS	Arthroscopic Subacrominal Decompression of the shoulder (ASAD)
	Knee arthroscopy for patients with osteoarthritis
	Injection for non-specific low back pain
	Surgery to fuse the bones in the back for back pain - Fusion surgery for mechanical axial low back pain
	Carpal tunnel Syndrome Surgery
	Common Hand Conditions - Dupuytrens release
	Common Hand conditions - Ganglion
	Common Hand Conditions - Trigger finger

	Hallux valgus surgery
	Total Knee replacement
	Total Hip Replacement
	Knee arthroscopic surgery for meniscal tears
	Lumbar Discectomy - Spinal surgery for a slipped disc
	Knee MRI when symptoms are suggestive of osteoarthritis
	Knee MRI for suspected meniscal tears
	Vertebral augmentation (vertebroplasty or Kyphoplasty) for painful osteoporotic vertebral fractures
	Imaging for shoulder pain
	MRI scan of the hip for arthritis
	Low back pain imaging
	Lumbar Radiofrequency facet joint denervation
PAEDIATRICS	Helmet therapy in the treatment of positional plagiocephaly in children*
PAIN CLINIC	Acupuncture for non-specific back pain
PLASTIC SURGERY	Breast reduction / asymmetry and Gynaecomastia
UROLOGY	Male circumcision
	Vasectomy under GA
	Surgical removal of kidney stones
	Cystoscopy for men with un-complicated lower urinary tract symptoms
	Surgical intervention for benign prostatic hyperplasia
	Prostate- specific antigen (PSA) testing

The CFO policy and the list of clinical criteria for each treatment are available on the internet at: https://www.healthandcaretogethersyb.co.uk/about-us/useful-documents

Further information about the policy, including how to raise concerns or make a complaint can be found at the links below, please choose the CCG that is responsible for the area where you live.

Please be assured that your details will remain confidential and will only be shared with relevant staff in order to address your concerns.

BARNSLEY
http://www.barnsleyccg.nhs.uk/about-us/feedback-and-enquiries.htm

Write to: Quality Team, NHS Barnsley CCG, Hillder House, 49 – 51 Gawber Road, Barnsley, S75 2PY
Telephone: 01226 433772
Email: qualityteam.safehaven@nhs.net

For further advice you can also contact Healthwatch at; Priory Campus, Pontefract Road, Barnsley, South Yorkshire. S71 5PN or Tel: 01226 320106

BASSETLAW
Write to: Complaints Department, Retford Hospital, North Road, Retford, Notts, DN22 7XF
Telephone: 01777 863321
Email: BASCCG.CommunicationOffice@nhs.net

For further advice you can also contact Healthwatch at; Unit 2, Byron Business Centre, Duke St, Hucknall, Notts, NG15 7HP or Tel: 01159635179

DONCASTER
Write to: Patient Experience Manager, Doncaster CCG, Sovereign House, Heaven's Walk, Doncaster, DN4 5HZ
Telephone: 01302 566228
Email: Donccg.enquiries@nhs.net

For further advice you can also contact Healthwatch at: 3 Cavendish Court, South Parade, Doncaster, DN1 2JD or Tel: 0808 8010391

ROTHERHAM
http://www.rotherhamccg.nhs.uk/concerns-and-complaints.htm
Write to: Rotherham CCG, Oak House, Moorhead Way, Rotherham, South Yorkshire S66 1YY
Telephone: 01709 302108
Email: complaints@rotherhamccg.nhs.uk

For further advice you can also contact Healthwatch at: Thornbank House, 38 Moorgate Rd, Rotherham S60 2AG or Tel: 01709717130

SHEFFIELD
http://www.sheffieldccg.nhs.uk/about-us/contact-us.htm
Write to: Complaints Team, NHS Sheffield CCG, 722 Prince of Wales Road, Sheffield, S9 4EU
Telephone: (0114) 305 1000
Email: SHECCG.complaints@nhs.net

For further advice you can also contact Healthwatch at: The Circle, 33 Rockingham Lane, Sheffield, S1 4FW or Tel: 01142536688

Appendix 5 – Diagnostic and Procedure Codes (v5)

For each of the interventions, the clinical definitions have been converted into combinations of one or more OPCS procedure codes and ICD-10 diagnosis codes. The following descriptors use Microsoft SQL Server structure but are easily adaptable to other systems.

For reference:

- A "%" symbol represents a wildcard for zero or more characters.
- Values in square brackets mean "one of these characters". E.g. [03] mean 0 or 3 and [0-3] means 0 or 1 or 2 or 3.
- The field "der_diagnosis_all" is a concatenation of all diagnosis fields in all episodes within the spell.

Please note this appendix is subject to national amendments. A copy of the latest code is available electronically on request from roccg.intelligence@nhs.net

National Evidence Based Interventions Phase 1 (1) and Phase 2 (2) and Local Evidence Based Interventions (Z)

Intervention		Diagnostic and procedure codes
1A	Intervention for snoring (not OSA)	when left(der.Spell_Dominant_Procedure,4) in ('F324','F325','F326') and der.Spell_Primary_Diagnosis not like '%G473%' and APCS.Age_At_Start_of_Spell_SUS between 18 and 120 then 'A_snoring'
1B	Dilatation & curettage for heavy menstrual bleeding	when left(der.Spell_Dominant_Procedure,4) in ('Q103') and apcs.der_diagnosis_all not like '%O0[0-8]%' and apcs.der_diagnosis_all not like '%O6[0-9]%' and apcs.der_diagnosis_all not like '%O7[0-5]%' then 'B_menstr_D&C'
1C	Knee arthroscopy with osteoarthritis	when der.Spell_Dominant_Procedure in ('W821','W822','W823','W828','W829','W851','W852','W853','W858','W859','W861+KNEE','W831+KNEE','W832+KNEE','W833+KNEE','W834+KNEE','W835+KNEE','W836+KNEE','W837+KNEE','W838+KNEE','W839+KNEE','W841+KNEE','W842+KNEE','W843+KNEE','W844+KNEE') and (APCS.Age_At_Start_of_Spell_SUS between 18 and 120) and apcs.der_diagnosis_all not like '%C[0-9][0-9]%' and der.Spell_Primary_Diagnosis like 'M1[57]%' then 'C_knee_arth'
1D	Injection for nonspecific low back pain without sciatica	when left(der.Spell_Dominant_Procedure,4) in ('A521','A522','A528','A529','A577','A735','V363','V368','V369','V382','V383','V384','V385','V386','V388','V389','V544','W903') and left(der.spell_primary_diagnosis,4) in ('G834','G551','M518','M519','M545','M549') and apcs.der_procedure_all like '%Z67[67]%' then 'D_low_back_pain_inj'

1E	Breast reduction	when left(der.Spell_Dominant_Procedure,4) in ('B311') and apcs.der_diagnosis_all not like '%C[0-9][0-9]%' then 'E_breast_red'
1F	Removal of benign skin lesions (EBI)	when left(der.Spell_Dominant_Procedure,4) in ('S063','S064','S065','S066','S067','S068','S069','S081','S082','S083','S088','S089','S091','S092','S093','S094','S095','S098','S099','S101','S102','S111','S112','D021','D022','D028','D029') and APCS.Der_Diagnosis_All not like '%C4[3469]%' then 'F_skin_lesions'
1F	Removal of benign skin lesions (Additions)	when (left(der.Spell_Dominant_Procedure,4) not in ('S063','S064','S065','S066','S067','S068','S069','S081','S082', 'S083','S088','S089' ,'S091','S092','S093','S094','S095','S098','S099','S101','S102','S111','S112', 'D021','D022','D028','D029','S103','S104','S105','S108','S109','S113','S114','S115','S118','S119') and der.Spell_Dominant_Procedure is not null and (der.spell_primary_diagnosis in ('D170', 'D171', 'D172', 'D173') or der.spell_primary_diagnosis like 'L82%') then 'F_skin_lesions (Addition)' when left (der.Spell_Dominant_Procedure,4) in ('S103','S104','S105','S108','S109','S113','S114','S115','S118','S119') and apcs.der_diagnosis_all not like '%C4[3469]%' then 'F_skin_lesions (Addition)'
1G	Grommets	when left(der.Spell_Dominant_Procedure,4) in ('D151','D289') and (der.Spell_Primary_Diagnosis like 'H65[23]%' or der.Spell_Primary_Diagnosis like 'H66[1-9]%') and (apcs.age_at_start_of_Spell_SUS between 1 and 17 or apcs.age_at_start_of_Spell_SUS between 7001 and 7007) then 'G_gromm'
1H	Tonsillectomy (EBI)	when left(der.Spell_Dominant_Procedure,4) in ('F341','F342','F343','F344','F345','F346','F347','F348','F349','F361') and apcs.der_diagnosis_all not like '%C[0-9][0-9]%' and apcs.der_diagnosis_all not like '%G47%' and apcs.der_diagnosis_all not like '%J36%' then 'H_tonsil'
1H	Tonsillectomy (Additions)	when left (der.Spell_Dominant_Procedure,4) in ('F341','F342','F343','F344','F345','F346','F347','F348','F349','F361') and (der.spell_primary_diagnosis like 'G47%' or der.spell_primary_diagnosis like 'J36%') and der_diagnosis_all not like 'C[0-9][0-9]%' then 'H tonsil (IFR Required)'
1I	Haemorrhoid surgery	when left(der.Spell_Dominant_Procedure,4) in ('H511','H512','H513','H518','H519') and apcs.der_diagnosis_all not like '%C[0-9][0-9]%' then 'I_haemmor'
1J	Hysterectomy for heavy bleeding	when left(der.Spell_Dominant_Procedure,4) in ('Q072','Q074','Q078','Q079','Q082','Q088','Q089') and apcs.der_diagnosis_all not like '%C[0-9][0-9]%' and apcs.der_diagnosis_all not like '%O0[0-8]%' and apcs.der_diagnosis_all not like '%O6[0-9]%' and apcs.der_diagnosis_all not like '%O7[0-5]%' then 'J_hysterec'
1K	Chalazia removal (EBI)	when left(der.Spell_Dominant_Procedure,4) in ('C121','C122','C124','C191','C198') and left(der.Spell_Primary_Diagnosis,4) in ('H001') and apcs.der_diagnosis_all not like '%C4[3469]%' then 'K_chalazia'

1K	Chalazia removal (additions)	when left(der.Spell_Dominant_Procedure,4) in ('C123','C125','C126','C128','C129','C131', 'C132','C133','C134','C138','C139','C161','C162','C163','C164','C165','C168','C169') and der.Spell_Primary_Diagnosis like 'H001%' and apcs.der_diagnosis_all not like '%C4[3469]%' then 'K_ Chalazion(additions)'
1L	Shoulder decompression (EBI)	when (der.Spell_Dominant_Procedure ='W844+SHOULDER' or (der.Spell_Dominant_Procedure ='O291' and apcs.der_procedure_all like '%Y767%')) and (der.Spell_Primary_Diagnosis like 'M754%' or der.Spell_Primary_Diagnosis like 'M2551%') then 'L_should_decom'
1L	Shoulder decompression (Additions)	when (der.Spell_Dominant_Procedure is not null and substr(der.Spell_Dominant_Procedure, 1,1) <> 'T' and (der.spell_primary_diagnosis like 'M750%' or der.spell_primary_diagnosis like 'M751%' or der.spell_primary_diagnosis like 'M754%') then 'L_should_decom (Addition)'
1M	Carpal tunnel syndrome release	when left(der.Spell_Dominant_Procedure,4) in ('A651','A659') and der.Spell_Primary_Diagnosis like '%G560%' then 'M_carpal'
1N	Dupuytren's contracture release	when left(der.Spell_Dominant_Procedure,4) in ('T521','T522','T525','T526','T541') and (APCS.Age_At_Start_of_Spell_SUS between 18 and 120) and left(der.Spell_Primary_Diagnosis,4)='M720' then 'N_dupuytr'
1O	Ganglion excision	when left(der.Spell_Dominant_Procedure,4) in ('T591','T592','T598','T599','T601','T602','T608','T609') and der.Spell_Primary_Diagnosis like '%M674%' then 'O_ganglion'
1P	Trigger finger release	when der.Spell_Dominant_Procedure in ('T692+HAND','T691+HAND','T698+HAND','T699+HAND','T701+HAND','T702+HAND','T718+HAND','T719+HAND','T723+HAND','T728+HAND','T729+HAND','Z894+HAND','Z895+HAND','Z896+HAND','Z897+HAND') and (APCS.Age_At_Start_of_Spell_SUS between 18 and 120) and der.Spell_Primary_Diagnosis like '%M653%' then 'P_trigger_fing'
1Q	Varicose vein surgery	when left(der.Spell_Dominant_Procedure,4) in ('L832','L838','L839','L841','L842','L843','L844','L845','L846','L848','L849','L851','L852','L853','L858','L859','L861','L862','L863','L868','L869','L871','L872','L873','L874','L875','L876','L877','L878','L879','L881','L882','L883','L888','L889') and der.Spell_Primary_Diagnosis like ('%I8[03]%') then 'Q_var_veins'
Z	ENT - Grommets for Children	When left(der.Spell_Dominant_Procedure,4) in ('D151','D153' and (s.AgeAtStartofSpell between 1 and 17 OR s.AgeAtStartofSpell between 7001 and 7007) Then 'Z ENT - Grommets for Children'
Z	ENT - Grommets for Adults	When left (der.SpellDominantProcedure,4) in ('D151','D153') And s.AgeAtStartofSpell between 18 and 120 then 'Z ENT - Grommets for Adults

Z	General Surgery - Benign Perianal Skin Tags	When left(der.Spell_Dominant_Procedure,4) = 'H482' then 'Z General Surgery - Benign Perianal Skin Tags'
Z	General Surgery - Cholecystectomy (Asymtomatic Gallstones)	When left(der.Spell_Dominant_Procedure,4) in ('J181','J182','J183','J184','J185','J188','J189','J211','J212','J213','J218','J219') and(der.Spell_Primary_Diagnosis like 'K802%' or der.Spell_Primary_Diagnosis like 'K805%') then 'Z General Surgery - Cholecystectomy (Asymtomatic Gallstones)'
Z	General Surgery - Hernia Repair	when left(der.Spell_Dominant_Procedure,4) in ('T191','T192','T198','T199') and (der.Spell_Primary_Diagnosis like 'K402%' or der.Spell_Primary_Diagnosis like 'K409%' or der.Spell_Primary_Diagnosis like 'K439%' or der.Spell_Primary_Diagnosis like 'K469%') and Age between 18 and 120 and der_procedure_all not like '%N132%' then 'Z General Surgery - Hernia Repair'
Z	General Surgery - Hernia Repair	when left(der.Spell_Dominant_Procedure,4) in ('T201','T202','T203','T204','T208','T209','T211','T212','T213','T214','T218','T219','T251','T252','T253','T258','T259','T261', 'T262','T263','T264','T268','T269','T271','T272','T273','T274','T278','T279') and (der.Spell_Primary_Diagnosis like 'K402%' or der.Spell_Primary_Diagnosis like 'K409%' or der.Spell_Primary_Diagnosis like 'K439%' or der.Spell_Primary_Diagnosis like 'K469%') and.Age between 18 and 120 and der_procedure_all not like '%G693%' and der_procedure_all not like '%H111%' and der_procedure_all not like '%G762%' and der_procedure_all not like '%H175%' then 'Z General Surgery - Hernia Repair'
Z	General Surgery - Hernia Repair	when left(der.Spell_Dominant_Procedure,4) in ('T241','T242','T243','T244','T248','T249') and der.Spell_Primary_Diagnosis like 'K429%' and Age between 18 and 120 then 'Z General Surgery - Hernia Repair'
Z	Ophthalmology - – Blepharoplasty	when left(der.Spell_Dominant_Procedure,4) in ('C121','C122','C123','C124','C125','C126','C128','C129', 'C131','C132','C133','C134','C138','C139','C161','C162','C163','C164','C165','C168','C169') and left(der.Spell_Primary_Diagnosis,4) <> ('H001') and der.spell_primary_diagnosis not like 'C4[3469]%' then 'Z Ophthalmology – Blepharoplasty'

Z	Ophthalmology - Cataract Surgery	when left(der.Spell_Dominant_Procedure,4) in ('C711','C712','C713','C718','C719','C721','C722', 'C723','C728','C729','C741','C742','C743','C748','C749','C751','C752','C753','C754','C758','C759') and left(der.Spell_Primary_Diagnosis,4) in (‘H25’,’H26’) then 'Z Ophthalmology - Cataract Surgery'
Z	Orthopaedics - Hallux Valgus	when left(der.Spell_Dominant_Procedure,4) in ('W151','W152','W153','W154','W155','W156','W158', 'W159','W591','W592','W593','W594','W595','W596','W597','W598','W599','W791','W792','W799') and der.Spell_Primary_Diagnosis like 'M201%' then 'Z Orthopaedics - Hallux Valgus'
Z	Orthopaedics - Hip Replacement for Osteoarthritis	when left(der.Spell_Dominant_Procedure,4) in ('W371', 'W378', 'W379', 'W381', 'W388', 'W389', 'W391', 'W398', 'W399', 'W931', 'W938', 'W939', 'W941', 'W948', 'W949', 'W951', 'W958', 'W959') and (der.Spell_Primary_Diagnosis like 'M15%' or der.Spell_Primary_Diagnosis like 'M16%' or der.Spell_Primary_Diagnosis like 'M17%') then 'Z Orthopaedics - Hip Replacement for Osteoarthritis'
Z	Orthopaedics - Knee Replacement for Osteoarthritis	when left(der.Spell_Dominant_Procedure,4) in ('W401', 'W408', 'W409', 'W411', 'W418', 'W419', 'W421', 'W428', 'W429', 'O181', 'O188', 'O189') and (der.Spell_Primary_Diagnosis like 'M15%' or der.Spell_Primary_Diagnosis like 'M16%' or der.Spell_Primary_Diagnosis like 'M17%') then 'Z Orthopaedics - Knee Replacement for Osteoarthritis'
Z	Orthopaedics - Ingrowing Toe Nail	when Spell_Primary_Diagnosis = ‘L600’ and left(der.Spell_Dominant_Procedure,4) in ('S641', 'S642', 'S681', 'S682', 'S683', 'S701') and (der_procedure_all Like '%Z906%' or der_procedure_all Like '%Z907%' or der_procedure_all Like '%Z506%') then 'Z Orthopaedics - Ingrowing Toe Nail'
Z	Urology - Male Circumcision	When left (der.Spell_Dominant_Procedure,4) = 'N303' then 'Z Urology - Male Circumcision'
Z	Urology – Vasectomy	When left (der.SpellDominantProcedure,4) = 'N171' Then 'Z Urology - Vasectomy'
Z	Acupuncture	When left (der.SpellDominantProcedure,4) IN ('A705', 'A706','Y331') Then 'Z Acupuncture'

2A	2A Diagnostic coronary angiography for low risk, stable chest pain	o LEFT(der.Spell _ Dominant _ Procedure,4) like '%K63[12345689]%' AND (apcs.der _ diagnosis _ all not like '%I20[01]%' AND apcs.der _ diagnosis _ all not like '%I2[12345]%') and isnull(APCS.Age _ At _ Start _ of _ Spell _ SUS,APCS.Der _ Age _ at _ CDS _ Activity _ Date) between 19 and 120
2B	2B Repair of minimally symptomatic inguinal hernia	left(der.Spell _ Dominant _ Procedure,3)='T20' and der.Spell _ Primary _ Diagnosis like 'K40[29]%' and isnull(APCS.Age _ At _ Start _ of _ Spell _ SUS,APCS.Der _ Age _ at _ CDS _ Activity _ Date) between 19 and 120 and APCS.Admission _ Method not like ('2%')
2C	2C Surgical intervention for chronic rhinosinusitis	(apcs.der _ procedure _ all like '%Y76[12]%' OR apcs.der _ procedure _ all like '%E1[2-7][1-9]%'OR apcs.der _ procedure _ all like '%E081%')and der.Spell _ Primary _ Diagnosis like'J3[23]%'and APCS.Admission _ Method not like ('2%')
2D	2D Removal of adenoids for treatment of glue ear	apcs.der _ procedure _ all like '%E20[1489]%'and apcs.der _ procedure _ all like '%D151%'and (der.Spell _ Primary _ Diagnosis like'H65[2349]%' OR der.Spell _ Primary _ Diagnosislike 'H66[1349]%'OR der.Spell _ Primary _ Diagnosis like 'H681%' OR der.Spell _ Primary _ Diagnosis like'H69[89]%')and (apcs.der _ diagnosis _ all not like'%G473%' and apcs.der _ diagnosis _ all not like '%J32%' and apcs.der _ diagnosis _ all not like '%Q3[57]%')and isnull(APCS.Age _ At _ Start _ of _ Spell _ SUS,APCS.Der _ Age _ at _ CDS _ Activity _ Date)<=18 and APCS.Admission _ Method not like ('2%')
2E	2E Arthroscopic surgery for meniscal tears	left(der.Spell _ Dominant _ Procedure,3)='W82' and (der.Spell _ Primary _ Diagnosis like '%M23[23]%' or der.Spell _ Primary _ Diagnosis like '%S832%') and APCS.Admission _ Method not like ('2%')
2F	2F Troponin test	ecds.Der_EC_Investigation_All like '%105000003%' or ecds. Der_EC_Investigation_All like '%121870001%' or ecds.Der_EC_Investigation_All like '%121871002%' or ecds. Der_EC_Investigation_All like '%313724009%' or ecds.Der_EC_ Investigation_All like '%313616005%' or ecds.Der_EC_Investigation_All like '%314068007%' or ecds. Der_EC_Investigation_All like '%166794009%' or ecds. Der_EC_Investigation_All like '%105001004%' or ecds.Der_EC_ Investigation_All like '%784261000000103%'
2G	2G Surgical removal of kidney stones	(left(der.Spell _ Dominant _ Procedure,4) in ('M094','M098','M164','M261','M262','M263','M271','M272','M273','M278') OR left(der.Spell _ Dominant _ Procedure,3)='M28') and der.Spell _ Primary _ Diagnosis like '%N20[0129]%' and isnull(APCS.Age _ At _ Start _ of _ Spell _ SUS,APCS.Der _ Age _ at _ CDS _ Activity _ Date) between 19 and 120

2H	2H Cystoscopy for men with uncomplicated lower urinary tract symptoms	left(der.Spell _ Dominant _ Procedure,3)='M45' and apcs.sex=1 AND apcs.der _ procedure _ all NOT LIKE '%M45[1-4]%' and isnull(APCS.Age _ At _ Start _ of _ Spell _ SUS,APCS.Der _ Age _ at _ CDS _ Activity _ Date) between 19 and 120 and APCS.Admission _ Method not like ('2%')
2I	2I Surgical intervention for benign prostatic hyperplasia	l(left(der.Spell _ Dominant _ Procedure,4) like '%M61[123489]%'or left(der.Spell _ Dominant _ Procedure,4) like '%M641%'or left(der.Spell _ Dominant _ Procedure,4)like '%M65[1234589]%'or left(der.Spell _ Dominant _ Procedure,4)like '%M66[12]%'or left(der.Spell _ Dominant _ Procedure,4)like '%M68[13]%') and der.Spell _ Primary _ Diagnosis like'%N40%' and apcs.sex=1 and isnull(APCS.Age _ At _ Start _ of _ Spell _ SUS,APCS.Der _ Age _ at _ CDS _ Activity _ Date) between 19 and 120 and APCS.Admission _ Method not like ('2%')
2J	2J Lumbar Discectomy	left(der.Spell _ Dominant _ Procedure,4) in ('V331','V332','V333','V334','V335','V336','V337','V338','V339','V351','V358','V359','V511','V518','V519','V521','V522','V525','V528','V529','V583','V588','V589 ','V603','V608','V609')and (der.Spell _ Primary _ Diagnosis like '%M51[01]%' or der.Spell _ Primary _ Diagnosis like '%M54[134]%') and isnull(APCS.Age _ At _ Start _ of _ Spell _ SUS,APCS.Der _ Age _ at _ CDS _ Activity _ Date) between 19 and 120 and APCS.Admission _ Method not like ('2%') AND (der _ procedure _ all LIKE '%V55[12389]%')
2K	2K Lumbar radiofrequency facet joint denervation	der.Spell _ Dominant _ Procedure like '%V48[57]%' and left(der.spell _ primary _ diagnosis,4) in ('M518','M519','M545','M549') and (apcs.der _ procedure _ all like '%Z67[567]%' or apcs.der _ procedure _ all like '%Z993%') and isnull(APCS.Age _ At _ Start _ of _ Spell _ SUS,APCS.Der _ Age _ at _ CDS _ Activity _ Date) between 19 and 120 and APCS.Admission _ Method not like ('2%')
2L	2L Exercise ECG for screening for coronary heart disease	der.Spell _ Dominant _ Procedure like '%V48[57]%'and left(der.spell _ primary _ diagnosis,4) in ('M518','M519','M545','M549')and (apcs.der _ procedure _ all like '%Z67[567]%' or apcs.der _ procedure _ all like'%Z993%')and isnull(APCS.Age _ At _ Start _ of _ Spell _SUS,APCS.Der _ Age _ at _ CDS _ Activity _ Date)between 19 and 120 and APCS.Admission _ Method not like ('2%')
2M	2M Upper GI endoscopy	**APC extract** left(der.Spell _ Dominant _ Procedure,3) in ('G16','G19','G45','G65','G80') and isnull(APCS.Age _ At _ Start _ of _ Spell _ SUS,APCS.Der _ Age _ at _ CDS _ Activity _ Date) between 19 and 120 and APCS.Admission _ Method not like ('2%') **OPA extract** left(der.Spell _ Dominant _ Procedure,3) in ('G16','G19','G45','G65','G80') and isnull(APCS.Age _ At _ Start _ of _ Spell _ SUS,APCS.Der _ Age _ at _ CDS _ Activity _ Date) between 19 and 120 and APCS.Admission _ Method not like ('2%')
2N	2N Appropriate colonoscopy in the management of	**APC extract** (apcs.Der _ Procedure _ All like '%H22[189]%' or apcs.Der _ Procedure _ All like '%H68%') and apcs.der _ diagnosis _ all not like '%Z121%' And isnull(APCS.Age _ At _ Start _ of _ Spell _ SUS,APCS.Der _ Age _ at _ CDS _ Activity _ Date)

	hereditary colorectalcancer	between 19 and 120 AND APCS.Der _ Procedure _ All NOT like '%H68[13]%' and APCS.Admission _ Method not like ('2%')
20	2O Repeat Colonoscopy	**OPA extract** (opa.Der _ Procedure _ All like '%H22[189]%' or opa.Der _ Procedure _ All like '%H68%') and ISNULL(opa.der _ diagnosis _ all,'') not like '%Z121%' And ISNULL(opa.Age _ at _ Start _ of _ Episode _ SUS,opa.Der _ Age _ at _ CDS _ Activity _ Date) between 19 and 120 AND opa.Der _ Procedure _ All NOT like '%H68[13]%'
2P	2P ERCP in acute gallstone pancreatitis without cholangitis	Refer to P.128 of Guidance (Codes are too lengthy to list)
2Q	2Q Cholecystectomy	Der.Spell _ Dominant _ Procedure like '%J18%' and der.Spell _ primary _ diagnosis like '%K851%' and isnull(APCS.Age _ At _ Start _ of _ Spell _ SUS,APCS.Der _ Age _ at _ CDS _ Activity _ Date) between 19 and 120
2R	2R Appendicectomy without confirmation of appendicitis	Der.spell _ dominant _ procedure like '%H0[12]%'
2S	2S Low back pain imaging	(opa.Der _ Procedure _ All like '%U05[45]%' or ((opa.Der _ Procedure _ All like '%U13[2356]%' or opa.Der _ Procedure _ All like '%U21[1267]%') and (opa.Der _ Procedure _ All like '%Z665%' or opa.Der _ Procedure _ All like '%O162%'))) and ISNULL(opa.Age _ at _ Start _ of _ Episode _ SUS,opa.Der _ Age _ at _ CDS _ Activity _ Date) between 19 and 120
2T	2T Knee MRI when symptoms are suggestive of osteoarthritis	opa.Der _ Procedure _ All like '%U133%' and (opa.Der _ Procedure _ All like '%Z846%' or opa.Der _ Procedure _ All like '%O132%') and ISNULL(opa.Age _ at _ Start _ of _ Episode _ SUS,opa.Der _ Age _ at _ CDS _ Activity _ Date) between 19 and 120
2U	2U Knee MRI for suspected meniscal tears	opa.Der _ Procedure _ All like '%U133%' and (opa.Der _ Procedure _ All like '%Z846%' or opa.Der _ Procedure _ All like '%O132%') and ISNULL(opa.Age _ at _ Start _ of _ Episode _ SUS,opa.Der _ Age _ at _ CDS _ Activity _ Date) between 19 and 120
2V	2V Vertebral augmentation (vertebroplasty or kyphoplasty) for	left(der.Spell _ Dominant _ Procedure,4)='V444' and der.Spell _ Primary _ Diagnosis like '%M80%'and isnull(APCS.Age _ At _ Start _ of _ Spell _ SUS,APCS.Der _ Age _ at _ CDS _ Activity _ Date) between 19 and 120 AND (der _ procedure _ all LIKE '%V55[12389]%')

	painful osteoporotic vertebral fractures	
2W	2W Shoulder Radiology: Scans for Shoulder Pain and Guided Injections	**W(i) – scans for shoulder pain:** (opa.Der _ Procedure _ All like '%U13[23456]%' or opa.Der _ Procedure _ All like '%U21[1267]%') and (opa.Der _ Procedure _ All like '%Z81[23489]%' or opa.Der _ Procedure _ All like '%Z891%' or opa.Der _ Procedure _ All like '%Z54[289]%' or opa.Der _ Procedure _ All like '%Z68[89]%') AND opa.Der _ Procedure _ All NOT LIKE and ISNULL(opa.Age _ at _ Start _ of _ Episode _ SUS,opa.Der _ Age _ at _ CDS _ Activity _ Date) between 19 and 120 **W(ii) – image guided injections for shoulder pain:** (opa.Der _ Procedure _ All like '%U13[23456]%' or opa.Der _ Procedure _ All like '%U21[1267]%') and(opa.Der _ Procedure _ All like '%Z81[23489]%' or opa.Der _ Procedure _ All like '%Z891%' or opa.Der _ Procedure _ All like '%Z54[289]%' or opa.Der _ Procedure _ All like '%Z68[89]%') AND opa.Der _ Procedure _ All LIKE '%W90[34]%' and ISNULL(opa.Age _ at _ Start _ of _ Episode _ SUS,opa.Der _ Age _ at _ CDS _ Activity _ Date) between 19 and 120
2X	2X MRI scan of the hip for arthritis	(opa.Der _ Procedure _ All like '%U133%' or opa.Der _ Procedure _ All like '%U211%') and (opa.Der _ Procedure _ All like '%Z84[389]%' or opa.Der _ Procedure _ All like '%Z902%') and ISNULL(opa.Age _ at _ Start _ of _ Episode _ SUS,opa.Der _ Age _ at _ CDS _ Activity _ Date) between 19 and 120
2Y	2Y Fusion surgery for mechanical axial low back pain	(left(der.Spell _ Dominant _ Procedure,4) like '%V38[23456]%' or left(der.Spell _ Dominant _ Procedure,4) like '%V404%') and der.Spell _ Primary _ Diagnosis like '%M54[59]%' and apcs.der _ diagnosis _ all not like '%M40[012]%' and apcs.der _ diagnosis _ all not like '%M41[01234589]%' and apcs.der _ diagnosis _ all not like '%M42[019]%' and apcs.der _ diagnosis _ all not like '%M43[01589]%' and apcs.der _ diagnosis _ all not like '%M872%' and isnull(APCS.Age _ At _ Start _ of _ Spell _ SUS,APCS.Der _ Age _ at _ CDS _ Activity _ Date) between 19 and 120 and APCS.Admission _ Method not like ('2%')
2Z	2Z Helmet therapy for treatment of positional plagiocephaly/brachycephaly in children	No coding included
2AA	2AA Pre-operative chest x-ray	We have been unable to accurately identify diagnostic and procedure codes and produce activity figures. Exploring the option of using linked Diagnostic Imaging Dataset (DIDs) data, available later this year.
2BB	2BB Pre-operative ECG	We have been unable to accurately identify diagnostic and procedure codes and produce activity figures. Exploring the option of using linked Diagnostic Imaging Dataset (DIDs) data, available later this year.

2CC	2CC Prostate-specific antigen (PSA) test	No coding is available for the procedure, diagnoses or indications.
2DD	2DD Liver function, creatinine kinase and lipid level tests – (Lipid lowering therapy)	No coding is available for the procedure, diagnoses or indications.
2EE	2EE Blood transfusion	No coding is available for the procedure, diagnoses or indications.

EBI Phase 2 National Based Interventions policy: P. 96 -145
EBI_list2_guidance_050121.pdf (aomrc.org.uk)

Appendix 6 - Definitions

Definition of Clinical Thresholds

Clinical thresholds are a predetermined set of criteria that must be met before some procedures are considered. The threshold may be such that medication would deal with the problem. Surgery should be a last resort for a number of conditions and should not take place before considering and trying other non-surgical, reasonable options.

Definition of Commissioning

Assessing local needs, agreeing priorities and strategies, and then buying services on behalf of our population from a range of providers whilst constantly responding and adapting to changing local circumstances.

Definition of Individual Funding Request

An individual funding request is where prior approval for a patient's treatment is required due to that treatment or symptom criteria being outside of our approved commissioning policies and in such cases exceptionality will need to be proven.

Definition of Exceptionality

In order to demonstrate exceptionality the patient

1. Must be significantly different to the population of interest (i.e. patients with pulmonary hypertension and/or the subpopulation), and,
2. Be more likely to benefit from this intervention than might be expected than other patients with the condition

Appendix 6 - DEFINITIONS

AESTHETIC	Concerned with beauty or the appreciation of beauty.
ADENOIDS	Small lumps of tissue at the back of the nose, above the roof of the mouth
ANGIOGRAPHY	Imaging used to check blood vessels
ARTHROSCOPY	A type of keyhole surgery used to diagnose and treat problems with joints
ANTIGEN	A substance that induces the immune system to produce antibodies against it is called an antigen
BLEPHAROPLASTY	A type of surgery that repairs droops eyelids
COLONOSCOPY	A camera to check inside your bowels
COSMETIC	Relating to treatment intended to restore or improve a person's appearance
CHOLECYSTECTOMY	Surgical procedure to remove your gallbladder
CHOLANGITIS	Inflammation of the bile duct
CYSTOSCOPY	A procedure to look inside the bladder using a thin camera called a cystoscope
DUPUYTRENS	A condition when one or more fingers bend towards the palm
ENDOSCOPY	Procedure where organs inside the body are looked at using an instrument called an endoscope
GYNAECOMASTIA	A condition in the male in which the mammary glands are excessively developed.
CUTIS LAXA	A rare, inherited or acquired connective tissue disorder in which the skin becomes inelastic and hangs loosely in folds

GANGLION	Noncancerous lumps that most commonly develop along the tendons or joints of your wrists or hands
HALLUX VALGUS	Most common foot deformity of the big toe
HYPERPLASIA	An increase in the number of cells in an organ or tissue
LABIAPLASTY	A surgical procedure to alter the size or appearance of the labia minora.
LIPODYSTROPHY	A disorder of fat tissue.
LIPOSUCTION	A method of fat removal through suction.
LIPOMA	A benign lump/tumour composed of fatty tissue.
MENISCAL TEARS	Injury to the part of the cartilage of the knee
MEIBOMIAN CYST (CHALAZION)	A Chalazion is a firm round lump in the upper or lower eyelid caused by a chronic inflammation/blockage of the meibomian gland
MORPHOLOGIC	Relating to form and structure.
OSTEOARTHRITIS	Condition that causes joints to become painful and stiff. Most common type of arthritis
PERIANAL	Conditions that affect the rectum and anus
PLAGIOCEPHALY	Head flattened on one side causing it to look asymmetrical
PTOSIS	When the upper eyelid droops over the eye
RHINOPLASTY	A surgical procedure to change the shape or structure of the nose.
RHINOPHYMA	Enlargement of the nose with redness and prominent blood vessels.

TONSILLECTOMY	Removal of the tonsils
TRIGGER FINGER	A condition that affects one or more of the hands tendons, making it difficult to bend the affected finger
TROPONIN	Protein that is released into the bloodstream during a heart attack
VERTEBROPLASTY	Procedure in which a special cement is injected into a fractured vertebra

Appendix 7 – Links to South Yorkshire and Bassetlaw Individual Funding Request Policies

Barnsley CCG - Individual Funding Requests Policy

Bassetlaw CCG - Individual Funding Requests Policy

Doncaster CCG - Individual Funding Request Policy

Rotherham CCG - Individual Funding Request Policy

Sheffield CCG - Individual Funding Request Policy

NHS
Barnsley
Clinical Commissioning Group

Governing Body

8 July 2021

Quality & Patient Safety Committee - Quality Highlights Report

PART 1A – SUMMARY REPORT

1.	**THIS PAPER IS FOR**
	Decision ☐ *Approval* ☐ *Assurance* ✓ *Information* ✓
2.	**PURPOSE**
	Provide the July 2021 Governing Body with the agreed highlights of the discussions at the Quality & Patient Safety Committee on 17 June 2021. The information provided is in addition to the monthly performance report and ongoing risk management via the Assurance Framework and Risk Register.
3.	**REPORT OF**

	Name	**Designation**
Executive / Clinical Lead	Jayne Sivakumar	Chief Nurse
Author	Hilary Fitzgerald	Quality Manager

4.	**SUMMARY OF PREVIOUS GOVERNANCE**
	The matters raised in this paper have been subject to prior consideration in the following forums:

Group / Committee	**Date**	**Outcome**
Quality and Patient Committee	17 June 2021	To raise as highlights to the Governing Body

5.	**EXECUTIVE SUMMARY**
	At the Quality and Patient Safety Committee meeting on 17 June 2021, it was agreed that the following six quality issues are highlighted to the Governing Body and rated: • Green – Barnsley Integrated Community Stroke Team • Green – Annual Patient Experience Report • Green – Removal of LeDeR from Risk Register • Green – Primary Care Update • Red – Barnsley Hospice • Red – SWYPFT Community Services Waiting Lists

	Details of the highlights can be found in Appendix A of this report.
6.	**THE GOVERNING BODY / COMMITTEE IS ASKED TO:**
	Note the Quality Highlights identified for information and assurance.
7.	**APPENDICES / LINKS TO FURTHER INFORMATION**
	Appendix A – Quality Highlights Report

Agenda time allocation for report:	10 minutes.

PART 1B – SUPPORTING INFORMATION & ASSURANCE

1. Links to Corporate Priorities, GBAF and Risk Register

This report provides assurance against the following corporate priorities on the Governing Body Assurance Framework

1.1 Urgent & Emergency Care		6.1 Efficiency Plans	
2.1 Primary Care		7.1 Transforming Care for people with LD	
3.1 Cancer		8.1 Maternity	
4.1 Mental Health		9.1 Digital and Technology	
5.1 Integrated Care @ System		10.1 Compliance with statutory duties	✓
5.2 Integrated Care @ Place			

The report also provides assurance against the following red or amber risks on the Corporate Risk Register:	N/A

2. Links to statutory duties

This report has been prepared with regard to the following CCG statutory duties set out in Chapter A2 of the NHS Act:

Management of conflicts of interest (s14O)		Duties as to reducing inequalities (s14T)	✓
Duty to promote the NHS Constitution (s14P)	✓	Duty to promote the involvement of each patient (s14U)	
Duty to exercise its functions effectively, efficiently and economically (s14Q)	✓	Duty as to patient choice (s14V)	
Duty as to improvement in quality of services (s14R)	✓	Duty as to promoting integration (s14Z1)	
Duty in relation to quality of primary medical services (s14S)	✓	Public involvement and consultation (s14Z2)	

3. Governance Considerations Checklist

3.1 Clinical Leadership

Have GB GPs and / or other appropriate clinicians provided input and leadership?	**Y**
Jayne Sivakumar, Chief Nurse	

3.2 Management of Conflicts of Interest (s14O)

Have any potential conflicts of interest been identified and managed appropriately, having taken advice from the Head of Governance & Assurance and / or the Conflicts of Interest Guardian if appropriate?	**NA**

3.3 Discharging functions effectively, efficiently, & economically (s14Q)

Have any financial implications been considered & discussed with the Finance Team?	**N**
Where relevant has authority to commit expenditure been sought from Management Team (<£100k) or Governing Body (>£100k)?	**NA**

3.4 Improving quality (s14R, s14S)

Has a Quality Impact Assessment (QIA) been completed if relevant?	**NA**
Have any issues or risks identified been appropriately addressed having taken advice from the Chief Nurse (or Deputy) if appropriate?	**NA**
See Appendix A	

3.5	**Reducing inequalities (s14T)**	
	Has an Equality Impact Assessment (EIA) been completed if relevant?	**NA**
	Have any issues or risks identified been appropriately addressed having taken advice from Equality Diversity & Inclusion Lead if appropriate?	**NA**
3.6	**Public Involvement & Consultation (s14Z2)**	
	Has a s14Z2: Patient and Public Participation Form been completed if relevant?	**NA**
	Have any issues or risks identified been appropriately addressed having taken advice from the Head of Comms & Engagement if appropriate?	**NA**
3.7	**Data Protection and Data Security**	
	Has a Data Protection Impact Assessment (DPIA) been completed if relevant?	**NA**
	Have any issues or risks identified been appropriately addressed having taken advice from the SIRO, IG Lead and / or DPO if appropriate?	**NA**
3.8	**Procurement considerations**	
	Have any issues or risks identified been appropriately addressed having taken advice from the procurement Shared Service if appropriate?	**NA**
	Has a Single Tender Waiver form been completed if appropriate?	**NA**
	Has a Primary Care Procurement Checklist been completed where GPs, networks or Federations may be a bidder for a procurement opportunity?	**NA**
3.9	**Human Resources**	
	Have any significant HR implications been identified and managed appropriately, having taken advice from the HR Lead if appropriate?	**NA**
3.10	**Environmental Sustainability**	
	Have any significant (positive or negative) impacts on the environment or the CCG's carbon footprint been identified?	**NA**

Appendix A - Quality Highlights Report

Issue	Consideration	Action
Barnsley Integrated Community Stroke Service	QPSC received a report setting out a summary of the key achievements of the Barnsley Integrated Community Stroke Service in its inaugural year (2020/21), and what additional measures would allow the service to fully deliver the ambition of the Long-Term Plan.	QPSC was assured regarding the quality of service provided in 2020/21, and that the residents of Barnsley have benefited from the implementation of the service.
BCCG Annual Patient Experience Report	QPSC received for assurance BCCG's Annual Patient Experience Report for 2020/21. This report is to comply with NHS Complaints Regulations 2009. The report demonstrates that the CCG met its statutory duties in 2020/21 in relation to complaints handling apart from 1 breach in relation to the acknowledgement timescale. The Quality Team maintained an average response time of 24 days despite staff shortages and a significant increased workload relating to the Covid pandemic. The service provided by GP Practices continues to be the most common subject of the complaints received by the CCG. Changes to working practices due to the Covid pandemic is a significant contributory factor in the substantial increase in the number of contacts about practices in 2020/21.	The Committee was assured that complaints and concerns received by the Quality Team are being managed effectively and that learning from complaints has been acted upon.
Removal of LeDeR from Risk Register	QPSC was asked to consider the removal of the risk on the Risk Register relating to LeDeR as it is no longer active. All outstanding LeDeR reviews within the cohort were completed by 31st December. There is a new LeDeR process from June 2021 with a Review Team across the ICS.	QPSC agreed the removal of the risk on the Risk Register relating to LeDeR
Primary Care Update	**GP Appointments Data** QPSC has previously been notified that the GP appointment data is not yet fully developed. The Network Contract DES requires that by 30 June 2021 all practices in the PCN will have mapped all active appointment slot types to the new set of national appointment categories and are complying with the August 2020 guidance on recording of appointments.	QPSC noted that future data should provide accurate information about the different types of appointments being offered by GP practices in Barnsley.

Issue	Consideration	Action
	QPSC was asked to consider the removal of the risk on the Risk Register relating to the Rose Tree Practice. This request was due to an improvement in the Practice's CQC rating to "Good" following a CQC inspection on the 18 May 2021.	QPSC agreed the removal of the risk on the Risk Register relating to Rose Tree Practice.
Barnsley Hospice CQC Warning Notice	QPSC was updated regarding four warning notices issued to Barnsley Hospice by the CQC on 21 May 2021 following an unannounced inspection on 28, 29 April 2021 and 4 May 2021. The notices are in relation to failing to comply with: Regulation 12 – Safe Care and Treatment Regulation 13 – Safeguarding Regulation 17 – Good Governance	QPSC was reassured that the Hospice has set up a working group to review and respond to the issues raised and relevant work is underway. An action and improvement plan has been developed. The CCG's Quality Team is providing support with this.
SWYPFT Waiting Lists	QPSC was briefed on the response from SWYPFT to an information request submitted the CCG on 19 May 2021 relating to waiting lists in SWYPFT's Community Services. The Committee raised concerns regarding the accuracy of waiting list data due to data quality issues and whether the waiting lists are being managed effectively.	QPSC was not assured that the waiting lists in SWYPFT's Community Services are being managed effectively. An update has been requested for the next Clinical Quality Board on 22 July 2021 in relation to data cleansing and data validation.

NHS
Barnsley
Clinical Commissioning Group

GOVERNING BODY

8 July 2021

RISK AND GOVERNANCE EXCEPTION REPORT

PART 1A – SUMMARY REPORT

1.	**THIS PAPER IS FOR**						
	Decision		*Approval*	✓	*Assurance*	✓	*Information*	
2.	**PURPOSE**						
	• To assure the Governing Body re the delivery of the CCG's annual strategic objectives • To assure the Governing Body that the current risks to the organisation are being effectively managed and monitored appropriately						
3.	**REPORT OF**						

	Name	Designation
Executive Lead	Richard Walker	Head of Governance & Assurance
Author	Paige Dawson	Governance, Risk & Assurance Facilitator

4.	**SUMMARY OF PREVIOUS GOVERNANCE**

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

Group / Committee	Date	Outcome
All Committees	Various	Review extracts of the GBAF and Risk register at every meeting

5.	**EXECUTIVE SUMMARY**
5.1	**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. One of the key priority areas (3 - Cancer) is rated as red meaning that there is currently a significant risk that the deliverables in this area may not be achieved in 2020-21.

	Refreshing the GBAF for 2021/22 Since 2017-18 the GBAF has been structured around the key priorities and deliverables in the *Next Steps on the NHS Five Year Forward View,* updated each year as necessary to reflect any changes in the planning guidance. Senior Management Team has recently undertaken a review of the GBAF in the light of the 2021/22 Planning Guidance, to ensure that it remains relevant and fit for purpose as we enter what is likely to be the final year of the CCG as currently constituted. In most cases the refresh process has entailed updating the existing priority areas on the GBAF to take account of any new deliverables or threats to delivery. However, three new priority areas have been added to the GBAF related to: • Maximising elective activity (3.2), • Implementing Population Health Management and Personalised Care (5.3), and • Delivering the covid vaccination programme & meeting needs of patients with covid-19. The updated GBAF 2021/22 is appended to this report for Governing Body's approval.
5.2	**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). There are currently 9 red (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: • Ref CCG 18/04 (rated score 20, '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 20/03 (rated score 16 'extreme') – Potential adverse consequences if the BCCG CHC team is unable to deliver its recovery

	plan to enable the backlog of reviews to be cleared and new cases to be processed in a timely way, with robust case management processes in place • Ref CCG 14/15 (rated score 15 'extreme') – Potential impact on quality & patient safety of incomplete D1 discharge letters. • Ref CCG 19/05 (rated score 15 'extreme') - If the health and care system in Barnsley is not able to commission and deliver end of life care services of sufficient quality and capacity to support end of life patients in the community, there are risks for the CCG across a number of areas. • Ref CCG 21/01 - If the CCG is does not implement robust arrangements to approve packages of Children's Continuing Health Care and associated NHS funding, there is a risk of: Challenge to decisions not to award funding in some cases – possible risk of litigation, Negative impact on patient safety due to lack of quality monitoring of placements for CCC funded children; adverse financial consequences for the CCG. • COVID 1 - Disruption to health and social care – hidden harm - During the C19 peak healthcare seeking behaviours changed along with service delivery models resulting in lower urgent and emergency care presentations and fewer referrals to healthcare services. This 'hidden harm' may cause a double burden that may be caused by people not presenting or delaying presenting with new or existing conditions. • COVID 2 - Backlog and demand surge - A backlog of non-COVID-19 care following the suspension of routine clinical care that is likely to result in an increased number of poorly-managed chronic conditions or undiagnosed diseases and be combined with a surge in post-COVID-19 morbidity (which needs to be quantified). Reducing the backlog of care will be hampered by reduced operational capacity across NHS organisations designed to prevent transmission of COVID-19. *Updates*: • Risk 20/02 in relation to LeDeR has been removed from the Risk Register as it is no longer active. There is a new LeDeR process that started in June 2021 with a Review Team across the ICS. Barnsley has moved from the West Yorkshire SYB to the South Yorkshire in terms of LeDeR. Discussions are taking place about learning and action from reviews. • Risk 19/03 in relation to White Rose Medical Practice has also been removed in light of a good recent CQC report. Risk owners continue to review and refresh all the risks allocated to them to ensure the risk register is complete and up to date. The CCG's Committees continue to review and manage all the risks identified.
	Governing Body Work Plan / Agenda Timetable 2021-22 As part of governance and assurance processes the Governing Body is required to have a timetable of agenda items and plan of its work. The work plan is submitted to the Governing Body on a quarterly basis for review and update as appropriate. The Governing Body Assurance Work Plan / Agenda Timetable at appendix 3 has been updated to March 2022.

6.	**THE GOVERNING BODY IS ASKED TO:**
	• Approve the refreshed Governing Body Assurance Framework 2021/22 • Review the Risk Register and consider whether all risks are being appropriately managed • Identify any potential new risks or risks for removal • Note removal of risks 20/02 and 19/03 • Receive and provide comments on the Governing Body work Plan & Agenda Timetable 2021/22
8.	**APPENDICES / LINKS TO FURTHER INFORMATION**
	• Appendix 1 – GBAF 2021/22 • Appendix 2 – Corporate Risk Register • Appendix 3 - Governing Body Work Plan / Agenda Timetable 2021-22
Agenda time allocation for report:	10 minutes

PART 1B – SUPPORTING INFORMATION & ASSURANCE

1. Links to Corporate Priorities, GBAF and Risk Register

This report provides assurance against the following corporate priorities on the Governing Body Assurance Framework

1.1 Urgent & Emergency Care	✓	6.1 Efficiency Plans	✓
2.1 Primary Care	✓	7.1 Transforming Care for people with LD	✓
3.1 Cancer	✓	8.1 Maternity	✓
4.1 Mental Health	✓	9.1 Digital and Technology	✓
5.1 Integrated Care @ System	✓	10.1 Compliance with statutory duties	✓
5.2 Integrated Care @ Place	✓		

The report also provides assurance against the following red or amber risks on the Corporate Risk Register:	*ALL*

2. Links to statutory duties

This report has been prepared with regard to the following CCG statutory duties set out in Chapter A2 of the NHS Act

Management of conflicts of interest (s14O)		Duties as to reducing inequalities (s14T)	
Duty to promote the NHS Constitution (s14P)	✓	Duty to promote the involvement of each patient (s14U)	
Duty to exercise its functions effectively, efficiently and economically (s14Q)		Duty as to patient choice (s14V)	
Duty as to improvement in quality of services (s14R)		Duty as to promoting integration (s14Z1)	
Duty in relation to quality of primary medical services (s14S)		Public involvement and consultation (s14Z2)	

3. Governance Considerations Checklist *(these will be especially relevant where a proposal or policy is brought for decision or approval)*

3.1 **Clinical Leadership**

Have GB GPs and / or other appropriate clinicians provided input and leadership?	***NA***

3.2 **Management of Conflicts of Interest (s14O)**

Have any potential conflicts of interest been identified and managed appropriately, having taken advice from the Head of Governance & Assurance and / or the Conflicts of Interest Guardian if appropriate?	***NA***

3.3 **Discharging functions effectively, efficiently, & economically (s14Q)**

Have any financial implications been considered & discussed with the Finance Team?	***NA***
Where relevant has authority to commit expenditure been sought from Management Team (<£100k) or Governing Body (>£100k)?	***NA***

3.4 **Improving quality (s14R, s14S)**

Has a Quality Impact Assessment (QIA) been completed if relevant?	***NA***
Have any issues or risks identified been appropriately addressed having taken advice from the Chief Nurse (or Deputy) if appropriate?	***NA***

3.5	**Reducing inequalities (s14T)**	
	Has an Equality Impact Assessment (EIA) been completed if relevant?	***NA***
	Have any issues or risks identified been appropriately addressed having taken advice from Equality Diversity & Inclusion Lead if appropriate?	***NA***
3.6	**Public Involvement & Consultation (s14Z2)**	
	Has a s14Z2: Patient and Public Participation Form been completed if relevant?	***NA***
	Have any issues or risks identified been appropriately addressed having taken advice from the Head of Comms & Engagement if appropriate?	***NA***
3.7	**Data Protection and Data Security**	
	Has a Data Protection Impact Assessment (DPIA) been completed if relevant?	***NA***
	Have any issues or risks identified been appropriately addressed having taken advice from the SIRO, IG Lead and / or DPO if appropriate?	***NA***
3.8	**Procurement considerations**	
	Have any issues or risks identified been appropriately addressed having taken advice from the procurement Shared Service if appropriate?	***NA***
	Has a Single Tender Waiver form been completed if appropriate?	***NA***
	Has a Primary Care Procurement Checklist been completed where GPs, networks or Federations may be a bidder for a procurement opportunity?	***NA***
3.9	**Human Resources**	
	Have any significant HR implications been identified and managed appropriately, having taken advice from the HR Lead if appropriate?	***NA***
3.10	**Environmental Sustainability**	
	Have any significant (positive or negative) impacts on the environment or the CCG's carbon footprint been identified?	***NA***

RISK REGISTER – June 2021

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)	9	Monthly
Likely	4	Major	4	Amber	High Risk	(8- 12)	20	3 mthly
Possible	3	Moderate	3	Yellow	Moderate Risk	(4 -6)	6	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**
COVID 1	5, 6	**Disruption to health and social care – hidden harm** During the C19 peak healthcare seeking behaviours changed along with service delivery models resulting in lower urgent and emergency care presentations and fewer referrals to healthcare services. This 'hidden harm' may cause a double burden that may be caused by people not presenting or delaying presenting with new or existing conditions.	**5**	**5**	**25**	• Relates to ability to recover • ongoing analysis of mental health, but growing severity includes suicides look likely. Local and national initiatives to encourage people to still access primary care services and mental health services if they have any concerns.	Director of Commissioning CCG Gold Command F&PC	COVID-19	**4**	**4**	**16**	06/21	**June 2021** No further update. **April 2021** No further update. **Feb 2021** Mitigating section updated to reflect more accurately. FPC recommended to reduce risk score in light of mitigations in place from 5x5=25 to 4x4=16 in light of mitigations now in place. Our integrated health	07/21

			Initial Risk Score						Residual Risk Score					
Ref	**Domain**	**Risk Description**	**Likelihood**	**Consequence**	**Score**	**Mitigation/Treatment**	**Lead Owner of the risk**	**Source of Risk**	**Likelihood**	**Consequence**	**Score**	**Date Risk Assessed**	**Progress/ Update**	**Date for re-assessment**
													and care partnership continues to monitor this risk. Specific work on planned care has taken place at ICS and this learning is now being taken to the Barnsley Planned Care Board for action. Barnsley is developing a Vulnerability Index to potentially add further holistic dimensions to clinical decision making in relation to long wait patients.	
COVID 2	1,5, 6	**Backlog and demand surge** A backlog of non-COVID-19 care following the suspension of routine clinical care that is likely to result in an	**5**	**5**	**25**	• Health and care saw a resurgence of COVID in the Autumn, with OPEL3-4 being hit and recovery being slowed. • National lockdown has seen COVID cases and OPEL level reduce.	Director of Commissioning CCG Gold Command F&PC	COVID-19	**4**	**4**	**16**	06/21	**June 2021** No further update. **April 2021** No further update. **Feb 2021** Mitigating section	07/21

			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**
		increased number of poorly-managed chronic conditions or undiagnosed diseases and be combined with a surge in post-COVID-19 morbidity (which needs to be quantified). Reducing the backlog of care will be hampered by reduced operational capacity across NHS organisations designed to prevent transmission of COVID-19.				Plans in place to revisit recovery in a flexible way, including COVID-surveillance.							updated to reflect more accurately. FPC recommended to reduce risk score in light of mitigations in place from 5x5=25 to 4x4=16. The Barnsley Health and Care recovery and stabilization plan will be updated in March 2021.	
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	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	Chief Operating Officer (Finance & Performance Committee)	Contract and Performance Monitoring	5	4	**20**	06/21	**June 2021** ECIST work ongoing. New IC model in place with increased capacity in community to provide step up care to avoid hospital admission. Ambulance pathways into Rightcare improved to	07/21

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		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.				and Emergency Care Delivery Board) with responsibility for delivering improvements to urgent care services and achieving related targets. The Board is overseeing work to develop appropriate services to ensure that patients are able to access appropriate care and support outside of hospital, or in a different way in hospital utilising SDEC pathways and implementing a new model at the front of A&E. Engagement with regional and SYB programme to implement 'Think 111' (Talk before you walk) model in partnership with Integrated Urgent Care providers Work ongoing with NHSE Emergency Care Improvement and Support Team (ECIST) to review pathways Additional Primary Care Capacity is in place for same day appointments through							reduce conveyance and provide direct access to community services. **May 2021** NEL activity (non covid) increasing. UEC Plan in place. Out of Hospital Services working to ensure appropriate urgent community response in place. Current block contract arrangement during COVID means that PbR is not in place as part of contracts.	

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						IHEART and Home Visiting Services Community 2 Hour rapid response in place accessed through the Rightcare Barnsley SPA Priority areas of work identified to support ICP vision and principles for proactive care and care out of hospital.								
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 meet the requirements and aspirations of the CCG for the people of Barnsley leading to increased health inequalities and poorer health	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)	Jeremy Budd (SSDG)	Added to the Corporate Risk register in context of long standing and frequently articulated concerns with respect to a basket of BMBC commissioned services notably: 0-19 Health Checks	4	4	**16**	06/21	**June 2021** No further update. **April 2021** No further update. **Feb 2021** BMBC and the CCG have restarted work on Joint Commissioning, A series of successful workshop events for senior commissioning leaders has been held and resulted	07/21

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		outcomes.						Weight management & smoking cessation					in commitment to a shared commissioning plan and also to further work to agree the scope of joint commissioning and to understand how we can align our resources to deliver the best outcomes for Barnsley and make best use of the Barnsley £.	
CCG 14/10	2, 5, 6	If the Barnsley area is not able to attract & retain a suitable & sufficient Primary Care clinical workforce e.g. due to delays in recruiting into the ARRS roles there is a risk that: (a)Primary Medical Services for patients are inconsistent (b)The people of Barnsley will receive a poorer quality of healthcare services	**3**	**3**	**9**	The Long Term Plan includes a section on workforce planning and Network Contract DES includes provision for a number of Primary Care specific roles that will support the delivery of services. The Network Contract DES has several deliverables that will support existing service delivery, utilise roles under the Additional Roles Scheme, support reduction in healthcare inequalities, and that will work	Head of Primary Care. (Primary Care Commissioning Committee)	Governing Body	**4**	**4**	**16**	06/21	**June 2021** 2 wte FCP (Physio) have been recruited and work progresses with other recruitment. **May 2021** Work is underway to support the ARRs recruitment to the PCN. There are new staff expected in post from May to July.	07/21

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		(c)Patients services could be further away from their home.				towards achieving sustainable service delivery in Barnsley. The Primary Care Strategy Group has a workforce element included within its transformation plans and will support the Barnsley "Place" Workforce Plan. The Primary Care Strategy Group will incorporate the SYB ICS Primary Care Strategy to support consistent service delivery across the ICS reflecting the needs of Barnsley as a "place". NHS England has published an Interim People Plan to support the workforce challenge. Links have been developed with the Medical School to enhance attractiveness of Barnsley to students							**April 2021** As discussed at PCCC in March 2021 the wording of the risk has been reviewed and updated so that it more accurately reflects the current risks to the CCG in this regard however there is currently no recommendation to reduce the score related to this risk.	
20/03	3,5, 6	If the BCCG CHC team is unable to deliver its recovery plan to enable the backlog of reviews to be cleared and new	4	4	**16**	Adverts currently out to fill 3 vacant posts Extension of contracts of 2 agency nurses to 26.2.21 will support clearance of covid	Chief Nurse Finance & Performance Committee	SMT discussion	4	4	**16**	06/21	**June 2021** Training matrix / Plan in place and signed off. Both vacancies filled and nurses are	07/21

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		cases to be processed in a timely way, with robust case management processes in place that demonstrate value for money whilst not compromising quality of care , there is a risk of adverse financial consequences for the CCG and inappropriate or out of date care packages being provided for patients which potentially would not be meeting their health needs. This could also have implications on meeting the KPI's as set by NHSE.				backlog Seeking to recruit a further 2 agency nurses to support with both backlog and new cases although it is currently difficult to find available suitably qualified individuals Discussion of risks and issues to take place at Governing Body in January 2021 Development of training plan for the CHC team on case management and handling difficult conversations with patients, families and carers. Ensure protocols are developed to provide appropriate guidance and consistency to staff and patients in relation to the cost of care packages and rationale for the level of care provided.	And Quality & Patient Safety Committee						just finishing induction, both nurses remain in probation period. Operational Lead meets with Chief Nurse weekly to discuss position of the service and monthly to review trajectory plans. Review of current processes being undertaken. Backlog of outstanding reviews still present but now reducing currently 84 compared to 162 in 31st March 2021. **April 2021** Training plan now in draft format and reviewed by the Chief Nurse with comments made. To be signed off by 9th April. CHC process SOP approved	

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													and PHB SOP approved. **February 2021** Vacant posts – all post filled awaiting start dates. Agency nurses – 2 outstanding COVID backlog cases then the focus will be on the outstanding Fast track reviews which there is a trajectory in place to monitor productivity Training plan – competency framework in place and all nurses completed on line CHC training. The operational Lead and Team leader are reviewing a 12 months training plan for the team CPA panel – this	

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													commenced in November 2020 with senior clinicians and finance manager to ensure quality and assurance and Governance in place of care packages in excess of £1000 per week.	
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	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	4	5	**20**	06/21	**June 2021** A designated shared BHNFT email address for Community Pharmacy (CP) DMS reconciliation queries has been set up and clinical pharmacists are being copied into emails. A DMS working group has been established to plan & develop DMS and discuss issues.	07/21

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		risk being that the GP practice may either accept inappropriate changes when all the patients' risk factors have not been accounted for by the hospital clinicians or an error has been made or not accept clinically important changes as not confident about the reasons for the change. 2. 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											BHNFT is arranging a meeting for the D1 Group. **Feb 2021** Risk increase from 3x5=15 to 4x5=20. TO BE APPROVED AT Q&PSC IN APRIL 2021. The national Community Pharmacy Discharge Service was launched on 15th February 2021. Community Pharmacies will be receiving D1 letters and will (in addition to GP practices) be undertaking medicines reconciliation against their PMR systems (medicines supply pre admission). This service will be significantly	

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		the hospital is not reconciling medicines using the GP Practice Summary Care Record or that the reconciliation is not sufficiently robust.											affected (clinical risk and efficiency) by the quality of the discharge meds information. The mapping of hospital systems and audit work remains on hold due to impact of COVID-19.	
CCG 21/01 Added March 2021	3,5, 6	If the CCG is does not implement robust arrangements to approve packages of Children's Continuing Health Care and associated NHS funding, there is a risk of: • Challenge to decisions not to award funding in some cases – possible risk of litigation • Negative impact on patient safety due to lack of quality monitoring	5	4	**20**	Improved record keeping systems in line with CHC Adults and the CCC Framework CCG attendance at funding panels to provide clinical scrutiny and challenge Specialist Clinical Portfolio Manager has assumed responsibility for CCC CCC process brought under CCG control Recruited a permanent Specialist CCC Assessor / case manager and a DCO.	Chief Nurse Finance & Performance Committee And Quality & Patient Safety Committee	GBDS January 2021	4	4	**16**	06/21	**June 2021** Final 360 Audit report received and management response / timescales for actions added. CCC processes now formalized and panels are clear on decision making. Nurse CCC Assessor has aligned all reviews to EHCPs and there is a communication strategy around	06/21

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		of placements for CCC funded children; • adverse financial consequences for the CCG				Developed a CCG appeals and disputes procedure All specialist funding referred to IFR panel with a written clinical recommendation for the treatment / intervention / equipment being a prerequisite							cases that may not be eligible for CCC going forward. The CYP IFR funding process is beginning to take shape and discussions are ongoing with BMBC re: smoothing the process. The last two CRAG panels have been cancelled as no cases were referred. Requests for ad-hoc funding other than Psychological therapy have not been received so far into this quarter. Data cleansing and financial reconciliation is ongoing and there is confidence that the funding record system will show	

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													an accurate position in the next quarter. **May 2021** 360 Assurance audit completed and draft report presented by auditors and management response being formulated. CCC Nurse Assessor has benchmarked existing 27 CCC cases against the National Framework and it is likely that at review eligibility will cease for a number of these. IFR therapy requests now coded differently against CAMHS and not CCC. Work continues on relationships with BMBC colleagues. A review of CRAG	

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													is pending. **April 2021** SOP approved. All CCC reviews and new cases being aligned to EHCP and CiN reviews. Most challenge is expected in cases where eligibility was agreed by the BHNFT CCC nurse and DST assessment was not CCC Framework compliant. One case passed to media by parent. Discussions ongoing with BMBC partners re: best approach. New guidance issued to BMBC re: IFR funding for non CCC cases. Stock-take of all Children on Broadcare	

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													ongoing and being cross – referenced with BMBC reords.	

			Initial Risk Score						Residual Risk Score					
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CCG 19/05 *added Dec 2019*	6 5 3	**If the health and care system in Barnsley is not able to commission and deliver end of life care services of sufficient quality and capacity to support end of life patients in the community, there are risks for the CCG across a number of areas, as follows:** **a) Quality and Patient Safety Risks** Delayed discharges due to staff not being able to obtain care packages leading to patients not being able to be in preferred place of care at end of life. b) Patients at home without a care package or a care package that is not being delivered as required.	5	4	20	1) Chief Nurse has raised issue with BMBC Joint Commissioning Team. BMBC is due to hold meetings with both their in house provider and contracted providers to try and get more detail around current capacity as well as longer term issues and look at any possible options to address those. A wider meeting with home care providers is planned for November 2019. 2) CHC EOL team to: a) email all providers each morning requesting what care package vacancies they have b) liaise with Rightcare Barnsley to provide updates on care packages c) offer 24 hour placement in residential/NH to all patient awaiting a care package in hospital to prevent delayed discharge and then to continue to try and procure a care package to transfer patient to their own home. d) explore additional support	Chief Nurse QPSC	End of Life Team in BCCG Continuing Healthcare Team	5	3	**15**	06/21	**June 2021** BMBC have undertaken a review regarding the framework of domiciliary providers. CHC Operational Lead and Chief nurse discussed one provider approach for EOL care. There is a meeting arranged for June 2021 with BMBC Joint commissioner manager to scope out the possibility of one provider **April 2021** Work has recommenced to look at alternative options for EOL Care Provision.	07/21

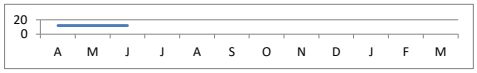
	2	**b)Financial Risks** Increased costs to CCG due to having to obtain care from specialist providers Delayed discharges will affect CCG's efficiency plans **c) Performance Risks** Delayed discharges impact upon patient flow which could affect delivery of 4 hour A&E standard and elective waiting times. Increase in non-elective admissions to hospital because of patients being left without care in the community.				from neighbourhood nursing service/ palliative care services in Barnsley e)Care packages to be spot purchased from any provider f) CHC EOL team to contact care providers on Barnsley borders to identify if they could pick up packages just over the borders.								

01/07/2021 **NHS Barnsley CCG Governing Body Assurance Framework 2021-22**

PRIORITY AREA 1: URGENT & EMERGENCY CARE	Delivery supports these CCG objectives:		PRINCIPAL THREATS TO DELIVERY
• Increased clinical assessment of calls to NHS 111 & CAS • Promote the use of NHS 111 as a primary route into all urgent care services - maximise the use of booked time slots in A&E • Delivery of 4 hour A&E standard (or new targets arising from the Clinical Review of Standards) • maximise the utilisation of direct referral from NHS 111 to other hospital services (including SDEC and specialty hot clinics) and implement referral pathways from NHS 111 to urgent community and mental health services • Enhance Same Day Emergency Care including acute frailty services, increasing the proportion patients discharged on the day of attendance and avoiding unneccessary hospital admission. • Improved patient flow and reduce length of stay • Rollout of the 2-hour crisis community health response at home (8am-8pm, seven days a week) by April 2022	Highest quality governance High quality health care ✓ Care closer to home ✓ Safe & sustainable local services ✓ Strong partnerships, effective use of £ ✓		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.
	Links to NHSE/I Planning Guidance		
	E2 - Ensuring the use of NHS111 as the primary route to access urgent care and the timely admission of patients to hospital who require it from emergency departments		

Committee Providing Assurance	**FPC**	*Executive Lead*	**JW**	*Clinical Lead*	**JH & MS**

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



Date reviewed	**Jun-21**

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 process is underway for 2021/22 in line with the NHS Planning Guidance. All activity plans are being developed in line with national expectations for increased activity levels back toward those in 2019/20, reflecting local restrictions and transformation work to redesign services. Plans at provider and commissioner level will be aligned to reflect the total Barnsley population.	CCG are working with the NHSE and the SYB ICS to formulate an ICS level activity plan. Plan will be submitted to NHSE in line with required deadlines. Activity levels are monitored on an ongoing basis to monitor delivery against submitted plans.	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 GB members (x2) and Chief Operating Officer represent the CCG as members of the local delivery board. 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. UEC Delivery Board Priorities have been agreed as: A&E Front Door & 111 First, Enahancement and expansion of SDEC, Reducing avoidable admissions and readmissions. Work is ongoing to reset the UEC Board Plan in line with Planning Guidance and other NHSE Guidance on the transformation of urgent and emergency care, including implementation of new standards. Barnsley Flu Plan has been developed by an operationla Flu group and was signed off by the UEC Delivery Board in September 2020	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.	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.	Community Services specification is being mobilised for integrated community and primary care services working as part of the PCN/Neighbourhood arrangements with a focus on providing proactive care at home or in a community setting and supporting people to be better able to manage their own conditions. Integrated Care Partnership Group principles have been agreed and partnership plans developed to support the overall vision for 'left shift'	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.	IUC/CAS is in place, increasing access to clinical advice and with the ability to book directly into primary care appointments for patients with a primary care need A&E waiting time performance 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 - These areas are subject to ongoing work to improve access and enhance the service offer to avoid attendance at ED where possible	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**

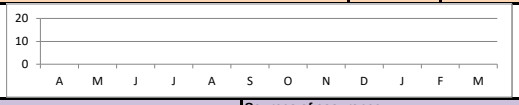
Gaps in control	**Actions being taken to address gaps in control / assurance**
RR 18/04: If the health and care system in Barnsley is not able to commission and deliver out of hospital urgent care services which have sufficient capacity and are effective in supporting patients in the community to avoid 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	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. The UEC Delivery Boardd is overseeing work to develop appropriate services to ensure that patients are able to access appropriate care and support outside of hospital, or in a different way in hospital utilising ambulatory care pathways and implementing a model to incorporate '111 First' CCG commissioned Out of Hospital Services being remodeled as part of the Neighbourhood Team mobilisation and includes PCN/Neighbourhood developments.

01/07/2021 **NHS Barnsley CCG Governing Body Assurance Framework 2021-22**

PRIORITY AREA 2: PRIMARY CARE	Delivery supports these CCG objectives:		PRINCIPAL THREATS TO DELIVERY
Delivery of the Long Term Plan Delivery of the Primary Care Network Contract DES to support the continued development of the Primary Care Network and sustainable primary care medical services. Support the reset of core GMS/PMS/APMS contract delivery across primary care Support the embedding of new ways of working learned from the pandemic Deliver investment into Primary Care and improve health inequalities via the Practice Delivery Agreement (PDA). The PDA for 2021-22 has schemes for practice delivery that supports the NHSE/I Planning Guidance and also plans in place to support using the Covid Expansion Funds (£120m). Support practice quality improvement and CQC rating by use of the Quality Dashboard and regular meeting to support action plan delivery for those practices having domains that "require improvement" Ensure recruitment/retention/development of the clinical and non-clinical workforce Work with the PCN to maximise recruitment under the Additional Roles Reimbursement Scheme and take action to support them to meet recruitment plans Support the recruitment and retention of extra doctors working in general practice. Improve access particularly during the working week with more bookable appointments at evenings and weekends. Improve access by offering online booking, online consultation, total triage and other digital options and to focus on supporting improvements in practices with long waits for routine appointments Provide CCG support to implement the current DES Service Specifications and to support preparation for the remaining Service Specification to be delivered from Oct 2021 Meet 2021/22 trajectories set out in the Network Contract DES and support planning to achieve the KPIs. Improve infrastructure, digital capability, digital literacy and inclusion. Deliver delegated Primary Care functions to be confirmed via mandated internal audit reviews	Highest quality governance High quality health care ✓ Care closer to home ✓ Safe & sustainable local services ✓ Strong partnerships, effective use of £ ✓ **Links to NHSE/I Planning Guidance** D1 - Restoring and increasing access to primary care services	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 providers and workforce - Workforce and capacity shortage, recruitment and retention - Under development of opportunities of primary care at scale, including new models of care - Primary Care Network and Neighbourhoods do not mature and develop to a level that supports the integrated delivery of Primary Care at place - BHF do not develop as a strong partner to support Primary Care at Scale - Not having quality monitoring arrangements embedded in practices - Inadequate investment in primary care - Independent contractor status of General Practice - Preparations for moving to ICS as a statutory body impacts on capacity to deliver transformation

Committee Providing Assurance	**PCCC**	*Executive Lead*	**JW / JF**	*Clinical Lead*	**MG**

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



Date reviewed	**Jun-21**

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?**
All practices are required to complete the National Workforce Data Return. ARRs roles identified in the PCN workforce plan and recruitment plans in place. Monitoring in place.	National database regularly updated to show workforce National PCN Dashboard developed and evolving CCG to monitor recruitment by PCN	Ongoing
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 A contract is in place with BHF for the BEST programme which enables the CCG to support the programme	BEST programme and Programme co-ordination being led by BHF Contract management meetings in place to assess and reporting via PCCC	Ongoing
Established a Primary care Strategy Group and delivery Group to support delivery of the primary Care Transformation programme. Development of Neighbourhood working within each of the 6 Neighbourhoods supported by the PCN and CCG. Bi-monthly PCN meetings established for all practices in the PCN. The 3 service specification from the Network Contract DES are now being undertaken by practices across each Neighbourhood. Work with the PCN to prepare for the next Service Specifications Work with the PCN regardin tackling health inequalites which have been further impacted by Covid. PCN Manager meetings set up with the CCG PC Team to support the Long Term Plan and DES delivery.	Primary Care Strategy Group working as a sub-group of PCCC Primary Care Delivery Group working to deliver the transformation programme6 Neighbourhood Networks have been agreed with the support of a single Primary Care Network facilitated by the GP Federation. This supports the transition and development of the PCN via the Neighbourhoods to deliver the primary care elements of the NHS Long Term Plan and Network Contract DES. Meetings are set for the year to ensure that the PCNs are able to meet regularly.	Ongoing
BHF - Existence of strong federation supports Primary Care at Scale	BHF contract monitoring, oversight by PCCC	Ongoing
Practices increasingly engaging with Community, voluntary and social care providers Personalisation/Social Prescribing - My Best Life is a successful programme supporting the people of Barnsley to work towards self care and the PCN are now delivering a young peoples Social Prescribing service. Work towards joining the services together as directed in the Network Contract DES. Collaboration to deliver primary care transformation and service delivery	Personalisation and Social Prescribing are key elements in the Long Term Plan. Care Coordiantios, Health and Wellbeing Coaches are in place to support people with self care. Primary Care Strategy Group working as a sub-group of PCCC Primary Care Delivery Group working to deliver the transformation programme	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. Ensuring BCCG stakeholders have a high level of satisfaction with the CCG's leadership & engagement.	Ongoing
SYB ICS has a workforce hub established, regular PC workforce meetings established which enables PC in Barnsley to collaborate with other CCGs, HEE, providers and Universities.	BCCG is represented on all workforce groups. Reporting is via PCCC for Primary care.	Ongoing

Gaps in assurance	**Positive assurances received**
APRIL 2021 - under recruitment in 2020-21 to ARRs roles has impacted on the additional support for the practices within the PCN - RISK HAS BEEN UPDATED TO REFLECT.	*APRIL 2021 - Workforce plans have been discussed with BHF who facilitate recruitment on behalf of the PCN to maximise the opportunity to recruit roles this coming year.*

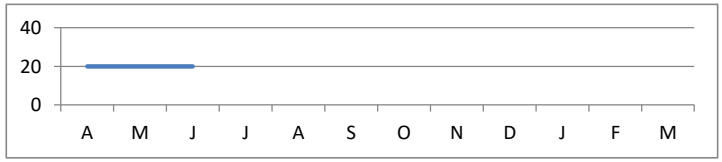
Gaps in control	**Actions being taken to address gaps in control / assurance**
Ref CCG 14/10 (rated score 16 'extreme') – Risks resulting from not being able to attract and retain a suitable and sufficient Primary Care clinical workforce.	The PC Team and PCN CDs work with member practices to address any gaps/ variance and to develop a workforce plan going forward supported by the Additional Role Recruitment via the Network Contract DES. The rolling recruitment and inclusion of new roles each year supports the PCN service delivery. Working closely with BHF to ensure the PCN maximise the recruitment opportunity for Barnsley. Practices encouraged to look at skill mix with innovative recruitment. The Primary Care Network and underpinning 6 Neighbourhood Networks are established and working on all elements of the Network Contract DES and Long Term Plan. The PC Team work closely with the PCN Managers to ensure delivery is on track. NHS England 360 Assurance audit in progress to provide NHS England with assurance of robust Primary Care processes. New topics are identified each year and the Head of Primary Care works with 360 to complete each plan.

01/07/2021 **NHS Barnsley CCG Governing Body Assurance Framework 2021-22**

PRIORITY AREA 3.1: CANCER	*Delivery supports these CCG objectives:*		PRINCIPAL THREATS TO DELIVERY
• 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 all tumour sites • Improve care and treatment - embed new cancer waiting times system • Improve Patient Experience along pathways and LWBAC • Increasing Positive Experience at EOL by increasing early identification and reducing 3 or more admissions in last 3 months of life • Deliver Survivorship Program (LWABC) including recovery package and stratified pathways • Commissioning for Value adopted if appropriate • Achieve 10 waiting time standards including the 62 day referral-to-treatment cancer standard and 28 day faster diagnosis standard and pre-covid position.	Highest quality governance	✓	1. Risk to delivery of the 62 day wait NHS Constitution standard if clear pathways from cancer diagnosis to treatment are not developed; capacity in place to meet the demand and services are able to respond to the impact of Covid restrictions on delivery of the Cancer Waiting Times. 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 and deliver the PCN DES . 3. Risk that, if the CCG does not have a clear local strategy for delivering cancer priorities and performance, Barnsley people morbidity and mortality from cancer will be impacted negatively for people at risk of cancer; Living With and Beyond Cancer (LWABC) and improving 62 day target and delivering 10 CWT 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.
	High quality health care	✓	
	Care closer to home	✓	
	Safe & sustainable local services	✓	
	Strong partnerships, effective use of £	✓	
	Links to NHSE/I Planning Guidance		
	C2 - Restore full operation of all cancer services		

Committee providing assurance	**FPC**	*Executive Lead*	**JW**	*Clinical Lead*	**Dr H Kadarsha**

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



Date reviewed	**Jun-21**

RATIONALE: Likelihood has been scored at 5 due to performance issues because of COVID impact but will be kept under monthly 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 are challenging and not delivering due to additional demand in the system and time required for demand to be addressed to reduce the back log plus P3 restoration targets

Key controls to mitigate threat:	**Sources of assurance**	**Rec'd?**
Programme Governance arrangements		

Steering Group: On track. CCG Contracting process: Reporting requirements relating to cancer coming via contracting plus weekly P3 restoration progress meetings. Monthly reporting to SMT about minimising harm and P3 restoration programme delivery progress plus areas that require escalation	HQS implementation group established, to develop and monitor quality priorities 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 Cancer Lead representation at CA board and CA Quality board . Steering group meeting 6 weekly and produces 6 weekly programme assurance and risk register that is approved by steering group and shared with CA. This group monitors programme delivery and updates shared with CCG SRO An 6 monthly assurance report submitted for governing body. contracting process ensures controls in place for BHNFT and STHT performance and contractual totals. This is reported to CCG via Finance & Performance committee and CQB /Quality and patient safety via Chief Nurse . 6 weekly reporting to SMT about minimising harm and P3 restoration programme delivery progress plus areas that require escalation	Ongoing
62 Day Waits		
Current CCG performance for Q1 is not being recorded (target 85%). Pre-Covid the CCG only had 1-2 people per quarter whom this affected past RTT 104 days and 6-10 for those breaching past 62 days compared to 115 now.. There are still 80 patients whom have no diagnosis or treatment date agreed. The total numbers breaching past 62 days have reduced from 180 to 115 patients over the last 8 weeks by 36%. Currently CCG diagnostic figures are diagnostic RTT pts waiting more than 6 weeks (3,027). 2019 level was 6.Current capacity levels not on track to meet phase 3 targets- increased COVID restrictions may stop endoscopy tests again	Performance is reported to CCG via Finance & Performance committee and via CA board reporting arrangements. CCG meets BHNFT cancer lead weekly to monitor performance and gain assurance about improvement actions to address minimising COVID impact and P3 restoration. Steering group meeting 4 weekly 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 with CCG SRO monthly . CCG attends BHNFT CPIG group and raises assurance points that are addressed via the action log process. Reduction in performance due to large number endoscopy backlog breaches and Urology. Escalated to CCG via Finance & Performance committee and mitigating actions provided for assurance . P3 Restoration plan agreed with BHNFT by CCG. DON gaining assurance about maintaining quality from BHNFT and STHT during restoration period.	Ongoing
Prevention		
Cervical started June 2020 Bowel restarted early September and Breast screening 5 days mid-September .CCG raised at BHNFT CQB that breast screening staff capacity is a risk and impacting on restoration. Extended Cervical screening running again via I-HEART .Escalated to PHE that breast screening reporting continues to be a high risks areas , as no permanent staff in place and only 1 person in place - risks that screening postponed again due to lack of staff resources.	Assurance is via 6 weekly cancer programme assurance process that ensures programme is on track and lack of progress addressed. The BCS work is reported to CCG via contractual process, via leads attendance at CCG Steering Group and bi-monthly assurance meetings with BCS by CCG cancer programme lead. Out of hours cervical screening pilot monitored via existing I-Heart contract assurance .	
Early Diagnosis		

Timed pathways: All timed pathway been affected - Lung, Lower & upper GI & urology (red rating): not meeting 28 day STT FDS. Endoscopy started extra slots and having an impact but still have 115 62 day breaches for RTT. BHNFT signed up to ICS endoscopy remote radiology procurement to increase capacity. Community diagnostic pathways/hub planning started and mapped overlaps with ICS elective care areas Scoping being undertaken with BHNFT and PCN . Will identify pathway efficiencies and how can reduce demand on current pathway. PCN agreed Early diagnosis DES project action plan with CCG – to reduce the variation in screening and early diagnosis rates across PCN practices and within the different Neighbourhood areas. vague symptoms pathway evaluation completed with primary care and improvement action plan agreed with BHNFT.	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 governance routes including reporting and gaining approval at MT for vague symptoms pathway and lower GI pathway implementations. CCG attends CA monthly ED group and reports back to CCG actions and ensures actions agreed are adopted via CCG governance routes including reporting and gaining approval at MT for vague symptoms pathway and lower GI pathway implementations. 6 weekly reporting to SMT about minimising harm and P3 restoration programme delivery progress plus areas that require escalation	Ongoing
Better treatment and care		
Waiting times: Start again rolling out timed pathway to reduce pressure on system. Tele dermatology : CCG SMT agreed VEAT contract to 31/12/2021. All 104 breaches had a RCA undertaken and safety netting in place by BHNFT for all patients on 2WW and routine pathway. Raised at CQB BHNFT that concern about breast screening and urology pathway quality due to staff turn over. Producing harm policy with CA that is more holistic definition that includes psychological harm of being on a prolonged pathway .	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 governance routes including reporting and gaining approval at MT and clinical forum . Quality Surveillance self-assessment reported to CCG quality and safety committee annually and exceptions raised via this route . Chief Nurse gaining assurance about maintaining quality from BHNFT and STHT during recovery period.	Ongoing
LWABC		
e-HNA/Care planning: Live pilot continues. CSW roles appointed. All templates completed in the 3 tumour sites. Supported self management: The Well has moved and reopened for face to face . Anxiety managements courses are well-attended. Risk stratified pathways: Clear pathways in place and being agreed regionally and locally –some delays still on local completion. Project evaluation: evaluation work on-going with the Regional LWABC programme. New men's peer group for prostate cancer starting in sept 2020.	Barnsley LWABC steering group governance framework in place and LWABC Leads membership of CA LWABC programme ensures programme reported to CCG	Ongoing
End of Life		
EoL strategy group meets to progress action plan - new objectives/actions agreed. Macmillan ANP for Care homes: Post-holder back in post after 4 month gap due to COVID. Continuing to roll out project.	Reporting is via CCG being member of EOL strategy group and having responsibility 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. EOL group focusing on reducing unavoidable admissions and early identification- action plan in place. EOL within D2A monitored by OH governance and via Chief Nurse	Ongoing
Communication and engagement		
Barnsley Resilience group started working on deliverables to reduce people's concerns and to target those that have unequal access to diagnostics and/or treatment or making choice to not engage - targeted communication undertaken by BMBC and ALMO housing provider staff and clients to dispel myths/concerns about using services and advertising alternative support services in place to help them have access e.g. NHS volunteer transport options.	Assurance is via 4 weekly cancer programme assurance process that ensures programme is on track and lack of progress addressed; Macmillan post educational 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 communication and engagement and Barnsley Communication and engagement group ensures actions and reporting are to CCG and via 4 weekly reporting for the cancer programme assurance reporting.	
Gaps in assurance	**Positive assurances received**	

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

01/07/2021 **NHS Barnsley CCG Governing Body Assurance Framework 2021-22**

PRIORITY AREA 3.2: MAXIMISING ELECTIVE ACTIVITY	*Delivery supports these CCG objectives:*		PRINCIPAL THREATS TO DELIVERY
There are four key areas of work: **1. Clinical Prioritisation -** Continue to prioritise the clinically most urgent patients and address the longest waiters whilst ensuring health inequalities are tackled. • *Greatest Harm* - Incorporate clinically led, patient focused reviews and validation of the waiting list on an ongoing basis, to ensure effective prioritisation and manage clinical risk • Build on the established clinical priorisation tool (FSSA recovery prioritisation matrix) to support the prioritisation of all referrals & draw on both primary and secondary care knowledge • *Long waiters* - Focus on reducing the number of 52 week waiters by end of March 2022, ensuring plan includes analysis of waiting times by ethnicity and deprivation **2. Communication** - maintain effective communication with patients including proactively reaching out to those who are clinically vulnerable.	Highest quality		There is a risk that the CCG will not be able to m activity if the following issues are not mitigated: 1. Clear and effective communication to the pub treatment and prioritsation. 2. Where necessary improve uptake of residents of barnsley for treatment. 3. If patients do not present for treatment. 4. If patients have a preference for face to face a 5. workforce capacity to deliver over 85% of acti account IPC, social distancing, staff leave, burnc access to diagnostics) 6. provider headspace to undertaken pathway tr adopt new ways of working e.g. PIFU
	High quality health care	✓	
	Care closer to home	✓	
	Safe & sustainable	✓	
	Strong partnerships, effective use of £	✓	
	Links to NHSE/I Planning Guidance		
	C1 - Maximise elective activity		

• Develop a system wide communications plan to inform public of approach and maintain effective proactive communication with patients.

3. Embedding Outpatient Transformation - support prioritisation in elective activity by minimising outpatient attendances of low clinical value and redeploying that capacity where it is needed.

• *Advice and Guidance* - (Maintain) Increased mobilisation of advice and guidance to provide specialist advice (this supports low conversion rates to outpatient appointments)

• *Patient initiated follow-up* (PIFU) - Expansion of programme so that PIFU is available in at least three major outpatient specialties by the end of Q2.

• *Remote Appointments* - Where outpatient attendances are clinically necessary, at least 25% should be delivered remotely by telephone or video consultation (equivalent to c.40% of outpatient appointments that don't involve a procedure).

4. Elective Activity / Elective Recovery Fund

• Monitoring elective recovery against the 85% target: From July 2021 deliver 85% of all electivity delivered in 2019/20 from July 2021 (and over 100% for those part of the accelerator programme via use of independent sector and insourcing)

Committee Providing Assurance			TBC	*Executive Lead*	JW	*Clinical Lead*
Risk rating	Likelihood	Consequence	**Total**			**Date reviewed**
Initial			3			Rationale: Likelihood has been sc
Current			4			(possible) but will be kept under r
Appetite	3	4	12			Consequence has been scored a
Approach	**Tolerate / Treat**					because there is a risk of significa
						quality of and access to care for p
						priorities are not delivered.

Key controls to mitigate threat:	**Sources of assurance**

Barnsley system Planned Care and Outpatients Group has been established and meets monthly, with CCG attending, to discuss system wide approach planned care, outpatient transformation and elective care recovery. This supports a system overview of the issues as well as to make improvements to system pathways and relationships.	Chief Operating Officer, CCG Chair and 2 x Governing Body members are represented on the board. Work is ongoing to align the elective care system wide plan to the planning Guidance and other NHSE Guidance on the transformation of outpatients / specialty redesign. The group has recently established the scope of 'elective care' and set key deliverables for 2021/22.
The CCG and Trust are leading on the developing a clear, prioritised delivery plan	
Operational planning process is underway for 2021/22 in line with the NHS Planning Guidance. All activity plans are being developed in line with national expectations for increased activity levels back toward those in 2019/20, reflecting local restrictions and transformation work to redesign services.	CCG are working with the NHSE and the SYB ICS to formulate an ICS level activity plan. Plan will be submitted to NHSE in line with required deadlines. Activity levels are monitored on an ongoing basis to monitor delivery against submitted plans.
Gaps in control	**Actions being taken to address gaps in control / assuranc**
Planned Care – backlog and demand surge There is a risk of delay to treatment of patients either through restricted access to services (due to social distancing, IP&C, need to travel) or hidden harm through people failing to present with issues due to fears around covid. This is likely to result in an increased number of poorly managed chronic conditions or undiagnosed diseases.	• All listed patients are clinically triaged, priority patients have throughout the year, a green pathway and protected bed capa agreed. • Patients with LTC have also been reviewed and prioritised ir • Primary, community, mental health , outpatients and diagno remain open. • Long waiters for Barnsley place are being reviewed and acti to further support improved care delivery. • A system wide comms plan has been drafted to help mainta communication with patients including proactively reaching ou

Elective Pathways There is a risk of delay to treatment of patients on elective pathways. This is caused by restrictions in terms of ipc and royal guidance re green sites e.g. orthopaedics. The impact will be to quality of life for individuals awaiting their operation and increased pressure on services to deliver. A further issue is the reticence of local residents to travel outside of Barnsley for treatment.	• All patients have been clinically triaged with emergency and being seen. External assurance has been obtained through na validation exercise. • System planned care group supports a system overview of t • Green pathway is now in place and dedicated beds for elect • Use of Independent sector and mutual aid. • Plans have been updated in response to the 21/22 planning participation in the elective accelerator programme (enhancing capacity beyond 85%, to excess of 100% from July 2021). The on streamlining and developing pathways in key surgical spec (orthopaedics, ophthalmology, paediatrics) and work with IS S

SCORE:	A	M	J	J	A	O	N	D	J	F
Likelihood	3	3	3							
Consequence	4	4	4							
Risk rating	12	12	12							
Tolerance	12	12	12							

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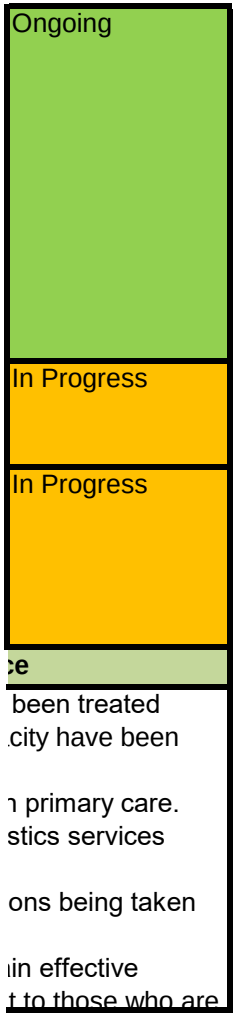
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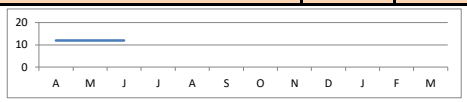
01/07/2021 **NHS Barnsley CCG Governing Body Assurance Framework 2021-22**

PRIORITY AREA 4: MENTAL HEALTH	*Delivery supports these CCG objectives:*		PRINCIPAL THREATS TO DELIVERY
A Barnsley Mental Health Partnership Board has been established, reporting directly to the Barnsley Health and Wellbeing Board and supported by a system-wide Mental Health Delivery Group. We continue to increase the number of children and young people receiving evidence-based treatment to improve their emotional health and wellbeing through the redesign of the CAMHS service and inreasing the number of MHST's and commissioning third sector organisations - the access target to be achieved in 2021/22 is 57% - CAMHS service beginning to implemement the new co-produced service specification focusing on establishing a Single point of Contact. A Children and Young People's Emotional Health and Wellbeing Hub is being developed on the first floor of the YMCA Building in the centre of Barnsley. A Children and Young Peoples Transformation Lead now in situ and leading on implementing recommendations of Overview and Scrutiny Committees which are also supported by the CCG IAPT services to be expanded to the level of investment available and working towards delivering the recoemmendations of the NHS Long Term Plan. Access targets will be challenging and the recommended targets unlikeley to be achieved. IAPT recovery target consistently above the national recommended target of 50% and support improving the recovery rate to an ambitious target of 60% Community Mental Health Transformationb bid successful and work progressing to develop a local Adult Eating Disorder pathway to link in with the regional service development led by RDASH as part of the SYB ICS; transformation funding also being utilised to develop improved services for people with Personality Disorders and to enhance Community Mental Health Rehab services linking with the newly developed Primary Care Mental Health posts as part of the ARRS (Additional Roles Reimbursement Scheme). Crisis Alternative bid has been successful and work is progressing to provide a 'safe space' for adults as part of the mental health crisis care support within the borough (it is anticipated that the childrens and young peoples Hub will provide a 'safe space' for children and young people as it evolves). Self-harm contines to be a key focus, particularly in the 10 - 24 years old age ranges where admissions to hospital in Barnsley are almost double the national average - Public Health are leading on work to reduce these admissions and provide more appropriate, early intervention. All-age liaison mental health (CORE 24) service now fully operational. Exemplar work progressing in Barnsley in respect of suicide prevention with targeted work continueing to be undertaken re men and older people. Specialist Perinatal Mental Health Services esablished and funding agreed to achieve the necessary expansion to achieve the LTP access requirements for 2021/22 Work is progressing to develop a single neurodevelopmental pathway for children and young people with the potential of achieving an all-age pathway within the next two years The Mental Health Investment Standard (MHIS) will be ahcieved. Improve access to healthcare and deliver annual physical health checks for the population the target to be achieved for 2019/20 of 60%was not achieved for patients on the GP SMI Register and improvements need to be made. 66.7% of people with dementia aged >65 should receive a formal diagnosis.	Highest quality governance High quality health care ✓ Care closer to home ✓ Safe & sustainable local services ✓ Strong partnerships, effective use of £ ✓ **Links to NHSE/I Planning Guidance** C3 - Expand and improve mental health services and services for people with a learning disability and/or autism	There is a risk that 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' - the CCG's ambitions for these services will not be achieved and that delivery of the recommendations within the NHS Long Term Plan (as explicitly outlined within the Mental Health Implementation plan 2019/20 - 2023/24) within the expected timeframes will not be possible

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	**Jun-21**

Key controls to mitigate threat:	**Sources of assurance**	**Rec'd?**
The Future in Mind funding allocations are now part of the CCG's baseline allocations and will continue to be utilised towards delivering the ambitions of the NHS Long Term plan	Quarterly Assurance reports / feedback to NHS England; monitored by C&YPT(Children and Young Peoples Trust) ECG (see note 1). ECG minutes to F&P Committee. Chilypep Quarterly monitoring reports	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. Regular updates to Governing Body. Mental Health service transformation overseen by the Mental Health Delivery Group	Ongoing
Service provider developing robust workforce plans in conjunction with Health Education England National Workforce Strategy - a local SWYPFT workforce strategy has been developed - SYB ICS Programe Board are leading on a regional wporkforce strategy to cover the next 5 years	Monitored at ICS level SYB ICS MHLD Steering Group.	Ongoing
Commissioning capacity for the adult autism service has been increased for 2021/22 and non-recurretn funding has been provided to eliminate the current backlog - by March 2022 it is anticipated that the current 3 year wait for an adult autism assessment will be reduced and sustained at 3 months. The newly commissioned service for the over 11 autism pathway has reduced the waiting time on this pathway from 2.5 years to a maximum of 9 months. All Barnsely's children and young peoples autism assessmentrand diagnositc pathwyas are fully NICE compliant	Performance data from SWYPFT (Adult service) and BHNFT (CYP service). Minutes of the ASD Steering Group	Ongoing
Continue to promote the local social prescribing service and the Children and young Peoples's Social Prescribing Service provided by the Barnsley Healthcare Federation	CAMHS Performance data received monthly and presented at ECG on a quarterly basis. Compass data in development. Chilypep provide a quarterly performance report that his shared with GB. Autism activity data in development and overseen by the Autism Steering Group	Ongoing
IAPT access targets are a key challenge in Barnsley - ther service is continuously promoted on social media and at GP surgeries and other community centres and self-referrals enabled via the Barnsley IAPT website. Limited university training places remain a constricting factor but HEE undertake to increase the places availalbe in future years.	Oversight by F&PC, reporting into Governing Body. New IAPT service is fully implemented and all national IAPT targets are achieved with the exception of the access targets - this reflects the regional picuture. Work is underway via the SYB ICS MHLD. Minutes of the SYB ICS MHLD Steering Group.	Ongoing
Barnsley Mental Health Partnership and a supporting Mental Health Delivery Group (MHDG) has been established which is providing robust oversight of the issues and challenges facing the local population. The work of the Crisis Care Concordat and Suicide Prevention Group is now merged in to the MHDG. Improved	Mental Health Partnership Board report to Barns;ey Health and Wellbeing Board	Ongoing
Barnsley CCG's bid for a MHST (as part of the Trailblazer programme) was successful and following a competitive procurement process Compass were awarded the contract. Recent bids as part of Waves 5 - 10 were submitted and Barnsley have been successful as part of Wave 8 (i.e. an additional MHST team will be funded by NHSE/I in 2022/23) with a possibility of a further team in Wave 10 (2023/24)	A small working group of key stakholders has been established to drive the transformation of the CAMHS service towards delivering the new service specification based on the iThrive model- this group reports to both the ECG and CCG Governing Body. CCG clinical leads support this group.	Ongoing
Barnsley CCG's bid to develop a Crisis Alternative and to access Community Mental Health Transformation Bids have been successful. Implementation of these bids is being overseen by the Mental Health Delivery Group and monitored / supported closely by SYB ICS MHLD Programme Board.	Performance and activity data submitted via contracts process. Quarterly Mental Health updates to CCG Governing Body	Ongoing
Note (1) - 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 regular 6 monthly / ad hoc Children's Services updates.		

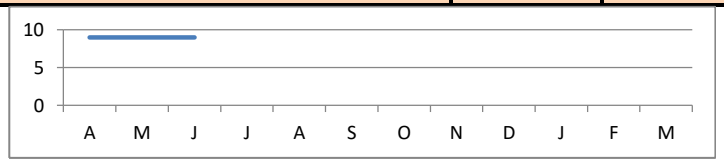
Gaps in assurance	**Positive assurances received**
Gaps in control	**Actions being taken to address gaps in control / assurance**

01/07/2021 **NHS Barnsley CCG Governing Body Assurance Framework 2021-22**

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 System-wide governance arrangements (including a system partnership board with NHS, Local Government and other partners) to enable a collective model of responsibility and decision-making between system partners. System capabilities including population health management, service redesign, workforce transformation, and digitisation required to fulfil the two core roles of an ICS. Agreed ways of working across the system in respect of financial governance and collaboration (noting that we propose, under the 2020/21 NHS Standard Contract streamlining commissioning arrangements, including typically one CCG per system). Capital and estates plans at a system level, as the system becomes the main basis for capital planning, including technology. Plans for how the system will iperate in 2021/22 will need to finalised for April 21. White paper on the formation of statutory ICS published Dec 20 with an ambition for statutory ICS to form in April 2022	Highest quality governance	✓	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. Effective governance of the ICS, changing role of the ICS eg allocation of funding to CCGs and providers . Managing change to system working during a pandemic could cause capacity issues, uncertainty for all stakeholders and could limit long term decision making.
	High quality health care	✓	
	Care closer to home	✓	
	Safe & sustainable local services	✓	
	Strong partnerships, effective use of £	✓	
	Links to NHSE/I Planning Guidance		
	F1 &F4 - Effective collaboration and partnership working across systems & Develop ICSs as organisations to meet the expectations set out in Integrating Care		

Committee Providing Assurance	**ICS CPB JCC of CCGs**	*Executive Lead*	**CE**		**NB**

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



Date reviewed	**Jun-21**

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?**
Governance review of the ICS currently underway to inform how the system operates in 2021/22	Minutes of HOB and JCCCG	Ongoing
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).	Complete (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. ICS governance arrangements for Level 3 ICS from April 19 in place	Complete
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.	Complete
Work underway to identify 2021/22 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 2020/21 ICS commissioning priorities and collaborative commissioning arrangements agreed in principle by BCCG Governing Body March 2019. Arrangements for delegation of decision making to JCCC subsequently signed off.	In progress
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.	Complete

Gaps in assurance	**Positive assurances received**
• 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.	SYB response to the NHS Long Term Plan collectively developed across partnership.
	Workshops with ICS and CCG Chairs and AOs held in December 2019 and January 2020 to agree the way forward with commissioning reform Jan 2020
Gaps in control	**Actions being taken to address gaps in control / assurance**

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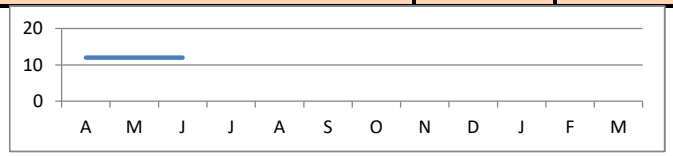
PRIORITY AREA 5.2: INTEGRATED CARE AT PLACE LEVEL	*Delivery supports these CCG objectives:*		PRINCIPAL THREATS TO DELIVERY
Development of partnership arrangements in Barnsley that deliver integrated services for patients and service users and create a weight-bearing structure in Barnsley to support maximum delegation with the integrated system from April 20222. This will include - -Development of the primary care network and neighbourhood networks - Embedding population health management to improve outcomes across the borough and targeted local action on health inequalities - Left-shift of investment and provision from secondary care to primary, community and out-of-hospital care - Strengthen joint commissioning between the CCG and Barnsley Council - Workforce and organisational development to system leadership and working - Growing the workforce for the future - Optimum use of the health and care estate across the borough and investment to facilitate shift of activity from hospital into community - Development of integated governance and shared leadership - Supporting and promoting the role of the community, voluntary and social enterprise sector in Barnsley in health and care	Highest quality governance	✓	There is a risk that if the following threats are not effectively managed and mitigated the key deliverables will not be achieved: - Financial pressures and maturity of the local partnership to manage risk - Uncertainties around the development of the integrated care system and role of place with the system and lack of clarity about the role and expectations of provider partnerships - Challenging timescales for organisational change with the reading of the draft integrating care bill delayed - The Government may fail to bring forward a legislative programme for adult social care and financial settlement or that the expected white paper does not fully support the developing partnership working in Barnsley - Clarity of the role of Barnsley Health and Wellbeing Board and local democratic accountability in the new system - Role of GPs and clinical commissioning in the new system - Staff retention through COVID recovery and system change - Ongoing COVID pandemic and associated pressures across services, particularly sustainability of the urgent and emergence care model in Barnsley and capacity of providers to constructively engage in development of the place partnership - Impact of COVID on the community, voluntary and social enterprise sector - Failure to demonstrate the impact and benefits of new ways of working in order to generate support and increase engagement - Lack of capacity to support expansion of student placements - Ability to recruit into new roles including additional roles in primary care - Sufficient focus and investment in transformation
	High quality health care	✓	
	Care closer to home	✓	
	Safe & sustainable local services	✓	
	Strong partnerships, effective use of £	✓	
	Links to NHSE/I Planning Guidance		
	A - Supporting the wellbeing of staff and take action on recruitment and retention (esp A4 grow for the future - system workforce planning) F1 & F2 - Effective collaboration and partnership working across systems & Develop local priorities that reflect local circumstances and health inequalities		

Committee Providing Assurance	**Governing Body**	*Executive Lead*	**JB**	*Clinical Lead*	**NB**

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



Date reviewed	**Jun-21**

Rationale:
- Major (4) 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 (3) as it is possible that the impacts could recur occasionally

Key controls to mitigate threat:	**Sources of assurance**	**Rec'd?**
Joint priorities and work programmes	Barnsley Health and Care Plan 2021/22 developed with partners and endorsed by the integrated care partnership group.	Ongoing
Oversight from the CCG Governing Body	Regular updates on integrated care received by Governing Body. Discussions at Governing Body Development Sessions. Representation from Governing Body by the Chair and Accountable Officer at Integrated Care Partnership Group meetings. Clinical leadership from Governing Body across partnership priority workstreams.	Ongoing

System engagement including primary care	Series of BEST events focussed on emerging guidance for primary care networks and the right model for Barnsley. Membership Council agreed to strategic direction at the meeting held on 3 July 2018	Complete
Local partnership governance arrangements	Compact and place agreement. Memorandum of Understanding between SWYPFT and the PCN for joint leadership. Senior responsible officers for all priorities set out in the Health and Care Plan	Complete
Alignment of resources	CCG commissioning and transformation staff aligned to partnership delivery groups. Additional interim support for the place design team	Complete
Independent legal advice	Appointed legal advisors that are also supporting the ICS and work nationally on integrated care.	Complete
Voice of place in the development of the integrated care system	Representatives of place on each of the ICS design workstreams and provider collaboratives feeding back into the place design team and integrated care partnership	Complete
Communications and engagement	Communications leads from across the partners have co-produced a communications and engagement place that has been signed off by ICPG.	Complete
Strong links between place and ICS workforce hub	Appointment of place workforce lead to work with the ICS workforce hub. Representation at the Local Workforce Action Board. Working with the ICS workforce hub on system priorities and alignment of local priorities including Barnsley Health and Social Care Academy, Project Echo and school engagement	Ongoing
Student placement expansion project	Appointed to a coordinator role to support student expansion hosted by Barnsley Hospital. Agreement to explore a place-based allocation model beginning with pre-registration nursing students. Completed CLiP project with ongoing evaluation	Ongoing

Gaps in assurance	**Positive assurances received**
Gaps in control	**Actions being taken to address gaps in control / assurance**
Establishment of a PMO function to support delivery of the health and care plan	Proposals being developed and will be presented to ICDG in July 2021. Proposals will ensure alignment of resources from across the partnership to support delivery
Pending guidance from the Department of Health and Social Care and NHS England Improvement regard constitution of integrated care systems and transitional arrangements	Place design team established and jointly Chaired by the CCG Accountable Officer and BMBC Chief Executive. Undertaken a self-assessment using the ICS Place Development matrix to identify priority areas and actions. Agreed preferred options for weight-bearing structure at Place. Ongoing discussions across SYB ICS leaders and Place leaders around preferred operating model

Development of collaborative commissioning	A series of workshop with CCG and BMBC commissioners to agree a joint approach around the life course. Developing a commissioning plan to support delivery of the Barnsley Health and Care Plan with CCG Governing Body.

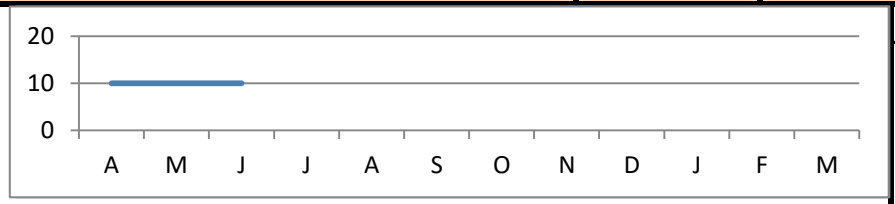
01/07/2021

NHS Barnsley CCG Governing Body Assurance Framework 2021-22

PRIORITY AREA 5.3: IMPLEMENTING POPULATION HEALTH MANAGEMENT AND PERSONALISED CARE	*Delivery supports these CCG objectives:*		PRINCIPAL THREATS TO
The CCG, local and system partners are committed to embedding a population health management approach to target recovery strategies, aiming for equitable access, excellent experience and optimal outcomes for all groups. This includes - - Use of person-centred segmentation and risk stratification to identify at-risk groups, those with the greatest health inequalities or the most complex needs, and those awaiting multiple appointments - Provide proactive, multidisciplinary, cross sector support to these patients, in line with the NHS Comprehensive Model for Personalised Care - Developing robust plans for the prevention of ill-health such as expansion of smoking cessation services, improving uptake of the NHS diabetes prevention programme and CVD prevention and high impact actions to support stroke, cardiac and respiratory care - Accelerating the delivery of existing requirements, including personal health budgets, social prescribing referrals and personalised care and support plans	Highest quality governance		There is a risk that the CCG will r Population Health Management a issues are not mitigated: - Lack of capacity in primary and because of ongoing operational p - Failure to successfully recruit, tr roles in primary care including so coordinators and health and wellb - Ability to access linked person-le target interventions and demonstr - Lack of sufficient technical analy delivery - Failure to properly engage and i care and service development
	High quality health care	✓	
	Care closer to home	✓	
	Safe & sustainable local services	✓	
	Strong partnerships, effective use of £	✓	
	Links to NHSE/I Planning Guidance		
	D2 - Implementing Population Health Management and Personalised Care		

Committee Providing Assurance	**TBC**	*Executive Lead*	**JB**	*Clinical Lead*

Risk rating	Likelihood	Consequence	**Total**
Initial	3	3	9
Current	3	3	9
Appetite	3	3	9
Approach	**Tolerate / Treat**		



Date reviewed

Rationale:
- Major (3) impact due
objective not being me
- Likely (3) as it is poss
occasionally

Key controls to mitigate threat:	**Sources of assurance**

Executive leadership and sponsorship	Designated executive leads for tackling health inequalities across al partner organisations. Workshop for health inequalities leads and in care delivery group representatives with outputs and framework enc ICPG. Health inequalities cross-cutting theme in Barnsley Health an Plan 2021/22 that has been endorsed by partners
Improving health intelligence infrastructure across the partnership	Health intelligence group established with positive engagement from the partnership. Population segmentation analysis completed. Popu health management analyst hosted by Barnsley Hospital funded thro COVID monies. Increased information sharing through COVID and I agreement endorsed by all partners. Regular reporting of health sur Integrated Care Outcomes Framework adopted by ICPG and Barns and Wellbeing Board
Risk stratification tool to support proactive case finding	Eclipse platform embedded within medicines management team. Sh secondary care data into Eclipse for pathway development
Prevention programmes in place and/or in development	Warm home healthy people team. Shaping Places Healthy Lives. M social prescribing service. Primary care network social prescribing li workers, care coordinators and health and wellbeing coaches. Diabe prevention programme. Barnsley Hospital Health Lives Team establ Barnsley Hospital selected to pilot an Alcohol Care Team. Get fit firs to support people to lose weight and stop smoking before surgery to risk of complications and achieve better outcomes
Personalised budgets	Embedding with NHS Continuing Healthcare practice and adult soci
Personalised care planning	Patient activation measures embedded with the SWYPFT long term conditions management services. Year of care in primary

Gaps in assurance	**Positive assurances received**
Gaps in control	**Actions being taken to address gaps in contro**

Pending publication of PCN service specification for anticipatory care	Working group established to develop proactive c moderate frailty building on the learning from sup COVID and population segmentation analysis. Or Solutions to configure local pathways for Barnsle of the Barnsley Vulnerability Index
Pending publication of PCN service specification for personalised care	Personalisation is identified as one of the cross-c and Care Plan 2021/22. Providing joint training a health and care staff including strengths-based p one of the priorities of the Barnsley Health and C the workforce group
Strength and balance offer for people at risk of falls	BMBC have identified funding and proposals are local prevention offer for healthy ageing

SCORE:	A	M	J	J	A	S	O	N	D	J
Likelihood	3	3	3							
Consequence	3	3	3							
Risk rating	9	9	9							
Tolerance	9	9	9							

DELIVERY

ıot be able to successfully implement
ınd Personalised Care if the following

community care to support delivery
ressures
ain, develop and retain additional
cial prescribing link workers, care
eing coaches
evel data to identify priority cohorts,
rate outcomes and impact
ytical capability and tools to support

nvolve people in decisions about their

	Dr M Guntamukkala
	Jun-21

to potential slippage leading to a key
et and potential for external challenge
sible that the impacts could recur

	Rec'd?

l NHS tegrated lorsed by d Care	Ongoing
ı across lation ɔugh high-level veillance. ley Health	Ongoing
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al care	Ongoing
	Ongoing
ol / assurance	

care model focussed on mild to porting vulnerable people through ngoing work with NHS Prescribing y beginning with frailty. Development
utting themes of the Barnsley Health nd development opportunities for ractice and shared decision making is are Plan being taken forward through
in development to strengthen the

F	M

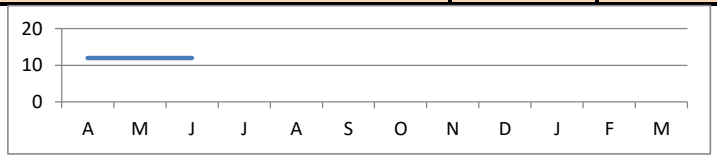
01/07/2021

NHS Barnsley CCG Governing Body Assurance Framework 2021-22

PRIORITY AREA 6: FINANCIAL BALANCE & EFFICIENCY PLANS	*Delivery supports these CCG objectives:*		PRINCIPAL THREATS TO DELIVERY
• Free up hospital beds • Best value across all CCG expenditure • Reduce avoidable demand • Reduce unwarranted variation in clinical quality and efficiency • Financial accountability and discipline for all trusts and CCGs • Deliver financial balance in 2021/22	Highest quality governance	✓	There is a risk that the continuation of the 2020/21 financial regime for Month 1-6 of 2021/22 limits the CCGs ability to deliver efficiency due to the impact of the Covid-19 pandemic and block contract arrangements in place for all NHS providers. Development of plans is critical in order that the CCG can achieve its statutory duty to breakeven with a balanced budget position as we transition into 2021/22.
	High quality health care	✓	
	Care closer to home	✓	
	Safe & sustainable local services	✓	
	Strong partnerships, effective use of £	✓	
	Links to NHSE/I Planning Guidance		
	F5 - Implement ICS-level financial arrangements		

Committee Providing Assurance	**FPC**	*Executive Lead*	**RN**	*Clinical Lead*	**Various**

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



Date reviewed	**Jun-21**
Rationale: Likelihood currently judged to be likely and 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	Monthly reports to Finance & Performance Committee and Governing Body	Ongoing
QIPP Delivery Group continues to be in place to maintain oversight of the QIPP programme a system wide efficiency group is also in place to ensure costs can be taken out of the system across partners	Ongoing engagement with primary care, secondary care and internal management to support delivery of schemes, with a view to taking costs out of the system and ensure effective use of the Barnsley £.	Ongoing
Clinical Forum provides clinical oversight of projects		Ongoing
Continued development and review of the CCG's Medicines Optimisation QIPP 2021/22 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. Medicines optimisation schemes have been commenced and the impact will be reported. There is a potential risk due to the covid vaccination programme that Prescribing QIPP may be restricted but this will be monitored with the Head of Medicines Management.	Ongoing

Gaps in assurance	**Positive assurances received**
If the BCCG CHC team is unable to deliver its recovery plan to enable the backlog of reviews to be cleared and new cases to be processed in a timely way, with robust case management processes in place that demonstrate value for money whilst not compromising quality of care , there is a risk of adverse financial consequences for the CCG and inappropriate or out of date care packages being provided for patients which potentially would not be meeting their health needs. This could also have implications on meeting the KPI's as set by NHSE.	Discussions with partners remain positive and are ongoing in relation to the contract position for 2021/22 and beyond.

Gaps in control	Actions being taken to address gaps in control / assurance
13/31 - There is a risk that if the CCG does not develop a robust QIPP plan supported by effective delivery and monitoring arrangements, the CCG will not achieve its statutory financial duties and NHS England business rules.	The CCG is currently monitoring the efficiency plans in place around Prescribing and CHC. All other efficiency requirements will be met through reductions in expenditure given the impact of Covid-19 and the timescales to deliver plans and the CCG has achieved its financial duties for the year ended 31 March 2021 (subject to audit). The programmes of work agreed at Governing Body do however need to continue to be progressed to ensure improved patient care and access as well as ensuring services remain financially sustainable through delivery of efficiency to close the gap that remains across Barnsley place from 2021/22 and beyond. Plans continue to be progressed, however the impact of Covid does remain a barrier to full implementation and is likely to continue as we appproach 2021/22.

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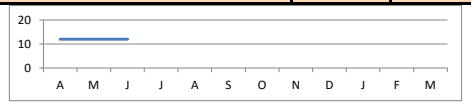
PRIORITY AREA 7: TRANSFORMING CARE FOR PEOPLE WITH LEARNING DISABILITIES AND / OR AUTISTIC SPECTRUM CONDITIONS	*Delivery supports these CCG objectives:*	PRINCIPAL THREATS TO DELIVERY
-Transform the treatment, care and support available to people of all ages with a learning disability, autism or both 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 Ofsted readiness in terms of the imminent local area Joint SEND Inspection Improve adult waiting times for autism and ADHD assessments - maintain the improvements within the Children and young peoples autism assessment and diagnostic pathways to ensure the pathwys remain NICE compliant	Highest quality governance High quality health care ✓ Care closer to home ✓ Safe & sustainable local services ✓ Strong partnerships, effective use of £ ✓ **Links to NHSE/I Planning Guidance** C3& E1 - Expand and improve mental health services and services for people with a learning disability and/or autism & Transforming community services and improve discharge	There is a risk that if the CCG and its partners are unable to provide focussed case management and wrap around services the following negative consequences may result: -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 Insufficent funding to develop improved pre and post diagnostic support for people with autism / ADHD / LD

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	**Jun-21**

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:	**Sources of assurance**	**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.	Commissioning updates provided to Governing Body with any Quality issues escalated to Quality & Patient Safety Committee. Twice yearly update reports to CCG Governing Body. Formal reporting / governance structure within the South Yorkshire and Bassetlaw Transforming Care Programme Board	Ongoing
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. Detailed plans, with timescales, have been 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		Ongoing
Formal reporting and Governance arrangements to transfer to the SYB ICS Transforming Care Programme Board whilst maintaining strong partnership arrangements with Calderdale, Wakefield and Kirklees (Transforming Care Partners CKWB). The West Yorkshire and Barnsley ATU provision has been re-designed and moves from 3 units to 2 units (based at Wakefield and Bradford) to deliver services as part of a Centre of Excellence.	Monthly meetings held with all CCG's and the regional lead for the Transforming Care Programme. Weekly reports provided by the TCP Complex Case Manager to NHS E/I.	Ongoing
An all-age Autism strategy is being developed to support service transformation and improve the life outcomes of people with autism.		Ongoing
An LD Strategic Health & Social Care Improvement Group has been established and is overseeing the action plan to improve the uptake of Annual Health Checks for people with LD and / or Autism. This group will also heavily influence the development of the autism strategy and connect the work progressing in terms of improving support for people with an LD and / or Autism. This group will also oversee the implementation of the keyworker role for children with autism and / or LD - currently there are keyworker pilots in operation in a number of South Yorkshire localities from which the learning will be shared - NHS E/I expect the children's keyworker role to be implemented by all areas no later than 2022/23.		Ongoing
The SEND lead for the CCG has been identifed as the Head of Commissioning (Mental Health, Children's, Maternity). A Designated Clinical Officer has been appointed and will be line managed by the Specialist Clinical Portfolio manager who together will take responsiblity for the SEND agenda from a CCG perspective. Barnsley local area are still awaiting the CQC/OfSted Joint SEND Inpspection. The outcomes of the inspection will be shared with Governing Body members		Ongoing
NHS E/I have amended the LeDeR review process. Local and regional processes will be enhanced / developed to ensure all learning from these reviews are embedded within practice within the Borough		Ongoing

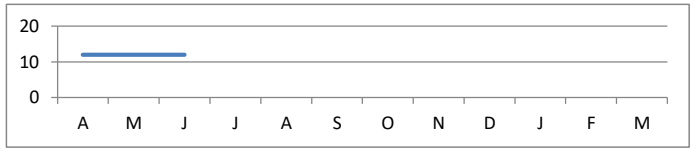
Gaps in control	**Actions being taken to address gaps in control / assurance**
Plans are to be established to improve the uptake of Annual physical Health chekcs for people with LD	

01/07/2021 **NHS Barnsley CCG Governing Body Assurance Framework 2021-22**

PRIORITY AREA 8: MATERNITY	*Delivery supports these CCG objectives:*		PRINCIPAL THREATS TO DELIVERY
Continue to work towards delivering the recommendations of 'Better Births' and the ambitions of the NHS Long Term Plan. implement the Saving Babies' Lives care bundle version 2 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 Deliver all recommendations contained within the Ockenden report within the required timescales Achieve the recommended targets in respect of the continuity of carer model	Highest quality governance		There is a risk that the key deliverables will not be achieved if the following risks to delivery are not appropriately managed and mitigated: 1/ Lack of sufficient investment in additional staff resources to enable 'continuity of carer' 2/ LMS to oversee responses to Ockenden report and influence developments of all localities implementing the recommendations of 'Better Births' 3) LMS to invest transformation funding fairly within the locality to ensure local service developments can be implemented as agreed 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 NHSE/I Planning Guidance		
	C4 - Deliver improvements in maternity care, including responding to the recommendations of the Ockenden review		

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	**Jun-21**

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?**
Continuity of carer teams are established in Barnsley and Barnsley is on track to achieve the recommended CoC target of 57% by March 2022.	NHSE LMS assurance process	Ongoing
CQB for each provider reports to Q&PSC	Yorkshire and Humber maternity dashboard (enables benchmark)	Ongoing
LMS oversight - Governing Body receive twice yearly / ad-hoc assurance reports	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**
	SYB ICS LMS positively assured Barnsleys response to the Ockenden report
Gaps in control	**Actions being taken to address gaps in control / assurance**

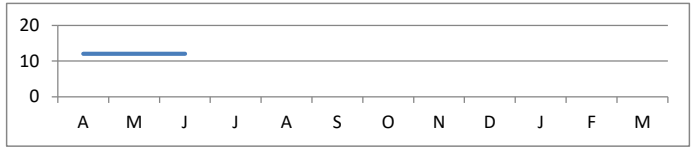
01/07/2021

NHS Barnsley CCG Governing Body Assurance Framework 2021-22

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 *(transition now complete)* - 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 *(noting that NHS App rolled out, APEX decommissioned, GPIT refresh in place, Govroam under review)* - Support the wider use of digital technology as described within the Long Term Plan - Comply with the transition from GPSoC to GP IT Futures *(transition now complete)* - Working closely with the SY&B digital and IT workstream to deliver the digital road map - Delivery of O365 across Barnsley - Support the catch up of Windows10 upgrades in primary care - Ensure full delivery of online consultation systems to general practices where these are not already in place - Lead the transition to the new GPIT Futures Digital Care Services Framework arrangements.	Highest quality governance High quality health care ✓ Care closer to home ✓ Safe & sustainable local services ✓ Strong partnerships, effective use of £ ✓ **Links to NHSE/I Planning Guidance** F3 - Develop the underpinning digital and data capability to support population-based approaches		There is a risk that the key deliverables will not be achieved if the following threats to delivery are not appropriately managed and mitigated: - Lack of IT technical expertise locally for input into projects and programmes of work / lack of technical support to ensure deliverables are robust - Primary Care colleagues fatigued with the amount of IT work scheduled - Short timelines to deliver projects - Supplier and equipment delays - constructive and timely engagement by system partners to deliver a SCR by 20/21 - system wide strategic digital strategy and planning currently under-resourced with no dedicated Barnsley resource available to progress this work - Incomplete information available from NHS Futures regarding future work.

Committees providing assurance	**PCCC & SMT**	*Executive Lead*	**JB**	*Clinical Lead*	**JH**

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



Date reviewed	**Jun-21**

Rationale: Likelihood has been scored at 3 as transition to new provider has been successfully completed but will be kept under review. Consequence has been scored at 4 given the major impact on the CCG and the system if digital and It technology is not safeguarded and fully exploited.

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	Ongoing
BBS IT Delivery Group and BBS Digital Strategy Group established	Monthly meetings to review progress of the delivery of key projects and programmes. Updates to SMT, GB and PCCC	Ongoing
GP IT and Corporate IT service commissioned from BBS IT Services, the successor to eMBED. The new shared service is now establishing working protocols. Shared staffing allows for technical and network experience to be available to the CCG. Additional staffing to be secured if Digital First EOIs are successful as bids include resource.	CCG representatives attend the BBS IT Delivery Group and BBS Digital Strategy Group. KPIs and other performance monitoring data is provided and reviewed. Isses would be escalated to SMT in first instance.	Ongoing
SYB has led a procurement leading to the identification of Doctorlink as the preferred local provider of online consultation services. Contact in place until Oct 2021 with another 2 year option.	Every Barnsley practice has Doctorlink installed for use within their practice.	Complete
Redcentric become the commissioned service to maintain HSCN	Transition to new HSCN network now complete across the Barnsley CCG & primary care estate	Complete

Gaps in assurance	**Positive assurances received**
Governance process to be established for the IT groups eg link with the IT Strategy group and the CCG Operational Group	
Gaps in control	**Actions being taken to address gaps in control / assurance**

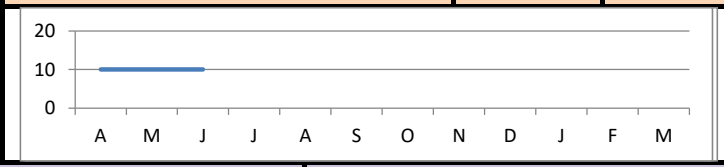
01/07/2021

NHS Barnsley CCG Governing Body Assurance Framework 2021-22

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	✓	There is a risk that 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 NHSE/I Planning Guidance		

Committee Providing Assurance	**Audit Committee**	*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	**Jun-21**
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, Governance Handbook, 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 development of a local/regional citizen's panel, Healthwatch Barnsley holds independent role on engagement and equality committee and primary care commissioning committee, co-ordination of activity with partners, appropriate engagement & involvement re service changes, membership of consultation institute, active patient reference groups locally, funding provided to Barnsley Council to provide community engagement activity and to support a robust and sustainable thrid sector.	Oversight by Equality & Engagement Committee. Assurance to Governing Body via minutes and bi-monthly PPI Summary reports. In previous years Internal Audit Reviews and NHSE assurance process also provided assurance re robustness of our arrangements. Compliance with statutory guidance on patient and public participation in commissioning health and care is assessed via the NHSE 'improvement and assessment framework'. (rated green in 2017/18, 2018/19 and 'Green Star' in 2018/19).	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 / compliant processes in place. DPO service provided by third party provider.	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 & Business Continuity 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**
	The CCG received a 'Green Star' rating from NHSE in respect to compliance with statutory guidance on patient and public participation in the 2018/19 IAF ratings published in July 2019, and the 2019/20 ratings published in November 2020. The CCG received a 'significant assurance' opinion from Internal Audit following its review of the Governance & Risk Management arrangements (Sep 2019). The CCG received a 'significant assurance' opinion from internal audit on its conflicts of interest arrangements (Dec 2020). The CCG received a 'substantial assurance' opinion from internal audit on the Integrity of the General Ledger and Financial Reporting (Jan 2021).
Gaps in control	**Actions being taken to address gaps in control / assurance**

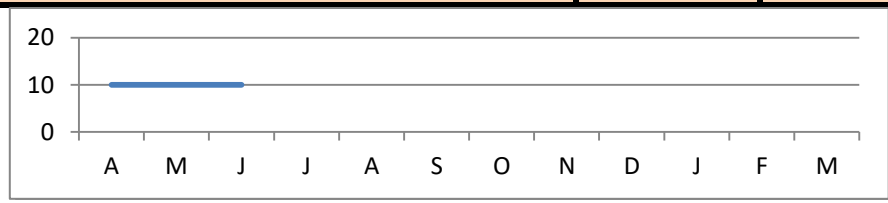
RR 20/03 If the BCCG CHC team is unable to deliver its recovery plan to enable the backlog of reviews to be cleared and new cases to be processed in a timely way, with robust case management processes in place that demonstrate value for money whilst not compromising quality of care , there is a risk of adverse financial consequences for the CCG and inappropriate or out of date care packages being provided for patients which potentially would not be meeting their health needs. This could also have implications on meeting the KPI's as set by NHSE.	Vacant posts – all post filled awaiting start dates. Agency nurses – 2 outstanding COVID backlog cases then the focus will be on the outstanding Fast track reviews which there is a trajectory in place to monitor productivity Training plan – competency framework in place and all nurses completed on line CHC training. The operational Lead and Team leader are reviewing a 12 months training plan for the team CPA panel – this commenced in November 2020 with senior clinicians and finance manager to ensure quality and assurance and Governance in place of care packages in excess of £1000 per week.
RR 21/01 If the CCG is does not implement robust arrangements to approve packages of Children's Continuing Health Care and associated NHS funding, there is a risk of: • Challenge to decisions not to award funding in some cases – possible risk of litigation • Negative impact on patient safety due to lack of quality monitoring of placements for CCC funded children; • adverse financial consequences for the CCG	Permanent Nurse Assessor / Case Manager commenced in post on 1st Feb 2021. DCO will line manage. The post-holder is already booking reviews and stock-taking the current caseload. DCO hours increased to full time to enable progress on: • outstanding reviews and aligning these to EHCPs / social care reviews • Firming up policy and process • Further discussions and negotiation with BMBC Childrens Services / Education Leads A meeting between key leads in BMBC and CCG took place in February 2021 to discuss joint working and CCG decision making, which has caused discomfort re: impact on social care budgets. Going forward, cases potentially stepping down for eligibility will be discussed at an early stage and based on potential impact to the child / family, step down timescales will be agreed.
RR 14/15 Discharge medication risks related to poor or incomplete D1 discharge letters	The volume of hospital discharges has significantly reduced since beginning of March 20 (due to COVID 19). The D1 Audit Report (November 2018 audit data) was received by the CCG Quality and Patient Safety Committee on 2nd July 2020. This showed an improvement; 61.4% of D1 forms had all medicines accurately accounted for at discharge. It was noted that the D1 e-form had been withdrawn at the beginning of the COVID pandemic and the Medway system introduced in July 20. BHNFT have advised they are re-establishing the pre-COVID D1 Task and Finish Group and are also undertaking a mapping of hospital pathways and primary care medicines management are being involved however these are paused due to the covid pandemic.

01/07/2021 **NHS Barnsley CCG Governing Body Assurance Framework 2021-22**

PRIORITY AREA 11: DELIVERY OF ENHANCED HEALTH IN CARE HOMES	*Delivery supports these CCG objectives:*		PRINCIPAL THREATS TO
Delivery of all 17 elements and sub elements of the Barnsley Care Homes Delivery Plan. This includes the elements of the Enhanced Health in Care Homes (EHCH) Framework and the Covid-19 Pandemic specific support. 1. Engagement with care homes on all requisites of the delivery plan 2. EHCH Primary Care Network (PCN) Specification 3. Named Clinician for each care home 4. Coordinated health and social care MDT support 5. Specialist Support 6. Out of Hours support 7. Infection Prevention and Control (IPC) including Personal Protective Equipment (PPE) 8. Mutual Aid 9. Testing / Swabbing 10. Medicines 11. Equipment 12. Discharge to Assess (D2A) and Intermediate Care (IMC) 13. Secondary Care support 14. Personalised care 15. Workforce support 16. Technology 17. Integrated Care System link-in	Highest quality governance		There is a risk that the CCG will r Care Homes Delivery Plan if the f 1.Acuity of the Covid 19 need acr transformational elements of the down occupancy and risk to business v 3. Financial pressures and prioriti 4. CCG not having direct input an monitoring and safeguarding in ca 5. Best use of technology in care used and in consistency of use 6. Potential IG issues in current m equipment 7. Insufficient staff/resource (Matı GP practices) to undertake delive 8. Availability of essential equipm 9. Interdependencies with other w communication and escalation of
	High quality health care	✓	
	Care closer to home	✓	
	Safe & sustainable local services	✓	
	Strong partnerships, effective use of £	✓	
	Links to NHSE/I Planning Guidance		

Committee Providing Assurance	**Q&PSC**	*Executive Lead*	**JS**	*Clinical Lead*

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



Date reviewed
Likelihood assessed a learning from Phase 1 risks; discussions abo phase; and emerging light of pending Winte 4 'major' given potenti deliverables are not ac

Key controls to mitigate threat:	Sources of assurance
Delivery work plan and risk log in place	Monitored and managed via a multi - agency Delivery Group and Br Discharge and Out of Hospital Group. Minutes and action logs available. Leads and co-leads in place with clear responsibility for delivery – su of leads within line management structures Escalation of risks and issues to Silver and other appropriate forums required. Regular reporting to Quality and Patient Safety Committee Weekly operational updates at Care Homes Delivery Group and reg log updates as indicated by BRAG rating

Gaps in assurance	Positive assurances received
If the BCCG CHC team is unable to deliver its recovery plan to enable the backlog of reviews to be cleared and new cases to be processed in a timely way, with robust case management processes in place that demonstrate value for money whilst not compromising quality of care , there is a risk of adverse financial consequences for the CCG and inappropriate or out of date care packages being provided for patients which potentially would not be meeting their health needs. This could also have implications on meeting the KPI's as set by NHSE.	

Gaps in control	Actions being taken to address gaps in contr

DELIVERY

ıot be able to deliver the elements of the
following issues are not mitigated:
oss Barnsley meaning that the more
plan will need to be shelved or slowed
2. Decrease in bed
viability and market sustainability
es
d oversight of quality assurance
are homes
homes - variance types of technology

nethods of remote consultation using IT

rons, Clinical Pharmacists and some
ry of MDTs in care homes.
ent (e.g PPE)
work streams and potential for gaps in
issues

	Dr J MacInnes
	Jun-21

ıs 3 'possible' taking into account
responses, service delivery, issues and
ut the risk and issues in recovery
picture in new phase of the pandemic in
r pressures. Consequence assessed as
al impact on Barnsley patients if the
chieved.

	Rec'd?
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upervision	
s as	
ular Risk	
ol / assurance	

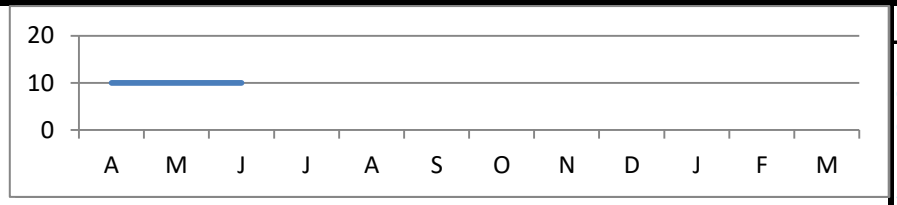
01/07/2021

NHS Barnsley CCG Governing Body Assurance Framework 2021-22

PRIORITY AREA 12: DELIVERING THE COVID VACCINATION PROGRAMME & MEETING THE NEEDS OF PATIENTS WITH COVID-19	*Delivery supports these CCG objectives:*		PRINCIPAL THREATS TO
• All adults to be offered a first dose of the vaccination by the end of July 2021 • Maximise uptake by engeging with local communities to increase vaccination uptake and reduce vaccine hesitancy • Work with partners to maximise capacity to deliver the vaccination programme through the mixed delivery model including GP/PCN sites, vaccination centres, hospital hubs and community Pharmacy • Support General Practice to deliver phase 2 of the vaccination programme for cohorts 10-12 (18 - 49 year olds) • Plan for the possibility of a COVID 19 re-vaccination programme from Autumn • Plan for the possibility of COVID 19 vaccination of Children - subject to any guidance by JCVI • Delivery of home oximetry, post covid assessment and support for	Highest quality governance		There is a risk that the CCG will r programme and meet the needs issues are not mitigated: 1. Staffing capacity being sufficie programme, 2. Vaccination supply being insuff 3. Negative public attitudes and h upon uptake rates 4. Engagement and support of all and uptake of the vaccine 5. Understanding of the number o of pathways to provide ongoing s
	High quality health care	✓	
	Care closer to home	✓	
	Safe & sustainable local services	✓	
	Strong partnerships, effective use of £	✓	
	Links to NHSE/I Planning Guidance		
	B - Delivering the covid vaccination programme and continuing to meet the needs of patients with covid-19		

Committee Providing Assurance	**TBC**	*Executive Lead*	**JW**	*Clinical Lead*

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



Date reviewed

Likelihood currently ju external factors such a could impact particula likelihood was likely bu supply concerns have possible. Consequenc impact on both the hea reputation.

Key controls to mitigate threat:	**Sources of assurance**
South Yorkshire and Bassetlaw COVID Vaccination Steering Board established providing oversight to the wider programme and ensuring arrangements for coordination across SYB including of vaccine allocations, addressing inequalities and ensuring appropriate mechanisms for delivery across Vaccination Centres, Hospital Hubs, General Practice and Community Pharmacy	Monthly - Steering Board made up of partners from key sectors acr Jointly Chaired by SRO for the Lead Provider (CE Sheffield Teachin Hospital) and SRO for the Primary Care Programme (AO Doncaste Representation is also included from PH and LA's to ensure wider s

SYB Vaccine Delivery Group established to support coordination of delivery, ensure learning across SYB and maximise uptake across SYB.	Weekly - Chaired by SRO for the Primary Care Programme, coordir allocation of the vaccine supply within SYB to ensure equitable supp progress across all areas. Workstreams include, delivery models, health inequalities, staffing, engagement, communications and data.
Barnsley Vaccination Group in place, bringing together local partners across Primary, Community and Acute Care and the Local Authority to support delivery of the local delivery programme in Barnsley	Weekly - Chaired by COO Barnsley CCG. All partners represented. on partnership support, working together, developing delivery model responding to changes to guidance or requirements in relation to va usage etc. Successfully coordinated delivery of vaccination progran H&SC workforce and phase 1 of the overall vaccination programme
Barnsley Vaccination Engagement Group in place, bringing together local partners across Primary, Community and Acute Care and the Local Authority to support engagement activities and development of plans to target vaccination delivery models to meet the needs of local communities and reduce inequality in uptake	Weekly - Chaired by Service Director for Public Health, BMBC. Coo of engagement activities and development of approaches including Every Contact Count' to maximise the reach of all teams across par have regular contact with local people and communities. Inequalities in uptake have been identified across different geograph communities and certain groups of the population and activity has b targetted to reacing these and maximising uptake.
Contractual arrangements in place with General Practices to delivery phase 1 and 2 of the vaccine programme working collectively as a single PCN Grouping	All GP practices in Barnsley have signed up to delivery of the Vaccir Programme via the Enhanced Service. BHF is leading delivery of the programme on behalf of BP practices support of each practice in relation to delivery of local clinics in prac workforce provision and inviting patients for vaccine/following up an for 2nd dose.

3 Primary Care Hub Sites in place from which to coordinate and deliver local vaccination on behalf of General Practice to Barnsley patients who are eligible for the vaccine (cohorts 1-9)	Designated sites were approved by NHS England at Apollo Court, D Valley Group Practice and Priory Campus. These Local Vaccinatior Hubs are managed by BHF on behalf of the Primary Care Network/(practices. All local vacination activity is coordinated via the 3 desigr sites. Roaving vaccination models in place to deliver to residential settings vulnerable groups such as those who are homeless and to housebo patients Pop up clinics in GP practices have taken place to deliver vaccine tc of patients who may not have been able to access the vaccine at a l designated site. A range of booking methods are in place to ensure everyone is able invited and acess a vaccine. This has included telephone calls, test messages, vaccine call centre and letter. All targets/expectations on uptake levels have been achieved with a 50's offered a vaccine by mid April and the remainder of the adult pc expected to be offered a first dose by the end of July 2021.

Gaps in control	Actions being taken to address gaps in contr
• COVID 1 - Disruption to health and social care – hidden harm - During the C19 peak healthcare seeking behaviours changed along with service delivery models resulting in lower urgent and emergency care presentations and fewer referrals to healthcare services. This 'hidden harm' may cause a double burden that may be caused by people not presenting or delaying presenting with new or existing conditions	
• COVID 2 - Backlog and demand surge - A backlog of non-COVID-19 care following the suspension of routine clinical care that is likely to result in an increased number of poorly-managed chronic conditions or undiagnosed diseases and be combined with a surge in post-COVID-19 morbidity (which needs to be quantified). Reducing the backlog of care will be hampered by reduced operational capacity across NHS organisations designed to prevent transmission of COVID-19	

SCORE:	A	M	J	J	A	S	O	N	D	J
Likelihood	3	3	3							
Consequence	4	4	4							
Risk rating	12	12	12							
Tolerance	12	12	12	12	12	12	12	12	12	12

DELIVERY	
ıot be able to deliver the covid vaccination of patients with covid-19 if the following ıt to continue to deliver the vaccination icient to meet targets esitancy towards the vaccination impact partners to maximise available capacity of 'Long COVID' patients and establishment upport	
	TBC
	Jun-21
dged to be 'possible' as there are many as supply and changes to vaccine that lry on the delivery of the programme. Initial ut good progress has been made and early improved reducing the likelihood to e is judged as major due to the potential alth of the population and organisations	
	Rec'd?
oss SYB. ıg r CCG) upooi	Ongoing

ıates ɔly and	Ongoing
. Focus ls, ccine ınme for .	Ongoing
ɔrdination 'Make tners who ıical een	Ongoing
ıe with the tice, d recalling	Ongoing

earne n Service GP nated s, und o groups ocal to be ll over opulation	Ongoing

ol / assurance

F	M
12	12

GOVERNING BODY – PUBLIC SESSION
ASSURANCE WORK PLAN/AGENDA TIMETABLE 2021/2022
March 2021 to March 2022

AGENDA ITEMS	Exec Lead	July-21	Sep-21	Nov-21	Jan- 22	Mar 22
OPENING ITEMS						
Housekeeping	NB	✓	✓	✓	✓	✓
Apologies	NB	✓	✓	✓	✓	✓
Quoracy	NB	✓	✓	✓	✓	✓
Declarations of Interests Report	RW	✓	✓	✓	✓	✓
Patient Story	JS	✓	✓	✓	✓	✓
Patient & Public Involvement Activity Report	KW	✓	✓	✓	✓	✓
Questions from the Public & Answers	KW	✓	✓	✓	✓	✓
Minutes of previous GB/Pu meeting	NB	May 21	July 21	Sept 21	Nov 21	Jan 22
Matters Arising Report	NB	✓	✓	✓	✓	✓
STRATEGY						
Report of the Chief Officer, inc as required: • SY&B ICS Updates • Assurance Letters from NHSE • NHSE IAF outcomes	CE	✓	✓	✓	✓	✓
Covid-19 Update	JW & JB	✓	✓	✓	✓	✓
UPDATE & ASSURANCE PRIOITY AREAS ON GBAF						
Urgent & Emergency Care Update	JW			✓		
Primary Care Update	JF/NB			✓		
Cancer Update	LS		✓			✓
Mental Health Update	PO			✓		
Integrated Care at place	JB	✓			✓	
Transforming Care Update	PO		✓			✓
Maternity Update	PO	✓			✓	
Digital and IT Updates	JB			✓		
Care Homes	JS		✓			✓
Assurance Report - Locked Rehabilitation (OOALR)	JS	✓				

AGENDA ITEMS	Exec Lead	July-21	Sep-21	Nov-21	Jan- 22	Mar 22
Assurance reports Continuing Health Care and Complex Cases (quarterly)	JS JH		✓		✓	
QUALITY AND GOVERNANCE						
Quality Highlights Report	JS	✓	✓	✓	✓	✓
Commissioning of Children's Services	PO		✓			✓
Risk and Governance Exception Reports, to include:	RW	✓	✓	✓	✓	✓
• Governing Body Assurance Framework	RW	Full	Full	Full	Ex	Full
• Corporate Risk Register	RW	Ex	Ex	Ex	Ex	Full
• Register of Interests & Register of Gifts Hospitality	RW					✓
• IG / GDPR / Cyber Update	RW					
• Policies – as required	RW					
• Constitution changes - as required	RW					
• EPRR & Business Continuity	JW		✓			
• Quarterly Workforce Reports o 2021-22 Q1 (Apr-Jun) to July 2021 GB o 2021-22 Q2 (Jul-Sep) to Nov 2021 GB o 2021-22 Q3 (Oct-Dec) to January 2022 GB o 2022-22 Q4 (Jan-Mar) to May 2022 GB	RW	✓		✓	✓	
Updating of Governing Body Assurance Work Plan/Agenda Timetable	RW	✓		✓		✓
Terms of Reference As required (AC, FPC, QPSC, EEC, RC, PCCC, ICOPC)	RW	✓	✓	✓	✓	✓
Committee Annual Assurance Reports for AC, F&P, Q&PSC, E&EC and PCCC	RW					
Annual Report & Accounts to EO meeting ON 10 June 2021	RN					
FINANCE AND PERFORMANCE						

AGENDA ITEMS	Exec Lead	July-21	Sep-21	Nov-21	Jan- 22	Mar 22
Integrated Performance Report inc QIPP	RN/JW	✓	✓	✓	✓	✓
2021/22 Budgets	RN					
Operational and Financial Plan 2021/22 –	RN/JW	✓			✓	
MISCELLANEOUS						
Annual Report – Childrens Safeguarding	JS		✓			
Annual Report – Adult Safeguarding	JS		✓			
PDA Schemes	JW	✓				
Commissioning for Outcomes Policy	JW	✓				
Add miscellaneous items as required						
COMMITTEE REPORTS AND MINUTES						
Minutes of Audit Committee	NBe	10/06/21		Sept 21		Jan 22
Minutes of Finance and Performance Committee	NB	06/05/2103/06/21	01/07/21	02/09/21 07/10/21	4/11/21 02/12/21	Jan 22 Feb 22
Minutes of Quality & Patient Safety Committee	SK	15/04/21	17/06/21	19/08/21	21/10/21	16/12/21
Assurance Report / Minutes of Equality and Engagement Committee	KW	18/02/21	20/05/21		12/08/21	
Primary Care Commissioning Committee Assurance Report / Minutes	CM	Ass Rep 27/05/21 Mins 25/03/21	Ass Rep 29/07/21 Mins 27/05/21	Ass Rep 30/09/21 Mins 29/07/21	Ass Rep 25/11/21 Mins 30/09/21	Ass Rep Jan 22 Mins 25/11/21
Minutes of Membership Council	NB		13/07/21	14/09/21	23/11/21	Jan 22
Minutes of Health and Well Being Board (Refer Peter Mirfin at the BMBC)	NB	✓	✓	✓	✓	✓
Minutes of the PUBLIC Joint Committee of Clinical Commissioning Groups	CE	✓ As reqd	✓ As reqd	✓ As reqd	✓ As reqd	✓ As reqd
CLOSING BUSINESS						
Reflection on how well the meeting's business has been conducted	NB	✓	✓	✓	✓	✓
Close meeting and move into Private Session	NB	✓	✓	✓	✓	✓

NHS
Barnsley
Clinical Commissioning Group

Governing Body

8 July 2021

Integrated Performance Report

PART 1A – SUMMARY REPORT

1.	**THIS PAPER IS FOR**						
	Decision		*Approval*		*Assurance*	X	*Information*	X
2.	**PURPOSE**						
2.1	This report provides an update on the CCGs performance against key performance indicators and an overview of the financial performance of the CCG up to 31 May 2021 or the latest available position.						
3.	**REPORT OF**						

	Name	Designation
Executive / Clinical Lead	Roxanna Naylor/ Jamie Wike	Chief Finance Officer/ Chief Operating Officer
Author		

4.	**SUMMARY OF PREVIOUS GOVERNANCE**
4.1	The matters raised in this paper have been subject to prior consideration in the following forums:

Group / Committee	Date	Outcome
Finance and Performance Committee	1 July 2021	Considered the paper and noted the actions

5.	**EXECUTIVE SUMMARY**
5.1	**Finance Update – April to September 2021 (H1)** The finance report, attached at Appendix 2 provides details of the forecast position as at 31 May 2021 for the six months to 30 September 2021, however 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 2021 reflect a balanced budget position, with the forecast overspend reported relating only to Hospital Discharge Programme Costs (HDP) and Elective Recovery Funding (ERF) which remain outside of envelope and further allocations to cover these costs are expected in line with national guidance. The year to date (April/May) allocation required is £637k and current forecast to Month 6 assume an allocation adjustment of £1,490k. Consequently, the CCG is forecasting to achieve financial duties and planning guidance requirements, with a balanced budget position to September 2021. This position is predicated on the delivery of the CCG's efficiency programme and plans being identified against the unidentified efficiency currently within the plan. The Governing Body is asked to note that whilst a balanced budget position is reported risks in relation to the delivery of efficiency plans (including unidentified QIPP) and continuing healthcare are being reviewed and may potentially require further mitigating action to allow achievement of financial duties to be achieved. Further information on the CCG's financial performance target and risks are set out in Appendix 2. The Finance and Performance Committee considered the potential underlying recurrent financial position of the CCG noting the level of uncertainty of the current finance regime and lack of clarity on the funding regime from October 2021. Further information on this position will be reported to the Governing Body once further guidance is received and the position can be confirmed to ensure immediate mitigating action can be taken across the Barnsley Partnership. Further updates will be provided through the Integrated Performance Report which is a standing agenda item of the Finance and Performance Committee and Governing Body.
5.2	**Performance Update** The summary performance report (attached at Appendix 1) provides the Governing Body with an overview of performance across key areas of CCG responsibilities and include NHS constitution standards and key operational performance indicators up to month 2 (May 2021) where data is available. The information included in the performance report continues to show the adverse impact of COVID19 upon delivery of some constitutional standards including referral to treatment times and waiting times for diagnostic waits. Performance has continued to improve in March against the 18 week referral to treatment target with performance the highest it has been since April 2020 and waits over 52 weeks continue to reduce. Urgent care related measures such as Ambulance and A&E continue to be below the target and have been impacted by significantly increased activity levels and

	challenges with flow due to COVID requirements in relation to social distancing. Performance on most of the cancer pathways is also below the national standards including 2 week waiting times which have historically been strong. IAPT performance against waiting times and recovery targets continue to be achieved and the access rate continues to improve but remains below the target rate.
6.	**THE FINANCE AND PERFORMANCE COMMITTEE IS ASKED TO:**
	Note the contents of the report including: • Performance to date 2021/22 • projected delivery of all financial duties, predicated on the assumptions outlined in this paper and mitigating
7.	**APPENDICES / LINKS TO FURTHER INFORMATION**
	Performance Section • Appendix 1 – IPR M2 2021/22 **Finance Section** • Appendix 2 – Month 2 Finance update

Agenda time allocation for report:	15 Minutes

PART 1B – SUPPORTING INFORMATION & ASSURANCE

1. Links to Corporate Priorities, GBAF and Risk Register

This report provides assurance against the following corporate priorities on the Governing Body Assurance Framework:

1.1 Urgent & Emergency Care	✓	6.1 Efficiency Plans	✓
2.1 Primary Care	✓	7.1 Transforming Care for people with LD	✓
3.1 Cancer	✓	8.1 Maternity	✓
4.1 Mental Health	✓	9.1 Digital and Technology	✓
5.1 Integrated Care @ System	✓	10.1 Compliance with statutory duties	✓
5.2 Integrated Care @ Place	✓	11.1 Delivery of Enhanced Health in Care Homes	✓

The report also provides assurance against the following red or amber risks on the Corporate Risk Register:	*18/04, 13/3, 13/31, 15/12, 17/05*

2. Links to statutory duties

This report has been prepared with regard to the following CCG statutory duties set out in Chapter A2 of the NHS Act:

Management of conflicts of interest (s14O)		Duties as to reducing inequalities (s14T)	
Duty to promote the NHS Constitution (s14P)	✓	Duty to promote the involvement of each patient (s14U)	
Duty to exercise its functions effectively, efficiently and economically (s14Q)		Duty as to patient choice (s14V)	✓
Duty as to improvement in quality of services (s14R)		Duty as to promoting integration (s14Z1)	
Duty in relation to quality of primary medical services (s14S)		Public involvement and consultation (s14Z2)	

3. Governance Considerations Checklist

3.1 Clinical Leadership

Have GB GPs and / or other appropriate clinicians provided input and leadership?	***NA***

3.2 Management of Conflicts of Interest (s14O)

Have any potential conflicts of interest been identified and managed appropriately, having taken advice from the Head of Governance & Assurance and / or the Conflicts of Interest Guardian if appropriate?	***NA***

3.3 Discharging functions effectively, efficiently, & economically (s14Q)

Have any financial implications been considered & discussed with the Finance Team?	***Y***
Where relevant has authority to commit expenditure been sought from Management Team (<£100k) or Governing Body (>£100k)?	***NA***

3.4 Improving quality (s14R, s14S)

Has a Quality Impact Assessment (QIA) been completed if relevant?	***NA***
Have any issues or risks identified been appropriately addressed having taken advice from the Chief Nurse (or Deputy) if appropriate?	***NA***

3.5 Reducing inequalities (s14T)

Has an Equality Impact Assessment (EIA) been completed if relevant?	***NA***
Have any issues or risks identified been appropriately addressed having taken advice from Equality Diversity & Inclusion Lead if appropriate?	***NA***

3.6 Public Involvement & Consultation (s14Z2)

Has a s14Z2: Patient and Public Participation Form been completed if relevant?	***NA***
Have any issues or risks identified been appropriately addressed having taken advice from the Head of Comms & Engagement if appropriate?	***NA***

3.7 Data Protection and Data Security

Has a Data Protection Impact Assessment (DPIA) been completed if relevant?	***NA***
Have any issues or risks identified been appropriately addressed having taken advice from the SIRO, IG Lead and / or DPO if appropriate?	***NA***

3.8 Procurement considerations

Have any issues or risks identified been appropriately addressed having taken advice from the procurement Shared Service if appropriate?	***NA***
Has a Single Tender Waiver form been completed if appropriate?	***NA***
Has a Primary Care Procurement Checklist been completed where GPs, networks or Federations may be a bidder for a procurement opportunity?	***NA***

3.9 Human Resources

Have any significant HR implications been identified and managed appropriately, having taken advice from the HR Lead if appropriate?	***NA***

3.10 Environmental Sustainability

Have any significant (positive or negative) impacts on the environment or the CCG's carbon footprint been identified?	***NA***

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Performance & Delivery Report

2021/22 : Position statement using latest information

for the July 2021 meeting
of the Governing Body

Performance Indicator		Target	CCG Quarterly	CCG Latest			CCG Performance	Latest Provider Total Monthly Position	
				Monthly Position		YTD Position		Barnsley Hospital	Yorkshire Ambulance Service
NHS Constitution									
Referral To Treatment waiting times for non-urgent consultant-led treatment	All patients wait less than 18 weeks for treatment to start	92%		Provisional 85.18%	May-21	Provisional 83.58%		Published Apr-21 81.90%	
	No patients wait more than 52 weeks for treatment to start	0		451	May-21	0		365	
Diagnostic test waiting times	Patients waiting six weeks or more for a diagnostic test	1%		Provisional 31.69%	May-21			Published Apr-21 35.32%	
			Q4 20/21						
A&E Waits	Patients are admitted, transferred or discharged within 4 hours of arrival at A&E	95%	83.46%	78.91%	May-21	78.66%		77.99%	
	No patients wait more than 12 hours from decision to admit to admission	0		0	May-21			0	
			Q4 20/21						
Cancer Waits: From GP Referral to First Outpatient Appointment	2 week (14 day) wait from referral with suspicion of cancer	93%	95.52%	89.39%	Apr-21	89.39%		89.79%	
	2 week (14 day) wait from referral with breast symptoms (cancer not initially suspected)	93%	94.90%	75.21%	Apr-21	75.21%		77.88%	
Cancer Waits: From Diagnosis to Treatment	1 month (31 day) wait from diagnosis with suspicion of cancer to first treatment	96%	94.91%	99.32%	Apr-21	99.32%		99.09%	
	1 month (31 day) wait for second/subsequent treatment, where treatment is anti-cancer drug regimen	98%	99.34%	97.50%	Apr-21	97.50%		100.00%	
	1 month (31 day) wait for second/subsequent treatment, where treatment is radiotherapy	94%	99.07%	97.30%	Apr-21	97.30%			
	1 month (31 day) wait for second/subsequent treatment, where treatment is surgery	94%	87.04%	84.21%	Apr-21	84.21%		100.00%	
Cancer Waits: From Referral to First Treatment	2 month (62 day) wait from urgent GP referral	85%	68.72%	78.26%	Apr-21	78.26%		82.91%	
	2 month (62 day) wait from referral from an NHS screening service	90%	77.27%	78.57%	Apr-21	78.57%		78.57%	
	2 month (62 day) wait following a consultant's decision to upgrade the priority of the patient	(85% threshold)	75.61%	100.00%	Apr-21	100.00%		100.00%	
Cancer Waits: Faster diagnosis standard	Cancer 28 day waits - Told within 28 Days	75%	67.68%	65.36%	Apr-21	65.36%			

Performance Indicator		Target	CCG Quarterly	CCG Latest			CCG Performance	Latest Provider Total Monthly Position	
				Monthly Position		YTD Position		Barnsley Hospital	Yorkshire Ambulance Service
Ambulance response times	Category 1 (life threatening) calls resulting in an emergency response arriving within 7 minutes (average response time)	7 mins		7mins 55secs	May-21				7mins 55secs
	Category 2 (emergency) calls resulting in an emergency response arriving within 18 minutes (average response time)	18 mins		25mins 22secs	May-21				25mins 22secs
	Category 3 (urgent) calls resulting in an emergency response arriving within 120 minutes (90th percentile response time)	120 mins		3hrs00mins26secs	May-21				3hrs00mins26secs
	Category 4 (less urgent) calls resulting in an emergency response arriving within 180 minutes (90th percentile response time)	180 mins		5hrs21mins16secs	May-21				5hrs21mins16secs
Ambulance handover / crew clear times	Ambulance Handover - reduction in the number of delays over 30 minutes in clinical handover of patients to A&E	Local Reduction		14.07%	May-21	12.98%			14.07%
	Ambulance Handover - reduction in the number of delays over 1 hour in clinical handover of patients to A&E	Local Reduction		3.45%	May-21	2.92%			3.45%
	Crew Clear - reduction in the number of delays over 30 minutes from clinical handover of patients to A&E to vehicle being ready for next call	Local Reduction		10.70%	May-21	10.54%			10.70%
	Crew Clear - reduction in the number of delays over 1 hour from clinical handover of patients to A&E to vehicle being ready for next call	Local Reduction		0.59%	May-21	0.58%			0.59%

Performance Indicator		Target	CCG Quarterly	CCG Latest			CCG Performance	Latest Provider Total Monthly Position	
				Monthly Position		YTD Position		Barnsley Hospital	Yorkshire Ambulance Service
IAPT	Improved Access to Psychological Services-IAPT: People entering treatment against level of need	1.83%		1.55%	May-21	2.82%			
	Improved Access to Psychological Services-IAPT: People who complete treatment, moving to recovery	50%		62.77%	May-21				
	Proportion of people waiting 18 weeks or less from referral to first IAPT treatment appointment	95%		100.00%	May-21				
	Proportion of people waiting 6 weeks or less from referral to first IAPT treatment appointment	75%		98.65%	May-21				

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Finance Report 2021/22

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 2021 reflect a balanced budget position, with the exception of outside of envelope allocation adjustments which remain outstanding at Month 2. These relate to the Hospital Discharge Programme (HDP) and Elective Recovery Fund (ERF). Funding expected to Month 2 totals £637k and the current forecast position suggest a total allocation requirement to Month 6 of £1,490k. This will be reviewed on a monthly basis to ensure appropriate allocations are received to ensure financial balance. • The financial information contained within this report relates to April to September 2021 only (referred to as H1 period). • Primary Care prescribing data for Month 1 as at 31 May has not yet been received, however the Finance and Contracting team and Head of Medicines Management continue to meet to ensure any risks are captured within the financial position. To date no significant risks have been identified. • Continuing Healthcare continues to be a volatile area of expenditure and work continues to assess the impact of placements. Following a number of issues identified and the outcome of internal audit reports the Chief Nurse has also set up a task and finish group to focus on improvements within the team and processes which will support the delivery of the efficiency target set. • The CCG's Efficiency Programme Management Office (PMO) will continue to monitor and review delivery of the CCG's £7.2m efficiency programme (H1 April-September 2021) with any risks identified within this report. • The Finance and Performance Committee considered the position on Risk and Mitigations as at 31 May 2021, with the position in the most likely scenario showing an overspend of £269k. It is expected that this position will be managed through underspends across other budget areas and investments discussions with providers considering the impact of black contracts before release of further funding, but this will continued to be assessed as the year progresses to ensure financial balance is achieved.		

2 Financial Performance Targets

1) Financial Duties – April to September 2021 (H1)

NHS Act Section	Duty	2021/22 Target £'000	2021/22 Actual Performance £'000	2021/22 Actual Achievement
223H (1)	Expenditure not to exceed income	254,737	254,737	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	254,727	254,727	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	2,441	2,141	YES

2) Financial targets/NHS England Business Rules requirements – April to September 2021 (H1)

Target/Business Rule Requirement	2021/22 Target £'000	2021/22 Actual Performance £'000	2021/22 Actual Achievement
Delivery of in year balanced position	0	0	YES
0.5% Contingency to manage in-year pressures	1,214	1,214	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. The historic surplus balance in 2021/22 now totals £12,532k.

3 Monthly Finance Monitoring Statement – Executive Summary

PROGRAMME AND RUNNING COST AREAS	BUDGET RECURRENT (APRIL-SEPT - H1) £	BUDGET NON RECURRENT (APRIL-SEPT - H1) £	TOTAL BUDGET (APRIL-SEPT - H1) £	YTD BUDGET £	YTD ACTUAL £	YTD VARIANCE OVER / (UNDER) £	FORECAST APRIL-SEPT - H1 £	VARIANCE OVER / (UNDER) £
PROGRAMME EXPENDITURE								
Acute	121,094	13,409	134,503	44,834	44,834	0	134,503	0
Patient transport	1,214	0	1,214	405	405	0	1,214	0
Mental Health	20,360	865	21,225	7,075	7,075	0	21,225	0
Community Health	25,964	(968)	24,996	8,332	8,332	0	24,996	0
Continuing Health Care	15,430	0	15,430	5,143	5,143	0	15,430	0
Primary Care Other	31,743	(142)	31,601	10,437	10,437	0	31,601	0
Primary Medical Services (Co-Commissioning)	21,714	0	21,714	7,238	7,238	0	21,714	0
Other Programme Costs	1,856	(50)	1,806	602	836	234	2,241	435
TOTAL COMMISSIONING SERVICES (INCLUDING PRIMARY CARE RESERVES)	**239,374**	**13,115**	**252,488**	**84,066**	**84,300**	**234**	**252,923**	**435**
Corporate Costs - EMBED/DSCRO	76	0	76	25	25	0	76	0
Corporate Costs - IFR	22	0	22	7	7	0	22	0
NHS Property Services/Community Health Partnerships	377	0	377	126	126	0	377	0
Depreciation Charges	10	0	10	3	0	(3)	10	0
TOTAL CORPORATE COSTS	**485**	**0**	**485**	**162**	**158**	**(3)**	**485**	**0**
Coronavirus Costs - PrimCare	327	0	327	109	109	0	327	0
Coronavirus Costs - CHC - Hospital Discharge Programme (Outside of Envelope)	0	0	0	0	253	253	594	594
Coronavirus Costs - Community - Hospital Discharge Programme (Outside of Envelope)	0	0	0	0	103	103	330	330
Coronavirus Costs - Other Prog. - Hospital Discharge Programme (Outside of Envelope)	0	0	0	0	51	51	131	131
TOTAL CORONAVIRUS COSTS	**327**	**0**	**327**	**109**	**516**	**407**	**1,382**	**1,055**
TOTAL PROGRAMME COSTS (INCLUDING PRIMARY CARE RESERVES)	**240,186**	**13,115**	**253,301**	**84,337**	**84,975**	**637**	**254,790**	**1,490**
RUNNING COSTS								
Pay	1,308	0	1,308	436	436	0	1,308	0
Non Pay	1,133	(300)	833	278	278	0	833	0
TOTAL RUNNING COSTS	**2,441**	**(300)**	**2,141**	**714**	**714**	**0**	**2,141**	**0**
CCG Reserves - 0.5% Contingency	1,214	0	1,214	0	0	0	1,214	0
CCG Reserves - Risk Reserve	597	0	597	0	0	0	597	0
CCG Reserves - Covid allocation currently not committed	0	1,083	1,083	0	0	0	1,083	0
CCG Reserves - unidentified QIPP	0	(4,663)	(4,663)	0	0	0	(4,663)	0
In year (over)/underspend	0	0	0	0	0	0	0	0
TOTAL RESERVES/CONTINGENCY (EXCL. PRIMARY CARE RESERVES)	**1,811**	**(3,581)**	**(1,770)**	**0**	**0**	**0**	**(1,770)**	**0**
TOTAL EXPENDITURE	**244,438**	**9,234**	**253,672**	**85,051**	**85,688**	**637**	**255,162**	**1,490**
Programme	207,501	23,058	230,559	77,347	77,347	0	230,559	0
Primary Care Co-Commissioning	20,672	0	20,672	6,891	6,891	0	20,672	0
Running Costs	2,441	0	2,441	814	814	0	2,441	0
RESOURCE ALLOCATIONS	**230,614**	**23,058**	**253,672**	**85,051**	**85,051**	**0**	**253,672**	**0**
SURPLUS/(DEFICIT)	**(13,824)**	**13,824**	**(0)**	**0**	**(637)**	**(637)**	**(1,490)**	**(1,490)**

3.1 Resource Allocation – Detailed Summary

RESOURCE ALLOCATIONS - PROGRAMME, RESERVES & SURPLUS		ALLOCATION RECURRENT (APRIL-SEPT - H1)	ALLOCATION NON RECURRENT (APRIL-SEPT - H1)	TOTAL £000
Description	Month	£	£	£
Programme Allocation	M2	207,501		207,501
Primary Care Co-Commissioning	M2	20,672		20,672
BHNFT Provider Top-up	M2		9,570	9,570
CCG Top-up	M2		4,083	4,083
CCG Covid allocation	M2		1,410	1,410
BHNFT Covid allocation	M2		5,215	5,215
CCG Growth funding	M2		930	930
BHNFT Growth funding	M2		503	503
Primary Care: GP IT Infrastructure and Resilience	M2		15	15
Primary Care: Improving Access	M2		30	30
Mental Health (MH): Service Development Funding (SDF): CYP community and crisis	M2		161	161
MH: SDF: 18-25 young adults (18-25)	M2		48	48
MH: SDF: MHST 20/21 sites wave 3&4 (MHST20/21)	M2		128	128
MH: SDF: Adult MH Community (AMH Community)	M2		224	224
MH: Spending Review (SR): Children & Young People's Eating Disorders (CYPED)	M2		29	29
MH: SR: CYP community and crisis	M2		108	108
MH: SR: Adult MH Community (AMH Community)	M2		139	139
MH: SR: Adult MH Crisis (AMH Crisis)	M2		31	31
MH: SR: IAPT - adult and older adult	M2		77	77
MH: SR: 18-25 young adults (18-25)	M2		31	31
MH: SR: Memory assessment services and recovery of the dementia diagnosis rate	M2		37	37
MH: SR: Discharge	M2		209	209
MH: SR: Physical health outreach and remote delivery of checks	M2		29	29
Maternity: Long Term Plan - SBL Pre-term Birth	M2		24	24
Primary Care: Improving Access	M2		30	30
TOTAL RESOURCE ALLOCATION		**228,173**	**23,058**	**251,231**

RESOURCE ALLOCATIONS - RUNNING COSTS		ALLOCATION RECURRENT (APRIL-SEPT - H1)	ALLOCATION NON RECURRENT (APRIL-SEPT - H1)	TOTAL £000
Description	Month	£	£	£
2021/22 Allocation	M2	2,441		2,441
TOTAL RESOURCE ALLOCATION		**2,441**	**0**	**2,441**

SUMMARY	£'000	£'000	£'000
Programme	207,501	23,058	230,559
Primary Care Co-Commissioning	20,672	0	20,672
Running Costs	2,441	0	2,441
TOTAL RESOURCE ALLOCATION	**230,614**	**23,058**	**253,672**

Comments

Allocations to Month 2 remain in line with the financial plan approved by the Finance and Performance Committee and Governing Body except for £14k in relation to GP IT infrastructure funding. Only Q1 of this funding has been received and the H1 financial plan submission assumed allocations for Q1 and Q2. This funding is expected during Q2.

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Minutes of the Meeting of the Barnsley Clinical Commissioning Group AUDIT COMMITTEE held on Thursday 10 June 2021 at 9.30 via Microsoft Teams

PRESENT:

Nigel Bell	Audit Committee Chair – Lay Member for Governance
Chris Millington	Lay Member for Patient and Public Engagement and Primary Care Commissioning

IN ATTENDANCE:

Adrian Bailey	Head of Finance: Statutory Accounts and Financial Reporting
Nick Balac	CCG Chairman
Matthew Curtis	LCFS
Chris Edwards	Chief Officer
Rashpal Khangura	Director KPMG
Kay Meats	Client Manager, 360 Assurance
Kay Morgan	Governance and Assurance Manager
Roxanna Naylor	Chief Finance Officer
Monazzah Samad	KPMG Audit Manager
Niazi Usman	Assistant Client Manager 360 Assurance
Richard Walker	Head of Governance and Assurance

APOLOGIES

Dr Adebowale Adekunle	Elected Member Governing Body

Ref	Agenda Item	Action	Dead line
AC 21/06/01	**HOUSEKEEPING –** Microsoft Teams Meeting etiquette was noted.		
AC 21/06/02	**QUORACY -** The meeting was declared quorate		
AC 21/06/03	**DECLARATIONS OF INTEREST, SPONSORSHIP, GIFTS AND HOSPITALITY**		
	The Committee noted the Declaration of Interests Report. No other new declarations of interest were received.		
AC 21/06/04	**MINUTES OF THE PREVIOUS MEETING HELD ON 22 APRIL 2021**		
	The Minutes of the meeting held on 22 April 2021 were approved as a correct record of the proceedings.		

Ref	Agenda Item	Action	Dead line
AC 21/06/05	**MATTERS ARISING**		
	The Committee considered the Matters Arising Report. • **Minute reference AC 21/04/08 Revised Local Counter Fraud Plan - new Functional Standards.** It was noted that the Counter Fraud Functional Standard Return had been submitted, with the action plan being included in the next Local Counter Fraud Progress Report to the Audit Committee on 16 September 2021		
AC 21/06/06	**INTERNAL AUDIT PROGRESS REPORT INC CHILDREN'S CONTINUING CARE AND S117 FUNDING DECISIONS (FINAL REPORT)**		
	The Client Manager, 360 Assurance presented the Internal Audit Progress Report and Children's Continuing Care and s117 funding decisions Report to the Audit Committee. The Audit Committee noted that the 2020/21 Internal Audit Plan had been completed and Head of Internal Audit Opinion issued.		
	The Client Manager, 360 Assurance highlighted that there are four actions from 2020/21 which remain outstanding, beyond their due date. A meeting has been arranged to review progress against the outstanding CHC actions on 15 June 2021. The Committee Chair advised that it is important for the Audit Committee to receive assurance regarding the outstanding CHC actions prior to the next meeting of the Audit Committee on 16 September 2021. The Chief Finance Officer reported that an update on the outstanding CHC actions will be included in an assurance briefing to the Governing Body Development Session on 22 July 2021. The Assistant Client Manager 360 Assurance provided the Audit Committee with a summary overview of the Children's CHC Report, the overall assurance opinion of 'weak' and examples of cases tested. The Audit Committee expressed its concern at the report and the attached opinion. The opinion level is the lowest available and effectively means the system is not working. The Chair questioned whether the due dates for the agreed actions were challenging enough in the circumstances.		

Ref	Agenda Item	Action	Dead line
	The Audit Committee noted the Internal Audit Progress Report and Children's Continuing Care and s117 funding decisions Report. ***Agreed action*** ***To establish a task and finish group to consider findings and recommendations from the internal audit review of Children's, Adults Continuing healthcare and complex cases and report back the Audit Committee with an action plan.***	**CE**	**08.07.21**
AC 21/06/07	**NHS BARNSLEY CCG ANNUAL REPORT AND ACCOUNTS**		
	The Chief Finance Officer personally thanked the Head of Finance: Statutory Accounts and Financial Reporting, Head of Governance and Assurance and Head of Comms and Engagement for their hard work and contributions to the CCG Annual Report and Accounts documents presented to the Audit Committee. The Audit Committee also echoed their appreciation to all involved in the production of the Annual Report and Accounts.		
	The Head of Governance and Assurance introduced the NHS Barnsley CCG Annual Report and Accounts 2020/21 advising that the ask of the Audit Committee is to review the documents and make recommendation to the Governing Body that it approves and adopts the Annual Report and Accounts 2020/21 (subject to any final necessary amendments agreed at the meeting). It was noted that the Audit Committee had previously reviewed the Draft Annual Report and Accounts in detail on 22 April 2021 following which a small number of changes were made prior to submission to NHSE/I and the external auditors. The NHSE review of the draft annual report determined that the Annual Report substantially met all the requirements. NHSE had raised just a small number of minor suggestions all of which had been incorporated in the final draft version. The external audit also generated a small number of changes. The Head of Governance and Assurance brought to the attention of the Audit Committee three further changes to the Annual Report since the agenda papers were issued: • Remuneration Report added narrative around the Chief		

Ref	Agenda Item	Action	Dead line
	Officer - The remuneration of the Accountable Officer has been pro-rated to an annualised full-time equivalent for the purpose of the pay multiple • Amended a reference to the '20/21 NHS rating' to '19/20' • At the request of the CCG Chair - extended narrative regarding the work of the PCN delivering the Covid vaccination programme supported by the Barnsley Healthcare Federation. The Audit Committee noted the very few minor changes made to the Annual Report and Accounts from the change log provided. The Committee Chair highlighted that the agenda papers were very clear about the changes to the Annual Report and Accounts.		
	07.1 **Annual Report - Performance / Accountability Report & Final Accounts**		
	The Committee noted the Annual Report with amendments made and the final Accounts.		
	07.2 **Head of Internal Audit Opinion & Annual Report**		
	The Client Manager 360 Assurance presented the 2020/21 Internal Audit Head of Internal Audit Opinion and Annual Report to the Audit Committee. The Committee noted the overall opinion of 'significant assurance'.		
	07.3 **Annual Report Local Counter Fraud Specialist**		
	The Local Counter Fraud Specialist introduced the 2020/21 Counter Fraud, Bribery and Corruption Draft Annual Report to the Audit Committee. The Audit Committee noted the CCGs compliance and positive overall rating of 'green' against the new *Government Functional Standard 013: Counter Fraud* ("the Functional Standard"). The Local Counter Fraud Specialist described the small number of actions and work required to move the 'amber' and 'red' rated areas to 'green'. The Committee Chair commented that that the rating and outstanding actions are as expected given the		

Ref	Agenda Item		Action	Dead line
		standards were not issued until 1 April 2021.		
	07.4	**Annual Governance Report from External Auditors KPMG (ISA 260)**		
		The KPMG Director presented the External Audit Report 2020/21 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 10 June 2021. The KPMG Audit Manager described the duties of external audit and the procedures undertaken in auditing the CCGs final accounts and annual report. The KMPG Director wished to place on record, his thanks to the Chief Finance Officer, Head of Finance: Statutory Accounts and Financial Reporting and the wider team for the support with the audit which was complemented by a good standard of documents provided and positive responses to queries. The Audit had been completed earlier than the previous year and undertaken remotely. The Committee Chair added that in his career the CCGs final Accounts and Annual report is one of the best set of documents he had seen. He further congratulated everyone involved in the production of the final accounts and Annual Report.		
	07.5	**Draft Annual Audit Letter 20/21**		
		The Committee noted the draft Annual Audit Report 2020/21. The KMPG Director advised that the CCG had a duty to make the Annual Audit Report available to the public.		
	07.6	**Management Representation Letter**		
		The Committee noted the Management Representation Letter 2020/21.		
	07.7	**Third Party Assurances - Service Auditor Reports**		
		The Head of Governance and Assurance introduced to the Audit Committee, a Summary of Third Party		

Ref	Agenda Item	Action	Dead line
	Assurances received. It was noted that all services received a qualified or part qualified opinion. The Finance Team had reviewed the Service Auditor Reports (SAR) in detail and determined that any minor issues raised in the reports did not affect / impact upon the CCGs system of Internal Control. The KMPG Director commented that it is positive to see the Third Party Assurances - Service Auditor Reports being submitted to the Audit Committee, as this in not a standard for other Audit Committees. ***Action*** ***To describe the Third Party Assurances - Service Auditor Reports to the Governing Body meeting on 10 June 2021, (as the SAR are not included on the Governing Body agenda).***	**RW**	**10.06.21**
	The Audit Committee • **Reviewed the amended Annual Report and Accounts 2020/21** • **Received the final Head of Internal Audit Opinion 2020/21** • **Received the final Annual Report of the Local Counter Fraud Specialist 2020/21** • **Received and considered the ISA260 External Auditor's Report 2020/21 and the Draft Annual Audit Letter 2020/21** • **Reviewed the Management Representation Letter** • **Received the summary of Third Party Assurances appended to this report** **On the basis of the above to recommend to the Governing Body that it approves and adopts the CCGs Annual Report and Accounts 2020/21 and that the Accountable Officer can sign the management representation letter.** ***Agreed action*** ***To advise the Governing Body meeting on 10 June 2021 about the 360 Assurance review of Children's Continuing Care and s117 funding decisions and Report and proposed actions.***	**NB**	**10.06.21**

Ref	Agenda Item	Action	Dead line
AC 21/06/08	**DATE AND TIME OF NEXT MEETING**		
	The next meeting of the Audit Committee will be held on Thursday 16 September 2021 at 09.30 am, via Microsoft Teams.		

NHS Barnsley Clinical Commissioning Group

Minutes of the Meeting of the NHS Barnsley Clinical Commissioning Group FINANCE & PERFORMANCE COMMITTEE held on Thursday 6 May 2021 at 10.30am via Microsoft Teams.

PRESENT:

Dr John Harban (Chair)	- Elected Member Governing Body - Contracting
Chris Edwards	- Accountable Officer
Roxanna Naylor	- Chief Finance Officer
Jamie Wike	- Chief Operating Officer
Dr Andrew Mills	- Membership Council Member
Dr Jamie MacInnes	- Elected Member Governing Body
Nigel Bell	- Lay Member Governance

IN ATTENDANCE:

Leanne Whitehead	- Executive Personal Assistant

APOLOGIES:

Dr Nick Balac (Chair)	- Chair
Jeremy Budd	- Director of Strategic Commissioning and Partnerships
Patrick Otway	- Head of Commissioning (MH, Children, Specialised)
Dr Adebowale Adekunle	- Elected Member Governing Body

Agenda Item		Action & Deadline
FPC21/66	**QUORACY**	
	The meeting was declared quorate.	
FPC21/67	**DECLARATIONS OF INTEREST, SPONSORSHIP, HOSPITALITY AND GIFTS RELEVENT TO THE AGENDA**	
	The Committee noted the declarations of interest report. There were no declarations of interest raised relevant to the agenda. **Agreed Actions:** • **Chief Operating Officer reported the job title needed changing on the DOI and also his wife was a PCN Manager. Agreed to have these updated.**	**LW**
FPC21/68	**MINUTES OF THE PREVIOUS MEETING HELD ON 1 APRIL 2021** – Approved.	

FPC21/69	**MATTERS ARISING REPORT**	
	FPC21/57 Action now complete a full report on CHC will be discussed at the May Governing Body in Private. **FPC21/24** Numbers now received on the people using the 24 hour Mental Health helpline. **Agreed Actions:** • **Chief Operating Officer to share this with members. Also agreed to send a reminder to practices about the number available to patients.** **Members received and noted the matters arising report.**	**JW**
FPC21/70	**UPDATE ON RECENT PUBLISHED AND EXPECTED GUIDANCE**	
	The Chief Finance Officer presented a report to the committee in relation to recent published guidance for: 1. Proposed changes to the NHS standard contract for 2021/22 2. National Tariff consultation for 2021/22 3. NHS Operational Planning and Contracting Guidance 2021/22 The Chief Finance Officer reported that discussions were taking place and were working on an expenditure statement to draw out the joint position across health and would hope to bring this through committees in July as a draft, which would hopefully move things forward and improve transparency across our place on the underlying financial position. The first draft will just include NHS providers but will be expanded to include Primary Care and BMBC. It was noted that national tariff consultation is happening and still there and often referred to as blended payments models in guidance. The planning guidance is set out within the paper with timelines included which was submitted to the ICS on the 29 April and would be submitted to NHS England that day with the final version of the operational plan due on 3 June which will include operational activity plan and the focus is on recovery of activity pre pandemic levels around electives, cancers, 52 weeks waits etc. ICS to submit a narrative plan that sits above this and will ensure this is shared with Governing Body members. Discussion was had around outpatients and 25% of patients were expected to go online and the majority could be follow ups. Dr J	

	Harban asked if there was a baseline for this and plan around outpatients, the Chief Operating Officer agreed to pick this up at the Planned Care and Outpatients Group. **Agreed Actions:** • **Share ICS narrative plan with Governing Body members when available.** • **Chief Operating Officer to discuss outpatient's baseline at the Planned Care and Outpatients Group.** **The Committee were asked to note the contents of the report and supporting appendices.** **The Committee received and noted the report.**	**JW** **JW**
FPC21/71	**UPDATE ON CONTRACTING CYCLE**	
	The Chief Finance Officer presented the Contracting Cycle paper to the committee. It was reported that the Trust action plan for the Barnsley Integrated Diabetes Service had been received by the CCG and the CCG and Barnsley Hospital are meeting regularly, to understand the differences and pin point where tweaks can be made so that the service is seen as integral to the neighbourhood team model. An update on this would come to the July Governing Body. It was reported that the CCG agreed additional funding for Q1 First for Care additional journeys to a value of £49,000, however given continuation of block arrangements for H1 2020/21 this will need to be reviewed and potentially extended to Q2. These costs will be funded from the Hospital Discharge Programme but guidance for this programme remains outstanding. It was reported that the intermediate care ongoing costs had now been agreed and the medical oversight cover in relation to the practice who expressed an interest, withdrew from the process. Interim arrangements have been put in place for the period of 1 April 2021 – 31 May 2021 which involve clinicians from BHNFT (Acorn Unit) and Barnsley Healthcare Federation (BHF). It is still not clear what the arrangements will be 1 June 2021 and beyond, however, the steering group have engaged with the CCGs Medical Director and are gathering feedback from the BHNFT clinicians on a weekly basis to understand the issues/ asks and processes of medical oversight for intermediate care to put together with feedback from BHF. This will inform and updates to the specification required moving forward to allow sustainable service to be delivered. It was reported that everything was on track for Breathe and SWYPFT were engaging with Barnsley Hospital on this to ensure a smooth transition.	

	All contracts issued were listed within the report. **The Committee were asked to note the contents of the report including:** • **Barnsley Integrated Diabetes Service** • **Patient Transport Service additional crews Q1 2021/22** • **Intermediate Care** • **BREATHE Mobilisation** • **Contract documentation** **The Committee received and noted the report.**	
FPC21/72	**APPROVAL AND OR UPDATE ON PROCUREMENTS**	
	The Chief Operating Officer presented the report. It was noted that Breathe community service had been awarded to SWYPFT and had commenced mobilisation work supported by CCG colleagues. It was reported that the Medical Oversight for Intermediate Care RFQ was reported within the report that this had been awarded to the Kakoty Practice but this was withdrawn and an interim solution had been put in place partially covered by BHNFT for the Acorn Unit and by BHF for community beds in hours and out of hours iHeart Service and looking a solution for next phase from June. The Committee felt more information was required within this report for future meetings. **Agreed Actions** • **Chief Operating Officer agreed to pick up future reports with Head of Commissioning (MH, Children, Specialised) and also asked the Committee Secretary to share future reports when they are available.** **The Committee received and noted the report.**	**JW/LW**
FPC21/73	**FINANCIAL PLAN APPROVAL H1**	
	The Chief Finance Officer presented the 2021/22 Financial Plan April to September (H1) to the Committee as the final plan. Minor changes had been made since the last meeting but there was no change to the efficiency. This plan had been submitted to the ICS and accepted and would be submitted to NHS England later that day. **The Committee were asked to note the contents of the report including:** • **Support the recommendation that Governing Body approves these budgets for the period April – September 2021.**	

	The Committee received and noted the report.	
FPC21/74	**DATA QUALITY - POLICY REVIEW AND AUDIT PROPOSAL**	
	The Chief Operating Officer presented the report noting that one of the functions of the Committee is to provide oversight of the process for reviewing the CCG's suite of Finance policies. All Finance policies were originally approved by the Governing Body, and are now reviewed on a rolling 3 year basis. The policy had been updated which mainly reflected roles and assets changes. The annual data analysis commenced an audit last year via the Audit Committee and this work has commenced again this would be reported via the Audit Committee in a data quality report. **The Committee were asked to approve the changes with the policy. The Committee approved the report.**	
FPC21/75	**INTEGRATED PERFORMANCE REPORT**	
	<u>Finance</u> The Chief Finance Officer presented the finance section of the report to Committee highlighting that the CCG's outturn position is that all financial duties and planning guidance requirements have been delivered (subject to audit), with a surplus outturn position of £195k. Following NHS England review of the Month 12 position further allocations were received relating to Independent Sector activity and the Hospital Discharge Programme, this increased the CCGs financial position from breakeven to a surplus of £195k. Appendix 2 includes outturn details of the CCGs efficiency programme. The position as at year-end is that planned schemes delivered £2.8m against the £4.441m target. As expected and previously reported underspends within actual expenditure has mitigated against the non-delivery of efficiency plans to support the CCG to achieve financial performance targets. <u>Performance</u> The Chief Operating Officer updated members on the performance section of the report the information included in the performance report continues to show the adverse impact of COVID19 upon delivery of some constitutional standards including referral to treatment times and waiting times for diagnostic waits. Performance has continued to improve in March against the 18 week referral to treatment target with performance the highest it has been since April 2020. Diagnostic waiting times have also continued to reduce. Urgent care related measures such as A&E waits also continue to	

	be below standard and have been impacted by increased activity levels and challenges with flow due to COVID requirements in relation to social distancing. It was reported that A&E numbers were back up to pre pandemic numbers and were seeing a lot of paediatrics and walk in's. Performance on some cancer pathways is also below the national standards. 2 week wait times remain good however the number of people waiting over 31 days from diagnosis to treatment and over 62 days overall from referral to treatment has increased. IAPT performance against waiting times and recovery targets continue to be achieved however the access rate continues to be below the target and did not increase from 2019/20 in line with the NHS Long Term Plan expectations. A report was going to Governing Body in May including an update on IAPT. Dr J MacInnes raised the issues for younger children access as they are receiving increasing numbers in primary care and nothing for them to report in to. Dr A Mills also shared concerns around young people and not being able to refer in to CAMHS and the need to access some other services that are available. **Agreed Actions:** • **Chief Operating Officer to raise lower level MH and Anxiety access with the Head of Commissioning (MH, Children, Specialised).** • **Share the GB paper on Mental Health with Dr A Mills.** **The Committee were asked to note the contents of the report including:** • **Performance to date 2020/21** • **Finance update to Month 12** **The Committee received and noted the report.**	**JW** **LW**
FPC21/76	**ASSURANCE FRAMEWORK**	
	The Chief Operating Officer presented the Assurance Framework to the Committee. The Committee is the assurance provider for 6 risks (1 red risk and 5 amber risks) on the Governing Body Assurance Framework 2020/21. It should be noted that there is shared Committee responsibility for 3 of the risks with the Quality and Patient Safety Committee. **The Committee is asked to:** • **Review the risks on the 2020/21 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.** **The Committee received and noted the report.**	
FPC21/77	**RISK REGISTER**	
	The Chief Operating Officer presented the Risk Register to the Committee. There are currently five risks on the Finance and Performance Committee Risk Register with a residual rating of 'red' (extreme) after combing the COVID Risk Register with the Corporate Risk Register. **Agreed Actions** • **Agreed to flag when the review of full register is done to check the Mental Health and CAMHS risk and ensure they are appropriately reflected on the register.** • **Also to ensure if there are any issues in relation to Children and Young People they need to be raised with the Head of Commissioning (MH, Children, Specialised) at the Governing Body in May.** **The Committee were asked to:** • **Review the Finance and Performance Committee Risk Register for completeness and accuracy** • **Note and approve the risks assigned to the Committee** • **Review the risk assessment scores for all Finance and Performance risks** • **Identify any other new risks for inclusion on the Risk Register** • **Agree actions to reduce impact of extreme and high risks** **The Committee received and noted the report.**	**ALL** **ALL**
FPC21/78	**MINUTES OF THE BHNFT CONTRACT EXECUTIVE BOARD** – No meetings held.	
FPC21/79	**MINUTES OF THE SWYPFT CONTRACT EXECUTIVE BOARD** – No meetings held.	
FPC21/80	**MINUTES OF THE CHILDRENS EXECUTIVE COMMISSIONING GROUP – 1 JANUARY 2021 AND 8 MARCH 2021** - The minutes were noted.	
FPC21/81	**MINUTES OF THE ADULTS JOINT COMMISSIONING GROUP** – Meeting on 3 March 2021 was cancelled.	

FPC21/82	**MANAGEMENT TEAM DECISIONS WITH FINANCIAL IMPLICATIONS**	
	The Chief Operating Officer presented the report the Committee. The Finance & Performance Committee are asked to note the following decisions to commit expenditure taken by Management Team during April 2021: • Mobile Phones for Community Pharmacies – SMT agreed to fund the purchase of 56 bypass mobile phones for community pharmacies • Staff Survey - £4000 funding agreed to undertake a staff survey It was reported in the meeting that the cost of the mobile phones was £3500 as a one off costs, no running costs are associated they are pay as you go phones and the liability for repair and replace will lay with the individual community pharmacy contract holders. **The Committee received and noted the report.**	
FPC21/83	**ANY OTHER BUSINESS**	
	No items were raised under this heading.	
FPC21/84	**ITEMS FOR ESCALATION TO GOVERNING BODY**	
FPC21/85	**REFLECTION ON HOW THE MEETINGS BUSINESS WAS CONDUCTED**	
	The meeting went well and all business was covered.	
FPC21/86	**DATE AND TIME OF NEXT MEETING**	
	Thursday 1 July 2021 at 10.30am via Microsoft Teams.	

NHS
Barnsley
Clinical Commissioning Group

GOVERNING BODY

8 July 2021

PRIMARY CARE COMMISSIONING COMMITTEE HIGHLIGHT REPORT

PART 1A – SUMMARY REPORT

1. THIS PAPER IS FOR

Decision		*Approval*		*Assurance*	✓	*Information*	

2. PURPOSE

The purpose of this report is to provide Governing Body with the agreed highlights from the public Primary Care Commissioning Committee held on 27 May 2021.

3. REPORT OF

	Name	**Designation**
Lay Member Lead	Chris Millington	Chair PCCC
Author	Julie Frampton	Head of Primary Care

4. SUMMARY OF PREVIOUS GOVERNANCE

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

Group / Committee	**Date**	**Outcome**
Primary Care Commissioning Committee (PCCC)	27 May 2021	Highlights agreed

5. EXECUTIVE SUMMARY

This report provides the July 2021 Governing Body with the agreed highlights from the public Primary Care Commissioning Committee held on 27 May 2021.

It was agreed at the meeting that the following would be highlighted:

1. **Primary Care Strategy Group**

   As primary care works towards resuming normal working post the Covid pandemic the CCG has reviewed it's working groups for primary care and have established the Primary Care Strategy Group, as a subgroup of PCCC, and the Primary Care Delivery Group to support operational delivery as work progresses.

	The Barnsley Primary and Community transformation aims, in line with the NHS Long Term Plan (2019), Integrated Care System (ICS) Primary Care Strategy, and Network Contract Direct Enhanced Service (DES), to reflect the reinstatement of primary care services, transformation of services at "place" which will focus on seamless, accessible and integrated care, delivered by primary and community care teams whilst ensuring primary medical care is the foundation of a high performing "place" health care system. The Strategy Group has formed the Terms of Reference for the group and for the Operational Delivery Group. The Strategy group has also reviewed and established the high level Project Brief which sets out the work plan and is reflected in the start of the Primary Care Strategy – Barnsley Primary Care Delivery Model. These PCCC approved documents (Appendix 1-4) are the base for moving forward and as work progresses these documents will be reviewed, updated, and reported back to the PCCC. **2. Medicines Optimisation Scheme – 2021-22 Practice Delivery Agreement** The 2021/22 Barnsley Practice Delivery Agreement (PDA) has been reviewed and refreshed to align to the aims and investment in the COVID Recovery, the NHS Long Term Plan, and the changing landscape of the NHS in addition to delivering on the integration agenda. The Medicines Optimisation section has completed its review and is fully "worked up" for delivery against the Medicines Optimisation 2021/22 QIPP Plan, which is detailed down to delivery at GP practice level with preparatory work commencing in June 2021. The PCCC approved the 2021/22 Medicines Optimisation section of the Practice Delivery Agreement and budget.
6.	**THE GOVERNING BODY IS ASKED TO:**
	• Note the above which is provided for information and assurance.
7.	**APPENDICES / LINKS TO FURTHER INFORMATION**
	• Appendix 1 – Primary Care Strategy Group TOR • Appendix 2 – Primary Care Delivery Group TOR • Appendix 3 – Project Brief • Appendix 4 – Primary Care Delivery Model • Appendix 5 – PCC Committee adopted minutes 25 March 2021

Agenda time allocation for report:	*5 mins.*

PART 1B – SUPPORTING INFORMATION & ASSURANCE

1. Links to Corporate Priorities, GBAF and Risk Register

This report provides assurance against the following corporate priorities on the Governing Body Assurance Framework

1.1 Urgent & Emergency Care		6.1 Efficiency Plans	
2.1 Primary Care	✓	7.1 Transforming Care for people with LD	
3.1 Cancer		8.1 Maternity	
4.1 Mental Health		9.1 Digital and Technology	
5.1 Integrated Care @ System		10.1 Compliance with statutory duties	
5.2 Integrated Care @ Place			

The report also provides assurance against the following red or amber risks on the Corporate Risk Register:	*N/A*

2. Links to statutory duties

This report has been prepared with regard to the following CCG statutory duties set out in Chapter A2 of the NHS Act

Management of conflicts of interest (s14O)	**See 3.1**	Duties as to reducing inequalities (s14T)	**See 3.4**
Duty to promote the NHS Constitution (s14P)		Duty to promote the involvement of each patient (s14U)	
Duty to exercise its functions effectively, efficiently and economically (s14Q)	**See 3.2**	Duty as to patient choice (s14V)	
Duty as to improvement in quality of services (s14R)	**See 3.3**	Duty as to promoting integration (s14Z1)	
Duty in relation to quality of primary medical services (s14S)	**See 3.3**	Public involvement and consultation (s14Z2)	**See 3.5**

3. Governance Considerations Checklist *(these will be especially relevant where a proposal or policy is brought for decision or approval)*

3.1 Clinical Leadership

Have GB GPs and / or other appropriate clinicians provided input and leadership?	***NA***

3.2 Management of Conflicts of Interest (s14O)

Have any potential conflicts of interest been identified and managed appropriately, having taken advice from the Head of Governance & Assurance and / or the Conflicts of Interest Guardian if appropriate?	***Y***

3.3 Discharging functions effectively, efficiently, & economically (s14Q)

Have any financial implications been considered & discussed with the Finance Team?	***Y***
Where relevant has authority to commit expenditure been sought from Management Team (<£100k) or Governing Body (>£100k)?	***NA***

3.4 Improving quality (s14R, s14S)

Has a Quality Impact Assessment (QIA) been completed if relevant?	***NA***
Have any issues or risks identified been appropriately addressed having taken advice from the Chief Nurse (or Deputy) if appropriate?	***/NA***

3.5 Reducing inequalities (s14T)

Has an Equality Impact Assessment (EIA) been completed if relevant?	***NA***
Have any issues or risks identified been appropriately addressed having taken advice from Equality Diversity & Inclusion Lead if appropriate?	***NA***

3.6 Public Involvement & Consultation (s14Z2)

Has a s14Z2: Patient and Public Participation Form been completed if relevant?	***NA***
Have any issues or risks identified been appropriately addressed having taken advice from the Head of Comms & Engagement if appropriate?	***NA***

3.7 Data Protection and Data Security

Has a Data Protection Impact Assessment (DPIA) been completed if relevant?	***NA***
Have any issues or risks identified been appropriately addressed having taken advice from the SIRO, IG Lead and / or DPO if appropriate?	***NA***

3.8 Procurement considerations

Have any issues or risks identified been appropriately addressed having taken advice from the procurement Shared Service if appropriate?	***NA***
Has a Single Tender Waiver form been completed if appropriate?	***NA***
Has a Primary Care Procurement Checklist been completed where GPs, networks or Federations may be a bidder for a procurement opportunity?	***NA***

3.9 Human Resources

Have any significant HR implications been identified and managed appropriately, having taken advice from the HR Lead if appropriate?	***NA***

3.10 Environmental Sustainability

Have any significant (positive or negative) impacts on the environment or the CCG's carbon footprint been identified?	***NA***

APPENDIX 1

NHS Barnsley Clinical Commissioning Group

BARNSLEY PRIMARY CARE STRATEGY GROUP

1. OBJECTIVES

The Primary Care Strategy Group will support the development of a Primary Care delivery model by taking the opportunity to improve the quality of services for patients whilst also improving efficiency, lowering costs, and providing more care outside of hospital. Its priorities would include refocusing on prevention, putting people in charge of their own health and healthcare, and matching services more closely to individuals' risks and specific characteristics. The Primary Care Strategy Group will support the development and delivery of primary care services that are strongly aligned to national, regional, and local health and care priorities.

The Primary Care Strategy Group will:

- Maintain quality, safety and economic stability whilst transforming delivery
- Ensure clinicians are central to leadership and delivery
- Deliver coordination between place and system to agree and assure the delivery of transformation and service change
- Strengthen relationships
- Support community team integration and implementation
- Ensure the investment in Primary Care is delivered to maximum effect
- Support the delivery of Out of Hospital care
- Focus on Mental Health
- Focus on health inequalities
- Focus on prevention and self help
- Improve quality and patient experiences wherever care is being delivered

The Primary Care Strategy Group role is then to:

- Report progress to the Primary Care Commissioning Committee (PCCC)
- Co-ordinate the health & care priorities and system changes whilst ensuring delivery against agreed timescales
- Ensure that recommendations are made to the PCCC for decision to proceed
- Ensure that service changes have been developed in line with Commissioning Intentions and with strong clinical and professional leadership and ownership to ensure robust delivery of care
- Deliver the community wide financial plan
- Keep abreast of and link into wider system change and impact at local level – e.g. Integrated Care System Primary Care Plans and SYB Integration

- Support the provision of a sustainable Health and Care economy
- Provide direction to the Primary Care Forum for the operationalisation of service change and delivery

2. KEY RESPONSIBILITIES

The Primary Care Strategy Group will be responsible for:

- Providing leadership to ensure a co-ordinated and consensus approach
- Ensuring the necessary and required wider public engagement where significant changes to the Primary Care delivery model may occur
- Ensuring all service changes have been developed in line with strong clinical and professional leadership and ownership to ensure robust delivery of care which meets the Commissioning Intentions, outcomes, and measures
- Holding to account all colleagues in the delivery of the agreed plan to the timescales set out within it
- Ensuring that the health & care system performance is not compromised as service change and new delivery arrangements are implemented
- Ensuring that effective communication links are established with the wider Health and Care Partners
- Ensuring the Primary Care delivery model delivers sustainable services
- Developing a clear Work Programme under the following priorities:
  - Development and delivery of primary care transformation to incorporate the Long Term Plan and Primary Care Network developments
  - Quality improvement and reduction in health inequalities
  - Supporting the contractual requirements
  - Primary care workforce and training
  - Estates and digital IT
- Defining the following:
  - the scope (what is to be done)
  - timescales (when it will be done)
  - resource requirements (who will do it)
  - costs
  - risks and issues
  - quality expectations
  - planned outcomes

  - anticipated benefits

- Liaising with CCG Communication and Engagement Team to ensure that Patient and Public Engagement activities are coordinated across Barnsley.

3. MEMBERSHIP

CCG Chair
CCG Medical Director
CCG Head of Primary Care
CCG PC Finance Lead
Lead PCN Clinical Director
BHF Representative
SWYPFT Representative
Adhoc people as agenda requires

4. FREQUENCY OF MEETINGS

The meetings will be monthly unless instructed by the Chair (meetings could be more frequent if work requires a more responsive approach)

5. ADMINISTRATIVE ARRANGEMENTS

- There will be administrative support via the CCG Secretariate
- Wherever possible the agenda and papers will be circulated electronically 7 days in advance

APPENDIX 2

NHS
Barnsley
Clinical Commissioning Group

BARNSLEY PRIMARY CARE DELIVERY GROUP

1. OBJECTIVES

The Primary Care Delivery Group will support the Primary Care Strategy Group by ensuring the delivery of the emerging Primary Care Delivery Model. Its priorities would include developing project plans that enable the delivery of the new model of service provision and supporting the Task and Finish Groups established to deliver the transformation. The Task and Finish Groups will work across primary care focussing on improving services for people, reducing inequalities, and providing integrated and accessible services.

The Primary Care Delivery Group will:

- Support community team integration and implementation
- Support the delivery of Out of Hospital care
- Improve quality and patient experiences wherever care is being delivered
- Co-ordinate the Task and Finish groups to ensure the delivery of the work streams are on track and are congruent
- Ensure the Task and Finish groups have appropriate service/provider representatives

2. KEY RESPONSIBILITIES

The Primary Care Delivery Group will be responsible for:

- The operational delivery of the plans developed by the Primary Care Strategy Group
- Developing clear project plans that define the following:
    - the scope (what is to be done)
    - timescales (when it will be done)
    - resource requirements (who will do it)
    - costs
    - risks and issues
    - quality expectations
    - planned outcomes
    - anticipated benefits
- Reporting progress to the Primary Care Strategy Group
- Ensuring all appropriate people are represented on the Task and Finish groups

3. MEMBERSHIP

- CCG Head of Primary Care
- CEO BHF
- CCG Medical Director
- Task and Finish Group Project Managers
- Representative SWYPFT
- Representative Community Pharmacy
- Adhoc people as agenda requires

4. FREQUENCY OF MEETINGS

The meetings will be monthly unless instructed by the Chair of the Primary Care Strategy Group.

APPENDIX 3 - Project Brief and Plan: The purpose of this document is to outline the Barnsley Primary and Community transition aims in line with the NHS Long Term Plan (2019) and Network Contract Direct Enhanced Service (DES) to reflect the reinstatement of primary care services, transformation of services at "Place" which will focus on seamless, accessible and integrated care, delivered by primary and community care teams and ensuring primary medical care is the foundation of a high performing health care system.

Primary Care Transition Project Brief

Objectives	Scope	Interdependencies
Objectives for delivery are: • Restoration of Business as Usual across Primary Care • Development of a transition plan that incorporates a realistic implementation timeframe to maintain safety measures to prevent an increase in C-19 transmission • Uses pertinent clinical information to establish priority groups of services for restoration • Makes best use of the workforce to support people as they reconnect with health and care services • Embed changes to service delivery from technology and wider service collaboration from "place" and "system" provision	• Primary and Community Care • Mental Health Services • Long Term Condition management • Cancer Services • Community Pharmacy • Community Optometry • Community Dental • Voluntary Sector • Care Homes	• NHS Long Term Plan • SYB ICS PC Strategy • Integrated place based plans • PCN development and maturity • NHS People Plan • Capital and Revenue Plans • GPIT Futures • Local Authority Plans • Public Engagement Plans
Deliverables & Milestones	**Benefits & Measurement**	**Critical Success Factors**

• **Helping people to live a healthy and independent life** - Balancing health management, health promotion and facilitating secondary prevention for those with chronic conditions.
• **Detecting health problems quickly** - Detection and rapid response to health issues leading ultimately to better health outcomes. Improving access routes to primary care and develop community diagnostics. Utilise lessons from the pandemic response.
• **Delivering timely, effective local integrated care and support** integrated teams work together avoiding unnecessary admissions, proactively managing patients with complex needs, support and maximise timely discharges.
• **Health checks** reinstated across all sectors starting with LD and Mental Health
• **Plans for re-instating all screening, vaccinations, and Immunisations**
• **Reduce variability and health inequalities** – Practice performance and quality of care patients receive benchmarked with peers. Develop personalisation plans based on needs.
• **National Service Specifications** - Ensuring that the specific goals of the Long Term Plan make a significant impact against the "triple aim" of:
  ◦ Improving health and saving lives
  ◦ Improving the quality of care for people with multiple morbidities
  ◦ Helping to make the NHS more sustainable
	Benefit
	• **More coordinated services –** where people do not have to repeat their story
	• **Access to a wider range of professionals** in the community, enable access to people and services in a single appointment, Right Care principles
	• **Appointments that work around people's lives**, with shorter waiting times and different ways to get treatment and advice including digital, telephone-based, and face-to-face
	• **More influence,** giving more power over how their health and care are planned and managed
	• **Personalisation** and a focus on prevention and living healthily, recognising what matters to people and their individual strengths, needs and preferences
	• **Wider range of services in a community setting**, so people don't have to default to the acute sector
	• Developing a **more population-focused approach** to "system" and "place" decision-making, resource allocation, drawing on primary care expertise as central partners
	Measurement
	• **Greater resilience**: by making the best use of shared staff, buildings, and other resources to help balance demand and capacity over time
	• **Better work/ life balance**: with more tasks routed directly to appropriate professionals, such as clinical pharmacists, social prescribers, physician associates, physiotherapists and other ARRs roles
	• **More satisfying work** with each professional able to focus on what they do best
		• Maintain quality, safety and economic stability whilst transforming delivery
		• Ensure clinicians are central to leadership and delivery
		• Deliver coordination between" place" and "system" to agree and assure delivery of transformation and service change
		• Improved access to cancer care
		• Improved access to diagnostics
		• Improved access to Mental Health and Crisis services
		• Decrease in health inequalities
		• Focussed actions on prevention and self help
		• Ensure the investment in Primary Care is delivered to maximum effect
		• Support the delivery of Integrated Out of Hospital care

• **Workforce** - Ensure the workforce of the future have the skills to respond to a wider profile of services and PCN workforce plans are further developed and matured.	• **Improved care and treatment for patients**, by expanding access to specialist and support services such as social care • **Greater influence** on the wider health system, leading to more informed decisions about where resources are spent • **Cooperation across organisational boundaries** and teams to allow better coordination of services • **More resilient primary care**, acting as the foundation of integrated systems	
Plan	**Key Stakeholders**	**Risks and Issues**
Defining the following: • **Detailed project plans developed for all work streams including:** ▪ **the scope (what)** ▪ **timescales (when)** ▪ **resource requirements (who)** ▪ **costs** ▪ **quality expectations\ outcomes** ▪ **anticipated benefits** ▪ **Risk assessment and mitigation** ▪ **Clear roles and responsibilities** ▪ **Communications plan**	• **CCG & ICS** • **PCN/Providers/Local Authority/Voluntary sector/Acute Care** • **Staff across Primary, Community and Social care** • **Health Watch\PPGs\Expert Patient Groups**	• **Lack of engagement** • **People reluctant to access care due to safety fears** • **Stakeholders do not support delivery plans** • **Over ambitious plans that are not deliverable** • **C-19 variants resistant to vaccine** • **DES and GMS contracts do not support delivery** • **Non-recruitment to workforce plans** • **ICS\Integration process slows delivery progress**

APPENDIX 4

NHS
Barnsley
Clinical Commissioning Group

Primary Care Delivery Model Development

Author: Julie Frampton
Head of Primary Care
V1.1 April 2021

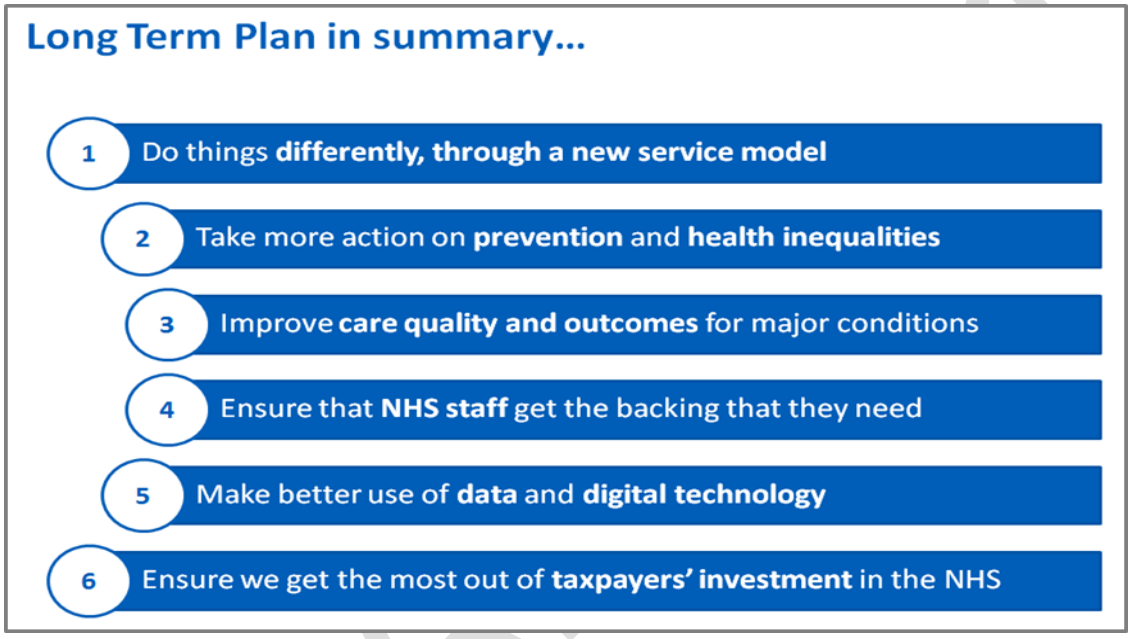
APPENDIX 4

NHS Barnsley Clinical Commissioning Group

Primary Care Delivery Model

Purpose

The purpose of this document is to outline the development of the Primary Care Delivery Model in line with the NHS Long Term Plan (2019) and Network Contract Direct Enhanced Service (DES) and to reflect the system sign up to the South Yorkshire and Bassetlaw (SYB) Integrated Care Systems (ICS) Primary Care Strategy. Barnsley Primary Care Delivery Model will focus on seamless, accessible, and integrated care, delivered by integrated primary care teams and ensuring primary medical care is the foundation of a high performing health care system.



The CCG will lead and support the development of the delivery model which takes a systematic approach to the planning and delivery of all care services provided in primary care settings and requires movement away from traditional fair shares to a more targeted approach for certain populations. The basis for this is described as 'layering' i.e. which activities and developments are most efficiently and effectively done at different levels of scale as noted in the diagram below. How primary care achieves these outcomes will be decided at the appropriate layer, recognising the concept of 'layering' and the principle of subsidiarity where decision making, and

empowerment are devolved to the most appropriate lowest level across our ICS.

Barnsley CCG aims to improve the health and wellbeing of the people of Barnsley. It shares this ambition with partners from across health and care as well as voluntary and community based organisations.

We recognise that fundamental to achieving this ambition we need strong and resilient primary and community care services. This requires a more integrated system to support a workforce that is multi-skilled and able to adapt to changes in the way that health and care services are provided as our services transform into a new model of care.

We recognise that in responding to new ways of working we need to develop these skills and competencies in collaboration with our partners and our patients. As such there will be a focus on what brings us together and how we will jointly tackle the challenge, whilst also highlighting locally sensitive solutions. This is not going to be an easy task, there are many challenges facing General Practice, including the covid pandemic, workforce, and rising demand. In Barnsley we will work together to develop a resilient and sustainable delivery model in which general practice can thrive.

Benefits

In Barnsley we already have a track record of working as one, investing consistently and equitably in primary care, in “at scale” networked provision via Barnsley Healthcare Federation for all our practice populations and in ensuring that no practice or its registered population are left behind.

Patients will benefit from extended access and responsiveness of the local care system by:

- **More coordinated services -** where they do not have to repeat their story multiple times
- **Access to a wider range of professionals** in the community, so they can get access to the people and services they need in a single appointment
- **Appointments that work around their lives**, with shorter waiting times and different ways to get treatment and advice including digital, telephone-based and face-to-face
- **More influence** when they want it, giving more power over how their health and care are planned and managed
- **Personalisation** and a focus on prevention and living healthily, recognising what matters to them and their individual strengths, needs and preferences

Practices will benefit by:

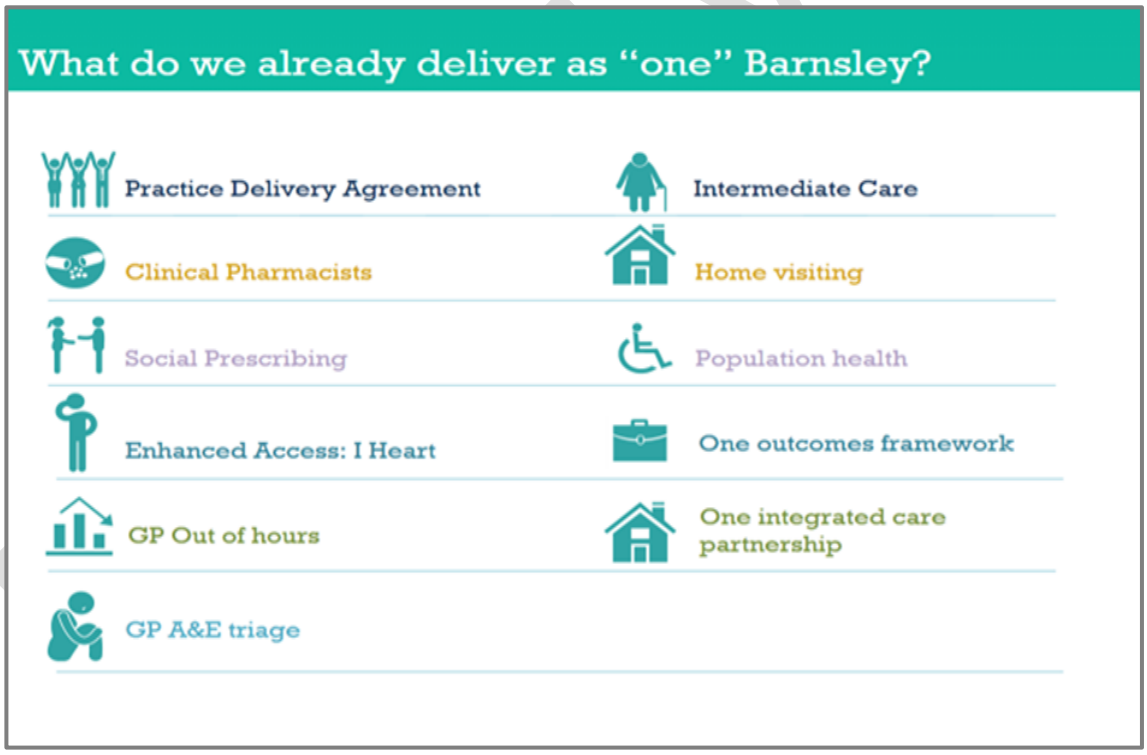
- **Greater resilience**: by making the best use of shared staff, buildings, and other resources, they can help to balance demand and capacity over time
- **Better work/ life balance**: with more tasks routed directly to appropriate professionals, such as clinical pharmacists, social prescribers, physicians’ associates, physiotherapists, care coordinators and other roles within the

Additional Roles scheme. Including wider system partners to support the delivery of care will also support

- **More satisfying work** with each professional able to focus on what they do best
- **Improved care and treatment for patients**, by expanding access to specialist and support services such as social care
- **Greater influence** on the wider health system, leading to more informed decisions about where resources are spent

Wider health and care system will benefit by:

- **Cooperation across organisational boundaries** and teams to allow better coordination of services
- **Wider range of services in a community setting**, so patients don't have to default to the acute sector
- Developing a **more population-focused approach** to system wide decision-making and resource allocation, drawing on primary care expertise as central partners
- **More resilient primary care**, acting as the foundation of integrated systems



Primary Care at "place" will have a wide reaching membership which should include providers from the local system such as:

- community pharmacy
- Optometrists
- dental providers
- social care providers

- voluntary sector organisations
- community services providers
- local government

Service Risks - Operational Stage:

- Failure to secure sustainable income streams to support ongoing services
  - Mitigation – The Network DES ensures a number of income streams that can be utilised to sustain finances across the PCN. There are several primary care contracts that could be utilised in ways to support the development of the delivery model
- Failure to source adequate, affordable staffing and facilities (within constraints of commissioned contract values)
  - Mitigation - The development will encompass existing practice and community infrastructure and there are opportunities for new staff in specific role/professions. The Neighbourhood Networks provide a structure to support delivery of more "hub and spoke" delivery that link with other provider structures enabling local provision within "place". There is an opportunity to look at the workforce model that we completed by WPS to support this model.
  - Mitigation – Exploring new roles and being creative regarding staffing skill mix could produce a workforce more stable and sustainable for delivering primary care

Interdependencies

The Primary Care Delivery Model will be strongly aligned to national, ICS and local health and social care priorities (place). It focusses heavily on addressing the health care needs of local people affecting our community and addresses the needs of the most vulnerable, reducing the health inequalities experienced by our population.

The development of the neighbourhood model will address the issues experienced by our communities, target those health inequalities specific to each neighbourhood and address the key public health themes such as lifestyle, social isolation, emotional health, alcohol intake, obesity, and smoking. It also links to mental health and the health and wellbeing strategy.

Barnsley GPs have a history of working together to innovate. Neighbourhood working Groups have already been established and now it is necessary to review these groups with a view to wider support mechanisms and to engage healthcare providers to implement the PCNs by promoting joint working with providers and the public.

Expected deliverables

Helping people to live a healthy and independent life

The need to balance health management with one of health promotion and protection is well documented with the following aspirations across the life course. They offer the basis of the outcome statements for this element of the plan in which primary and community services play a key role in facilitating secondary prevention for those with chronic conditions.

Outcome Statement

- Babies are born healthy
- Pre-school children are safe, healthy and develop their potential
- Children & young people are safe, healthy, and equipped for adulthood
- Working age adults live healthy lives for longer
- Older people age well into their retirement
- Frail people are happily independent.
- Those with chronic conditions are supported to make lifestyle choices which may prevent further exacerbation of the problem.

To achieve these, we will:

- Make every contact count, using any exchange with patients to share information that may aid their own well-being
- Engage with the "seldom heard" people – those who do not engage with traditional primary care and health promotion programmes
- Deliver seamless services
- Enhance preventative health activities, reduce clustering of unhealthy lifestyle behaviours
- Improve timely risk management to improve detection and early diagnosis of diseases such as cancers
- Seek to realise the capacity in individuals and communities through empowering people to be in control of their own Health & Well-being
- Chronic long term management programmes which relate to health promotion and the roles of community teams
- Increase uptake of screening programmes

Detecting health problems quickly

The ability to detect and therefore respond to health issues quickly is at the heart of modern healthcare. Early detection will lead to earlier care and advice and ultimately to better health outcomes.

Outcome Statements

- Individuals will have good and prompt access to healthcare provided through a variety of means
- Community teams will have access to a wide range of diagnostic tools to support early diagnosis and treatment
- Community teams will have prompt access to specialist advice

- Staff in hospitals who could be providing their service in a primary/community setting will be enabled do so
- Those who have a condition for which a risk stratification approach can be enabled will be enabled

To achieve these, we will:

- Continue to increase access and availability of core primary care services/teams
- Work with providers to develop the working models
- Work across frailty community resource teams
- Ensure the falls strategy supports general health promotion and falls prevention is followed by assessment and management of people at risk of falls or who have fallen.
- Provide a greater range of diagnostic tests and follow up checks and clinics closer to home, so people only travel to hospital for specialised services. Work with secondary care clinicians/teams to develop an appropriate model
- Review existing staffing resource across all sectors to build a holistic, integrated approach to a patient's needs rather than as a single/specialist service/pathway.
- Optimise and quality assures contractual arrangements to secure high quality and cost effective care from all sectors across Health and Social Care to include other services such as Dental, Optometry and Community Pharmacy and the third sector.

Delivering timely, effective local integrated care and support

The delivery of fast, effective, and local integrated care and support is the cornerstone of the Primary Care Delivery Model and will be delivered through a wide range of professionals and services working within integrated teams to meet communities and individual's needs. This will mean that all staff working at a community level will see themselves as part of an extended community team. The integrated care structure will be strengthened as the basis for planning, co-ordination, and delivery of local services by multi-agency teams against individual needs and clinically agreed pathways.

It is well recognised that when older people have protracted lengths of stay in hospitals this leads to poorer outcomes and increased dependency. It is therefore essential that integrated teams work together with the aim of avoiding unnecessary admissions to hospital. When a hospital admission is required, it is essential that the patient's length of stay is minimised and integrated teams proactively case manage patients with complex needs to support and maximise timely discharges.

Outcome Statements

- Patients will receive care from a team within their community and will not feel the boundaries that often exist between teams and sectors as those providing care will be seen as a single team regardless of professional background
- Integrated teams in the Neighbourhoods will be the point of influence for the delivery and resourcing of community based services
- Care will be co-ordinated at a Neighbourhood level, with local integrated teams holding responsibility for patient care and case management
- All patients with a chronic condition will have an individual care plan
- Services will be planned and delivered to support people to remain safely at home, or close to home, care will be delivered locally against agreed pathways and delivered by integrated teams across primary, community, social and third sector care with support packages tailored to the individual as necessary to their needs.
- Where more specialist care is required, specialist roles will support the Neighbourhood teams (e.g. CVD, Cancer/palliative care, Chronic Obstructive Pulmonary Disease {COPD}, Diabetes etc.) to access this in a timely way and ensure that the individual is supported through the specialist element of their need, returning where possible to community based care or indeed no need for further care

To achieve these, we will:

- Support Neighbourhood networks and teams, so they rapidly become the essential mechanisms for planning and delivering a truly integrated set of services
- Remove the boundaries between teams moving towards single integrated teams managed at a Neighbourhood level
- Develop a range of services to better manage patients within the community (e.g. CVD, diabetes, COPD, palliative care) though recognising that many of these already exist, seek to co-ordinate, and organise care better together
- Recognise that the older population have increasingly complex needs and co-morbidities. It is therefore essential that we treat the older person holistically rather than on an individual specialist based service/pathway.
- Systematically and proactively plan and co-ordinate packages of care using agreed care pathways and protocols, enabling all relevant professionals to talk to each other, utilising modern technology and case conferencing.
- Develop a more pro-active approach to the management of complex patients in the community
- Systematically and proactively identify the needs of people living within their local communities, including those at risk or requiring high levels of care and support to inform service planning and co-ordination.
- Optimise the use of modern technology to monitor, protect and communicate with each individual assessed as vulnerable, in their home.
- Develop and implement models of care and services which increases the range of services available 7 days per week, 24 hours a day

Involving people in decisions about local services and their care

Change is most effective when those that it affects are involved in bringing it about. A new approach to the involvement of individuals and communities should be enabled, one which engages people in formulating ideas about service development and change before any plans are made as well as seeks feedback on service experience. As such citizens become much more partners in the design of and quality of services rather than solely as recipients.

Outcome statements

Influence

- Communities feel ownership of their local services and know they can influence them
- Communities are offered opportunity to engage in the future shape of services for a community
- Communities and individuals know where to go and who to speak to if they have ideas about service development
- Communities receive consistent and equitable service provision and care

Feedback

- People receiving services know how they can give feedback on them
- People can see a direct link between their feedback and service improvement
- Every contact will count, local teams providing services will engage actively with people and seek their views on the services provided

Information

- Information (whether condition specific or related to service availability/improvement) is easily accessible to all
- Community infrastructure in the widest sense is used as a means through which information can be accessed

To achieve these, we will:

Work with and empower the local communities utilising a variety of methods to obtain the views of people on integrated team working within the Neighbourhood delivery model. This will focus initially on the areas with the highest levels of deprivation and resulting health inequalities to improve the health of the local population and to provide excellence in primary care.

Planning, organising, and delivering local integrated care

The model of care proposed here is one which draws on all expertise within a community, individuals and communities themselves, all primary care contractors, social care teams, community and wider community teams (i.e. health visitors,

district nurses, dentists, optometrists, community pharmacists) and the third sector providers and private providers as they relate to the model.

Effective planning systems are often the simplest, those that have the least bureaucracy, yet where everyone is clear on where decisions are made and how to influence this. The vision we have presented through the varying themes in this strategic plan, mean that a system of planning and organisation has to be enabled that engages a wide range of people, responds to National requirements but most importantly is able to reflect and respond to local needs.

Outcome Statements

- Expertise from communities and teams working within communities is harnessed and utilised to make local care as effective as it can be
- Local clinical leaders will set the vision for local care
- Quality and safe care is at the forefront of localised service delivery
- The primary and community workforce will have a wide range of skills developed across a team based concept of skill development
- Modern technology will be used where appropriate to support access to, and the delivery of local care

To achieve this, we will:

- Further develop local integrated teams with clear accountability relationships to the organisations that employ them
- Further develop partnerships for planning and building local services
- Further develop integrated teams for service delivery via existing resources/teams coming together and being recognised as one local team
- Enable pathways of care through clear clinical leadership
- Provide strong leadership and create capacity and capability for Neighbourhoods to plan and co-ordinate local integrated care.

Reduce the variability

The CCG has a duty to continually improve the quality of medical care services. This has been achieved through active engagement with our member practices and the development of a quality dashboard. This has enabled the CCG to work with practices to understand their performance and the quality of care their patients receive benchmarked with their peers. Whilst this has led to improvements there remains significant variation across practices. Covid-19 has further exposed some of the health and wider inequalities across our system, in order to address these, we will need to review the scale and pace of progress in reducing health inequalities.

Outcome Statements

- Develop a local quality improvement plan (benchmarking data) – promoted by strong accountable clinical leadership

- Practices have access to data and information tools to develop practice based improvement plans where necessary
- Development of a Neighbourhood/PCN quality dashboard that links to the ICS as “layers”
- Create a culture of sharing excellence

To achieve this, we will:

- Further develop local integrated teams with clear accountability relationships to the organisations that employ them
- Further develop partnerships for planning and building local services
- Further develop integrated teams for service delivery via existing resources/teams coming together and being recognised as one local team
- Enable pathways of care through clear clinical leadership
- Provide strong leadership and create capacity and capability for Neighbourhoods to plan and co-ordinate local integrated care.
- Build a “support team” to assist integrated teams with improving their quality performance

Delivering the Primary Care Development Model (needs developing)

The development of the Primary Care Delivery model is only the beginning of the journey. Much more important is the ability to realise its intent and translate the strategy to action.

It is clear that the plan offers a vehicle for the implementation of many organisational objectives and the delivery of the ICS, place, and neighbourhood plans. The CCG would support all partners to develop an approach to each of the key topic areas.

Technology (need to expand)

We will continue to support practices to increase the number of patients using online services to reduce the burden on them in relation to appointment booking, issuing prescriptions for repeat medication and dealing with access to medical records enquiries.

The increased amount of data and information available provides an important basis to focus on quality improvement. Bringing together the different skills and perspectives of people across the organisations in the PCNs to learn from each other, consider variation across providers and improve services for patients.

Estates (need to review)

The premises from which primary care services are delivered form a vital part of the infrastructure for Neighbourhoods. Increasingly premises will be required to support members of the multidisciplinary teams, visiting clinicians, pharmacists, physiotherapists, and specialist doctors. They will need to accommodate digital

solutions that support patients and streamlined administration and may be co-located with other support and community services.

The formation of the PCN provides an opportunity to reconsider the capacity, condition, and appropriateness of existing premises (last assessed in 2015 by Capita), split between clinical and non-clinical accommodation and the current ownership arrangements. A number of practices across Barnsley have utilised some of the existing capital funding routes including existing (BAU) capital for improvement grants, the Estates and Technology Transformation Fund to update their property.

The design of estate will be dependent on the local stock of premises and the extent to which existing premises can be used differently, have realistic investment opportunities to improve or extend, re-purpose buildings or invest in new developments linked to the Integrated Care System estates plan. Any emergent models will need to be supported by all partners to ensure patients are able to access services conveniently when they need to and may not always require physical co-location of all services under one roof. The model should facilitate improved, efficient use of existing estate rather than focus on initiatives requiring substantial capital investment and include key stakeholders for example Barnsley Metropolitan Borough Council, Barnsley NHS FT, and other providers.

Commissioners will support the revenue funding impact of existing and future premises and work to seek options to update, repurpose or extend existing premises where appropriate within the parameters of the NHS GMS (Premises Cost) Directions to maximise use of and ensure the provision of good quality health care accommodation.

Conclusion (need to review)

In Barnsley we will work collaboratively to make the NHS Long Term Plan a reality. We wish to create an environment in which everyone can continue to thrive, and our services become even more effective and efficient. Our strategy update aims to deliver community-based, person-centred care that:

- Promotes health and wellbeing
- Offers a true focus on prevention
- Supports people to be active in managing their own health and care
- Helps to keep people out of hospital as much as possible.

This will be a transformational journey for building patient-centred, out-of-hospital care, which will be realised over a number of years through a focus on improving outcomes for patients and thinking beyond traditional boundaries and business models.

NHS
Barnsley
Clinical Commissioning Group

Minutes of the PUBLIC Primary Care Commissioning Committee meeting held on Thursday, 25 March 2021 at 9.30pm via MS Teams

PRESENT: (VOTING MEMBERS)

Chris Millington (*Chair*)	Lay Member for Patient & Public Engagement and Primary Care Commissioning
Nigel Bell	Lay Member for Governance
Mike Simms	Secondary Care Clinician
Richard Walker	Head of Governance & Assurance
Chris Edwards	Chief Officer

CLINICAL MEMBERS (NON-VOTING)

Dr Madhavi Guntamukkala	Governing Body Member
Dr Mark Smith	Governing Body Member
Dr Nick Balac	Chair Barnsley CCG

IN ATTENDANCE:

Julie Frampton	Head of Primary Care
Angela Musgrave	Executive Personal Assistant
Nick Germain	Primary Care Manager, NHSEI
Carrie Abbott	Public Health, BMBC
Roxanna Naylor	Chief Finance Officer
Ruth Simms	Assistant Finance Manager

APOLOGIES:

Julia Burrows	Director of Public Health, BMBC

MEMBERS OF THE PUBLIC:

There were no members of the public present at the meeting.

Agenda Item	Note	Action	Deadline
PCCC 20/03/01	**HOUSEKEEPING**		
PCCC 20/03/02	**WELCOME AND APOLOGIES**		
	The Chair welcomed members to the meeting and apologies were noted as above.		
PCCC 20/03/03	**QUORACY**		
	The meeting was declared quorate.		
PCCC 20/03/04	**DECLARATIONS OF INTEREST RELEVANT TO THE AGENDA**		
	There were no declarations of interest relevant to the agenda.		

PCCC 20/03/05	**MINUTES OF THE LAST MEETING**		
	The minutes of the meeting held on 28 January 2021 were verified as a true and correct record of proceedings with the following amendments:- <u>Contractual Issues Report</u> • The Committee **approved the** sale and lease back application for Huddersfield Road Surgery. <u>PCCC Terms of Reference</u> • Remove reference to the Primary Care Operational Group as this meeting is the Primary Care Forum and is already included in the ToR. <u>Workforce Risk Review – Risk Reference CCG 14/10 on the CCGs Risk Register</u> • This risk had been discussed at a preceding Governing Body meeting. Following feedback from this meeting a review of the risk would be carried out and any amendments to the wording would be brought back to the next PCCC meeting.		
PCCC 20/04/06	**MATTERS ARISING REPORT**		
	<u>PCCC 20/01/10 - Workforce Risk Review</u> Members noted the update provided. <u>PCCC 20/07/07 – GP patient Survey 2020</u> Update included within the Contractual Issues Report at agenda item 10.		
STRATEGY, PLANNING, NEEDS ASSESSMENT AND CO-ORDINATION OF PRIMARY CARE			
PCCC 20/01/07	There was nothing to report relating to the strategy, planning, needs assessment and co-ordination of Primary Care.		
QUALITY AND FINANCE			
PCCC 20/01/08	**FINANCE UPDATE**		
	The Assistant Finance Manager presented an update of the financial position and details of funding allocations for delegated Primary Care Co-Commissioning budgets as at 31 January 2021 (month 10). <u>Forecast Position 2020/21</u> The forecast position as at 31 January 2021 (month 10), was £873k underspend with the largest variance of £439k		

	relating to an underspend against the Additional Roles Reimbursement funding. This figure was expected to increase further with the likelihood that none of the funding held nationally for additional roles would be accessed. Appendix A provided information on additional variances relating to GP services, premises cost reimbursement and the Quality Outcomes Framework (QoF) payments to practices. Following a discussion regarding QoF payments to practices the Chair of the CCG recommended that any underspends were managed throughout the year to ensure maximising investment and capacity in Primary Care. **The Committee:** • **Noted the information provided in the Finance Update report.**		
PCCC 20/03/09	**CQC REPORT** The Head of Primary Care presented the CQC report that provided members with an update on the current CQC position in relation to Barnsley GP Practices and Barnsley Healthcare Federation i-Heart contracts. Following the Care Quality Commission (CQC) implementation of a Transitional Regulatory Approach that focussed on existing Key Lines of Enquiry, current inspection activity was being limited to where there may be a serious risk of harm or where it supported the system's response to the pandemic. Three Barnsley CCG GP practices had been contacted in line with the CQC's Transitional Regulatory Approach. Following positive discussions with all three practices it was confirmed that no further monitoring activity was required at this stage. The remaining Barnsley CCG GP practices were currently low priority due to their score within the CQC monitoring dashboard and therefore no further CQC activity was planned. **The Committee noted:** • **The CQC's implementation of the Transitional Regulatory Approach and the assessments completed.**		

CONTRACT MANAGEMENT			
PCCC 20/03/10	**CONTRACTUAL ISSUES REPORT**		
	The Head of Primary Care presented the Contractual Issues Report that provided members with an update on the current contractual issues in relation to primary care contracts. <u>In Year Contract Variation</u> The CCG had received an application to remove Drs Baruah and Mahmood from the Hoyland Medical Practice contract due to their resignation on 31 July 2020 and 17 October 2019 respectively. The practice had informed the CCG that they would be recruiting salaried GPs to replace the lost sessions. It was reported that the practice had omitted to inform NHSE or the CCG of the resignations and the Primary Care team had since worked with the practice to remind them of the correct procedure to follow and to ensure due diligence had been carried out. <u>Extended Access and Out of Hours Contract Extensions – Barnsley Healthcare Federation (BHF)</u> The current contracts that had been in place since 2017 with BHF to provide Extended Access and Out of Hours services to Barnsley patients were due to end on 31 March 2021. NHS England had planned changes for extended access services that would introduce a new standardised service specification as part of the Network Contract DES. In January 2021 the CCG had been informed of a delay to this work and it was unlikely introduction would take place before April 2022. It was reported that ceasing the contracts with BHF would greatly impact patient access and ultimately put a considerable burden back onto GP practices. It was therefore recommended to extend the current Extended Access and Out of Hours contracts for a further 12 months from 1 April 2021 to 31 March 2022. Due to the timeline involved, voting members of the Committee had virtually confirmed their approval to extend the contracts for a further 12 months. The Committee was asked to ratify the approval of the extension to contracts. .		

	<u>GP Practice Premises Sale and Return</u> The CCG had received an application for Sale and Leaseback of:- a) Garland House Surgery, 1 Church Street, Darfield, Barnsley b) Woodgrove Surgery, 2 Doncaster Road, Wath-on-Dearne, Rotherham The Primary Care Team had worked with NHSE, PCC to review the information contained in the lease agreement to confirm the documentation was in line with regulations and to ensure the CCG had complied with the guidance and rules. It was recommended that the Committee approve the application given the assurance provided and the inclusion of the break clause in the lease if this were to be necessary to comply with future estates strategies. <u>GP Survey Feedback Analysis</u> The results of the GP Patient Survey published in August 2020 had been analysed. Attached at appendix A was a report that provided the Committee with information on the outcome and aims. Attention was brought to some of the questions and responses and in particular the number of patients who were not aware of what services GP practices offered online, had not used any online services or hadn't tried to use the practice website. In order to address this issue the CCG would be working with telephony providers to streamline this facility to ensure improved telephone access for patients. Overall Barnsley CCG benchmarked well both nationally and with peers with average feedback results being within 5% when compared with the national result. <u>E-Declaration Update</u> In December each year GP Practices were required to complete and electronically submit an Annual Practice Declaration (eDEC). Due to Covid-19 and the additional pressures faced by GP practices this year there had been a number of extensions to the deadline for submitting responses. All practices within Barnsley had now submitted their responses as required which ensured their contractual obligations had not been breached and the CCG was now compliant.		

	<u>Primary Medical Care Policy and Guidance Manual Update</u> NHS England periodically reviewed and refreshed the Primary Medical Care Policy and Guidance Manual to ensure it remained fit for purpose and reflected the latest legislation and national direction. In February 2021 a refresh was published that carried forward the planned changes from April 2021. The Committee received a summary of all the points changed within the guidance manual and noted that the CCG would ensure the changes were reflected within the reporting mechanism to ensure compliance. **The Committee: -** **1. Noted the resignation of Drs Baruah and Mahmood from Hoyland Medical Centre from 31 July 2020 and 17 October 2019 respectively.** **2. Ratified the 12 month extensions to the Barnsley Healthcare Federation Extended Access and Out of Hours contracts from 1/4/21 to 31/3/2022.** **3. Approved the Sale and Lease back application from Dr Mellor & Partners for the leases for Garland House Surgery and Woodgrove Surgery.** **4. Noted the GP survey analysis.** **5. Noted the update regarding practice completion of their eDec submission.** **6. Noted the summary provided of the update of the Primary Medical Care Policy and Guidance Manual.**		
PCCC 20/03/11	**CLINICAL SYSTEMS BRIDGING AGREEMENT**		
	The Head of Primary Care presented the Clinical Systems Bridging Agreement Report that informed members of the requirement to approve the Call-Off Order Forms for the Bridging Agreements for the CCG and our GP Practices following expiry of the Continuity Call Off Agreements (CCOA) in March 2021. The CCOA agreements were put in place during 2020 as a transition from GPSoC to GPIT Futures with the expectation that the entire GP IT estate would be re-competed under the new national GP IT Futures framework.		

	Unfortunately, due to the impact of Covid-19 and the re-focus of priorities at NHS Digital, the CCG and GP practices, there had been insufficient time to enable a full re-procurement 'Off Catalogue' as envisaged within the GP IT Futures Framework and Business Case. The CCOAs were due to expire at the end of March 2021 and therefore the CCG needed to put in place alternative agreements to bridge the period of time between the expiry of the CCOAs and when the CCG would be able to re-compete their requirements to ensure suitable contractual arrangements were in place. The Bridging Agreement process had therefore been completed enabling retention of all solutions within the existing Barnsley CCG GP IT estate. The Bridging Agreements would take effect from 1 April 2021 and would run for a maximum of 18 months. Members were informed that the CCG would work with NHS Digital to ensure the entire GP IT estate was re-competed under the new national GP IT Futures framework before the end of this period. **The Committee:** • **Approved the Call Off Order Forms for GP IT solutions.**		
PCCC 21/03/12	**360 ASSURANCE REPORT**		
	The Head of Primary Care presented the 360 Assurance Report that provided the Committee with an update on the 360 Assurance Audit regarding Primary Care Governance and Governance Contracting. Members were informed that as part of NHSE's requirement for independent assessments an annual assurance audit was carried out to ensure primary care delegated functions to the CCG were being properly discharged. The four domains set out in NHSE's Internal Audit Framework were: • Commissioning and Procurement of Services • Contract Oversight and Management Functions • Primary Care Finance • Governance (common to each of the above areas) The Committee's attention was brought to two areas of low risk, including actions to mitigate the risks, included in the final 360 Assurance Report that would be		

	implemented by the Head of Primary Care and the Primary Care Team. The Committee noted that this year's 360 Assurance Report was the highest level obtainable and reflected the CCGs position as an outstanding CCG. **The Committee:** • Noted the content of the 360 Assurance report.		
GOVERNANCE, RISK AND ASSURANCE			
PCCC 21/03/13	The Head of Governance & Assurance presented the risk and Governance report that provided the Committee with the:- • Assurance regarding the delivery of the CCG's annual strategic objectives • Assurance that the current risks to the organisation were being effectively managed and monitored appropriately <u>Assurance Framework</u> The Assurance Framework continued to be reviewed and updated. Appendix 1 of the report provided the Committee with an extract from the GBAF of the two risks for which the Committee were the assurance provider. Both risks 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 and; • Risk Ref 9.1 – the key deliverables of Digital Technology if identified threats(s) were not appropriately managed and mitigated. <u>Risk Register</u> There were currently five risks on the Corporate Risk Register for which the Committee were responsible for managing. Of the five risks, there was one red risk (extreme), one amber risk (high), one yellow risk (moderate) and two green (low) risks. It was reported that a review of the risk in relation to Primary Care Workforce would be carried out and any amendment to the wording would be brought back to the next Committee. All risks continued to be reviewed and updated regularly.		

	<u>Annual Assurance Report</u> The Committee was reminded that all of the CCG's Committees were required to produce an Annual Assurance Report that provided the Accountable Officer and the Governing Body with assurance that the Committees had carried out their delegated responsibilities and managed the key risks within their remit. It was noted that as part of the Delegation Agreement the PCCC Annual Assurance Report would be provided to NHSE. The Chair of the CCG commented that as the PCCC meetings had clashed with another meeting he had been unable to attend all the meetings; however to ensure attendance going forward the timing of the PCCC had been amended to facilitate better attendance. It was confirmed that a foot note would be included in the Assurance Report to reflect this comment. **The Committee:** • Considered and approved the Draft PCCC Annual Assurance Report 2020-21.	**RW/AM**	**Complete**
OTHER			
PCCC 21/03/14	**REFLECTION OF CONDUCT OF THE MEETING** The Committee agreed that the meeting had been conducted appropriately.		
PCCC 21/03/15	**QUESTIONS FROM MEMBERS OF THE PUBLIC RELEVANT TO THE AGENDA**		
	There were no questions received from the members of the public.		
PCCC 21/03/16	**ITEMS FOR ESCALATING TO THE GOVERNING BODY** It was agreed to escalate the following items to the Governing Body for information:- • To note the highest level of achievement as reported in the 360 Assurance Audit Report • That the Committee had received and reviewed the GP Survey Feedback Analysis		
PCCC 20/01/14	**DATE & TIME OF NEXT MEETING** Thursday, 27 May 2021 at 9.30am via MS Teams.		

NHS
Barnsley
Clinical Commissioning Group

Minutes of the NHS Barnsley Clinical Commissioning Group
QUALITY & PATIENT SAFETY COMMITTEE
Thursday 15 April 2021, 13:00pm-15:30pm (Microsoft Teams)

MEMBERS:

Dr Madhavi Guntamukkala	-	Medical Director (Chair)
Jayne Sivakumar	-	Chief Nurse
Mike Simms	-	Secondary Care Clinician
Dr Mark Smith	-	Practice Member Representative Contracting Lead from the Governing Body
Chris Millington	-	Lay Member for Public and Patient Engagement and Primary Care Commissioning
Chris Lawson	-	Head of Medicines Optimisation
Dr Adebowale Adekunle	-	GP Governing Body Member
Jo Harrison	-	Specialist Clinical Portfolio Manager

IN ATTENDANCE:

Richard Walker	-	Head of Governance and Assurance
Terry Hague	-	Primary Care and Transformation Manager
Hilary Fitzgerald	-	Quality Manager
Jill Auty	-	Quality Administrator (minutes)
Siobhan Lendzionowski	-	Lead Commissioning and Transformation Manager
Angela Fawcett	-	Designated Nurse Safeguarding Children
David Lautman (from agenda item 8)	-	Lead Commissioning and Transformation Manager

APOLOGIES:

Dr Shahriar Sepehri	-	Membership Council Representative

	Note	Action	Deadline
Q&PSC 21/04/01	**HOUSEKEEPING**		
	The Chair advised that everyone is responsible for their own safety within their environment during the meeting.		
Q&PSC 21/04/02	**APOLOGIES & QUORACY**		
	Apologies noted as above. The meeting was declared quorate.		
Q&PSC 21/04/03	**PATIENT STORY**		
	The Chief Nurse presented the patient story from the March 2021 Barnsley CCG Governing Body meeting. The story outlined the effects experienced by a patient of shielding for several months due to the COVID pandemic restrictions and how moving out of lock down had impacted their mental health. The Chair advised members that mental health		

	services are already experiencing a rise in referrals due to the impact of isolation and this will inevitably increase a need going forward. The Designated Nurse Safeguarding Children highlighted that levels of anxiety had also increased in young people.		
Q&PSC 21/04/04	**DECLARATIONS OF INTEREST RELEVANT TO THE AGENDA**		
	No new declarations of interest relevant to the agenda were declared.		
Q&PSC 21/04/05	**MINUTES OF THE MEETING HELD ON 18 FEBRUARY 2021**		
	Committee members approved the minutes of the previous meeting held on 18 February 2021 as an accurate record.		
Q&PSC 21/04/06	**MATTERS ARISING REPORT**		
	The Chair confirmed that all items were complete apart from the following: **Minute reference Q&PSC 20/02/07 – Quality and Patient Safety Report -** The Specialist Clinical Portfolio Manager to feed back any themes and lessons learnt from LeDeR reviews, in particular the post November 2020 deaths. **Minute reference Q&PSC 20/02/14 – QPSC Annual Report 2020/21 -** The Head of Primary Care to be removed from the Register of Interests QPSC report. **Minute reference Q&PSC 20/02/15 – Minutes of the 11 November 2020 and 16 December 2020 Area Prescribing Committee -** The Head of Medicines Optimisation to draft the risk relating to Denosumab medication provision. The Chief Nurse to raise the issue relation to Denosumab medication pathway at the provider Clinical Quality Board meetings. **Minute reference Q&PSC 20/12/13 Information Governance Update -** The Head of Governance to update the signature and dates on the BCCG Information Security Policy Equality Impact Assessment. The Head of Governance confirmed this action has been completed. **Minute reference Q&PSC 20/12/14 Minutes of the 14 October 2020 Area Prescribing Committee -** The Chair to follow up acutely ill patients being discharged from hospital to community. **Minute reference Q&PSC 20/12/17 Any Other**	**Ongoing** **Complete** **Ongoing** **Ongoing** **Complete** **Ongoing**	

	Business - Tom Davidson (BHNFT) to be invited to a future meeting to present Medway data capability. The Quality Administrator sent an email with meeting dates for 2021 on 4 March 2021. **Minute reference Q&PSC 20/10/06 Quality and Patient Safety –** The Primary Care Transformation Manager and Quality Manager to discuss what is in the Barnsley Healthcare Federation (BHF) contract around reporting of serious incidents, and report back to members. Due to BHF's involvement with the vaccination programme it has not been possible to meet. This action will be discussed at a contract meeting in March 2021.	**Ongoing** **Ongoing**	
QUALITY AND GOVERNANCE			
Q&PSC 21/04/07	**QUALITY AND PATIENT SAFETY UPDATE REPORT**		
	The Quality Manager took the report as read and so presented the following highlights: **Barnsley Hospital NHS Foundation Trust (BHNFT)** • Staffing –Staff isolating is still providing operational challenges particularly when pockets of absence occur in the same team. • ED Performance – Performance against the 4 hour standard declined slightly in February 2021 to 81.2% from 85.21% in January. • Referral To Treatment (RTT) – Performance for February 2021 was 75.3%. The Trust had 436 patients waiting over 52 weeks at the end of January 2021 versus 252 patients at the end of November 2020. The majority are currently waiting for orthopaedic surgery. • Cancer - Generally, pathways were successful in the early stages while performance for 62 day standards were below the national target as the COVID backlog clears. • Diagnostic Waits – Numbers of people waiting over 6 weeks for a diagnostic test has reduced over the past month to 46.79 %. Those waiting for imaging, specifically non-obstetric ultrasound is reducing due to the department increasing capacity through evening and weekend working. Endoscopy has reviewed the wait list and clinically prioritised all patients. • Falls –752 falls YTD, of which 16 (2%) resulted in moderate harm or greater. However, of these 16		

	falls, only 3 were avoidable falls and the last avoidable fall was in October 2020. • Pressure Ulcers – February 2021 the Trust reported 12 category 2 hospital acquired pressure ulcer, 2 of which have been found to have lapses in care. 7 hospital acquired deep tissue injuries of these 3 were found to have had a lapse in care. • Mortality – The Trusts Mortality Overview Group is currently investigating the divergence between SHMI and HSMR data. So far, the statistics and review of death process seem to indicate Covid related statistical anomalies. This will be followed in more detail at the next CQB. • StEIS Reportable Serious Incidents (SIs) – Trust reported 25 SIs between April 2020 and 31 March 2021 compared with 26 for 2019/20. Members were asked to note 4 Never Events in the same period. • Maternity Incidents – Ockenden Report - At the February 2021 CQB, the Trust provided reassurance that the 12 urgent clinical priorities and 3 mandated recommendations from the Immediate and Essential actions were implemented by the agreed deadline. The Trust has reported being compliant with the assurance assessment tool. Further updates will be provided by the Trust in CQB. • Infection Prevention and Control – The Trust reported as at February 2021 1 MRSA hospital onset case since April 2020 14 C-diff hospital onset cases since April 2020 (within target of 19) • Regulation 28 Update – Following the report at the December 2020 QPSC, BHNFT has confirmed that psychiatric support provision has been increased in Emergency Department and Wards and their falls assessment tools have been reviewed. The Coroner has received the completed action plan. • Ophthalmology - The deep dive peer review of the service due to be completed by 31 March 2021. At the February 2021 CQB meeting reassurance was provided that work had started on cataract pathways. • In relation to the failsafe prioritisation system a meeting was held with attendees from the CCG to		

finalise processes and pathways and to review the 2018 Royal College of Ophthalmology audit report. On the 8 April 2021 the CCG received confirmation that the actions relating to the Trust are now complete with just 1 action outstanding for the CCG.

- 2020 Staff Survey – The feedback from staff is mainly positive, particularly given the survey was conducted during the peak of the second wave of the pandemic.

South West Yorkshire Partnership NHS Foundation Trust

- Recovery update - The Trust provided assurance at the April 2021 CQB that the vast majority of services had been maintained through the Covid pandemic.

- % of service users waiting less than 18 weeks stands at 99.6% in February 2021 which remains above the target threshold of 92%.

- Diagnostic appointment within 6 weeks – performance has substantially improved since December 2020.

- IAPT treatment within 6 weeks – Since November 2020, there has been a decline in the IAPT performance relating to the proportion of people completing treatment who move to recovery. 51.8% - for February 2021 versus 57.3% in November 2020. It was noted this will be monitored via CQB.

- Staffing – fill rates on Willow Ward have been consistently lower than other wards. This has been followed up with the Trust to establish why this is an outlier compared to other wards.

Barnsley Mental Health Services

- PICU out of area activity has increased in part due to acuity of patients. The CCG's Specialist Clinical Portfolio Manager is looking to establish if alternative treatment options are available in the community along with looking at what provision is available locally for patients with eating disorders.

Child and Adolescent Mental Health Service

- Waiting numbers from referral to treatment in

	Barnsley remains positive. • Arrangements for transition into adult services is a concern with some late handovers identified. <u>Barnsley Community Services</u> • Health Integration Team – SWYPFT has logged a risk on the Barnsley BDU risk register in relation to being unable to recruit a nurse prescriber to the team. • Dietetics Service for Older People –There is currently a waiting list for the service. This is due to a gap in staffing and an upturn from care home residents. • Adult Epilepsy – Reassurance was provided at the April CQB in relation to the service's waiting list. The Trust is looking at different ways of working to manage the workload. **Yorkshire Ambulance Service** The findings of YAS' audit of excessive calls was shared. Further analysis will take place and linked to delayed handovers at Emergency Departments as this has been previously highlighted as a concern. <u>Primary Care Update</u> The Primary Care and Transformation Manager presented the Primary Care update highlighting: • <u>GP Appointments</u> – the anomalies between the 2019/20 and 2020/21 appointment mode data relates to how consultations have been coded within the practice clinical system. NHS Digital advise that the data is experimental statistics and is not fully developed. QPSC members discussed the data. The Primary Care and Transformation Manager agreed to look at working with practices and NHS Digital to improve the accuracy. • <u>Care Quality Commission (CQC)</u> At the time the report was produced the CQC has reviewed 5 practices in line with their Transitional Regulatory Approach. The CQC plan to recommence their programme of inspections in April 2021 and will visit the practices currently rated as Requiring Improvement. • <u>GP Surgery Survey</u> – The key highlights of the GP Survey (August 2020) were presented.	**TH**	

	• <u>Out of Hours/Extended Hours Access</u> A meeting has been arranged in April 2021 to further explore the activity data in the report. A theme has been identified relating to the "Very Poor" ratings where patients had felt a face to face appointment should have been offered and some patients have contacted the service for monitoring of long term conditions and been referred back to their GP practice. The service has explored various methods to gather patient feedback from text to survey monkey platforms but as more appointments have taken place remotely the patient feedback has not been as in depth.		
	Actions agreed: The Primary Care and Transformation Manager GP agreed to provide an update on improving the accuracy of GP Appointments data at the next meeting.	**TH**	
Q&PSC 21/04/08	**RECOVERY PLANS**		
	Minimising the Impact of Clinical Harm – Planned Care The Lead Commissioning and Transformation Manager presented the key elements of the report for assurance. BHNFT have started to track the impact of the pandemic on health inequalities and an initial analysis indicates a cross section of people referred for treatment. Work is underway to communicate with patients to manage expectations and to promote patients to come forward. The Planned Care and Outpatients Group has developed an action plan to mitigate the risks to patient outcomes. **Minimising the Impact of Clinical Harm – Cancer Pathways** The Lead Commissioning and Transformation Manager updated QPSC on the actions being taken to minimise harm in relation to cancer pathways. The Trust continues to clinically prioritise all patients on their waiting lists and is working with patients to reduce the wait times. Members were advised Urology and Head and Neck Services have not recovered due to a backlog at Sheffield Teaching Hospitals. Patients on the waiting list are being clinically prioritised and appropriate communication is taking place with patients.		

	The Breast Care team has seen an increase in referrals and as a result of this the service is not meeting the 2ww target. Dr Kadarsha, the CCG Clinical Lead has written to the service to thank the team for their continued work during the challenges of the pandemic and the increased referrals acknowledging staff wellbeing and motivation. Members were asked to note that that the cervical screening weekend service operated by i-Heart has had a positive effect on uptake.		
Q&PSC 21/04/09	**CARE HOMES QUALITY ASSURANCE**		
	The Specialist Clinical Portfolio Manager provided a verbal update for assurance, highlighting that there had been little activity since the previous update. BMBC has appointed a new Care Home Lead and a meeting has been arranged to look developing CCG's role in clinical quality in care homes. The Lay Member asked what percentage of care home staff has been vaccinated. The Specialised Clinical Portfolio Manager agreed to provide data on the take up rate of the vaccine within care homes.	**JH**	
	Actions agreed: The Specialised Clinical Portfolio Manager to provide data on the take up rate of the vaccine within care homes.	**JH**	
Q&PSC 21/04/10	**SAFEGUARDING UPDDATE**		
	The Designated Nurse Safeguarding Children presented for assurance a comprehensive update on adults and children safeguarding activity. Whilst Providers are not reporting any concerns in relation to safeguarding, there is concern about the strain that the pandemic has placed on young people, families and staff. The CCG needs to remain cognisant of this and vigilant to indicators that support where intervention is needed. The CCG must strive to support providers to deliver vital supervision, support and training to staff, and monitor adherence, whilst at the same time acknowledging the pressures within the system.		
Q&PSC 21/04/11	**PATIENT EXPERIENCE UPDATE**		
	Patient Experience Report Quarter 3 2020/21		

	The Quality Manager presented the report for assurance. It was highlighted that there had been a significant increase in Patient Experience Feedback during the quarter. Covid 19 issues and access to Primary Care were the predominant reasons for this. The Lay Member raised a concern regarding patients not being able to access Primary Care via telephone. Members discussed the measures being taken to address this. The Chief Nurse thanked Hilary Fitzgerald, Amy Hodgson and Jill Auty for their work behind the scenes resolving patient complaints and concerns. **Patient Feedback about Different Types of GP Appointments** The Quality Manager presented the report for information and assurance. The report highlighted that it is vital that the people using these services influence how they are delivered, and that more specific research is needed in Barnsley to understand in more detail patients' experiences of remote and virtual consultations.		
Q&PSC 21/04/12	**SWYPFT ADULT SALT SERVICE UPDATE**		
	The Chief Nurse provided a comprehensive verbal update on the latest position with regard to SWYPFT's Adult SALT service. The current backlog of dysphasia patients will be picked up by the Stroke SALT team. New referrals are still not being accepted, and this will be communicated to Primary Care. The CCG will be undertaking a full review of the service for assurance and a report will be presented at a future meeting. A discussion took place around how community providers are clinically prioritising and the link into the Minimising Harm Planned Care work. It was agreed a further meeting should take place to look in depth at waiting lists. **The Lead Commissioning and Transformation Managers left the meeting at 15:00pm.**		
	Actions agreed: The Chief Nurse to hold a meeting to look in depth at SWYPFT waiting lists.	**JA**	**Complete**
Q&PSC 21/04/13	**RISK REGISTER (STANDING ITEM)**		
	The Head of Governance and Assurance presented the Risk Register highlighting the following four risks		

	have been escalated to the Assurance Framework as a gap in control against one or more risks in the Assurance Framework. • Ref CCG 14/15 (rated score 15 'extreme') – discharge medication risks • Ref CCG 19/05 (rated score 15 'extreme') - End of Life care services. • Ref CCG 20/03 (rated score 16 'extreme') BCCG Adult CHC backlog of reviews. • Ref CCG 21/02 (rated score 16 'extreme') Children's Continuing Care Risk CCG 17/02 (rated score 9 'high') – cyber security to be increased to 12 'high' due to risks identified as part of the DSP Toolkit work. The rollout of Office 365 potentially increases a security risk due to files stored in the Cloud. Members agreed to the increased risk score.		
Q&PSC 21/04/14	**QPSC ANNUAL WORKPLAN**		
	The Quality Manager presented for comment and approval the annual QPSC Annual Workplan. It was agreed: • To retain Provider Quality Accounts (22) on the work plan for the time being subject to further discussion. • Remove Health Protection Board Minutes (26) • SY&B Quality Surveillance Group Update Briefing (27) - to be changed to exception reporting. • SYB ICS Quality Group Briefing (27) — to be changed to exception reporting.		
	Actions agreed: The Quality Manager to arrange a meeting to discuss removal of 22 – Provider Quality Accounts from the QPSC Annual Workplan	**HF**	
Q&PSC 21/04/15	**SYB QUIT PATIENT GROUP DIRECTION**		
	The Head of Medicines Optimisation presented the SYB QUIT Patient Group Direction (PGD)for approval. No comments were raised. Members approved the PGD which will be signed off by the Barnsley CCG Lead Pharmacist and Barnsley CCG Medical Director.		
COMMITTEE REPORTS AND MINUTES			
Q&PSC 21/04/16	**MINUTES OF 13 JANUARY 2021 & 10 FEBRUARY 2021 AREA PRESCRIBING COMMITTEE**		

	The Head of Medicines Optimisation presented the minutes for information. No comments were raised. The Head of Medicines Optimisation asked to add Area Prescribing Committee Reporting as an agenda item at the next meeting to provide members with information on incident reporting.	**JA**	
	Agreed action: Area Prescribing Committee Reporting to be added as an agenda item at the next meeting.	**JA**	**Complete**
Q&PSC 21/04/17	**PRIMARY CARE QUALITY & COST EFFECTIVE PRESCRIBING GROUP MEETING** • **MINUTES - 27 JANUARY 2021** • **MINUTES - 24 FEBRUARY 2021**		
	The Head of Medicines Optimisation presented the minutes for information and assurance. No comments were raised.		
Q&PSC 21/04/18	**CLINICAL QUALITY BOARDS** • **BHNFT – MINUTES 03 DECEMBER 2020** • **SWYPFT – MINUTES 01 OCTOBER 2020**		
	The Chief Nurse presented the minutes for information and assurance. No comments were raised.		
GENERAL			
Q&PSC 21/04/19	**ANY OTHER BUSINESS**		
	There were no items raised.		
Q&PSC 21/04/20	**AREAS FOR ESCALATION TO THE GOVERNING BODY via the QUALITY HIGHLIGHT REPORT**		
	Items for escalation are • Safeguarding Update • Patient Experience Qtr 3 Report • SYB QUIT PGD • SWYPFT Waiting Lists • Minimising Harm • Adult SALT Service		
Q&PSC 21/04/21	**REFLECTION ON HOW WELL THE MEETING'S BUSINESS HAS BEEN CONDUCTED:** • Conduct of meeting • Any areas for additional assurance • Any training needs identified		
	Despite the full agenda, the Chair managed to keep the meeting to time.		
Q&PSC 21/04/22	**DATE AND TIME OF NEXT MEETING** 17 June 2021, 1pm via MS Teams		

GOVERNING BODY

8 July 2021

EQUALITY & ENGAGEMENT COMMITTEE SUMMARY REPORT

PART 1A – SUMMARY REPORT

1. THIS PAPER IS FOR

Decision		*Approval*		*Assurance*	X	*Information*	

2. PURPOSE

This report is to highlight the work of the Equality & Engagement Committee and provide assurance to the Governing Body that this committee is discharging its statutory duty.

3. REPORT OF

	Name	Designation
Executive / Clinical Lead	Chris Millington	Lay Member
Author	Kirsty Waknell	Head of Communications and Engagement, Equality

4. SUMMARY OF PREVIOUS GOVERNANCE

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

Group / Committee	Date	Outcome
Equality and Engagement Committee	20/05/21	Refreshed CCG Patient and Public Involvement Strategy approved.

5. EXECUTIVE SUMMARY

Committee members agreed to highlight the following from the 20 May 2021 Equality & Engagement Committee meeting:

- The refreshed version of the CCG Patient and Public Involvement Strategy has been approved by the Committee and will now be adopted going forwards. This will be included in the separate paper on Patient and Public Involvement.
- To highlight the summary of the CCG equality objectives for information and reference.

The equality objectives have been developed and supported by underpinning actions, which are priorities by the Equality & Engagement Committee and are linked to the

	Equality Delivery System (EDS 2) goals which are; • Better health outcomes for all • Improved patient access and experience • Empowered, engaged and included staff • Inclusive leadership The CCG objectives which form part of our EDS2: 1. Ensure equality and inclusion are at the core of the commissioning process 2. Broaden the scope and content of information that we hold on protected groups and ensure maximum use from analysis 3. Build upon our understanding of patient experience of services, in relation to equality diversity and inclusion, and act upon instances of potential discrimination to continually improve service delivery 4. Develop strong and consistent leadership on equality, diversity and inclusion issues 5. Evidence an informed, empowered, engaged and well-supported staff team 6. Improve access to services through informed commissioning.
6.	**THE GOVERNING BODY / COMMITTEE IS ASKED TO:**
	• Note the contents of this report for information and assurance.
7.	**APPENDICES / LINKS TO FURTHER INFORMATION**
	• Appendix A – Unadopted Equality & Engagement Committee Minutes from 20 May 2021

Agenda time allocation for report:	5 minutes

NHS
Barnsley
Clinical Commissioning Group

UNADOPTED Minutes of the Meeting of the EQUALITY AND ENGAGEMENT COMMITTEE held on Thursday 20 May 2021 at 1pm via Microsoft Teams

PRESENT:

Chris Millington (Chair)	Lay Member for Patient & Public Engagement, CCG
Kirsty Waknell (KW)	Head of Communications & Engagement, CCG
Richard Walker (RW)	Head of Governance & Assurance, CCG
Colin Brotherston-Barnett (CBB)	Equality, Diversity & Inclusion Lead, CCG
Jayne Sivakumar (JS)	Chief Nurse, CCG
Dr Adebowale Adekunle (AA)	Elected Governing Body Member, CCG
Julie Frampton (JF)	Head of Primary Care, CCG
Martine Tune (MT)	Deputy Chief Nurse, CCG

IN ATTENDANCE:

Esther Short (ES)	HR&OD Business Partner, CCG
Emma Bradshaw (EB)	Engagement Manager, CCG
Angela Turner (AT)	Executive Personal Assistant

APOLOGIES:

Susan Womack (SW)	Manager, Health watch Barnsley

Agenda Item	Note	Action	Deadline
EEC 21/05/01	**HOUSEKEEPING / APOLOGIES**		
	The Chair informed everyone present of the etiquette for Microsoft Teams meetings. Apologies were received as above.		
EEC 21/05/02	**QUORACY**		
	The Chair of the committee declared that the meeting was quorate.		
EEC 21/05/03	**DECLARATIONS OF INTEREST RELEVANT TO THE AGENDA**		
	The committee considered the declarations of interest report; no new declarations of interest were noted.		
EEC 21/05/04	**MINUTES OF THE PREVIOUS MEETING HELD ON 25 FEBRUARY 2021**		
	The minutes of the meeting held on 25 February 2021 were adopted and verified as a correct record with one amendment regarding Julie Frampton's job title. Duly noted and amended. Martine Tune joined	AT	

Agenda Item	Note	Action	Deadline
	the meeting.		
EEC 21/05/05	**MATTERS ARISING REPORT**		
	The committee noted the actions from the 25 February 2021 meeting. A number of items are being discussed on the agenda and had been closed, one action had remained open: **EEC 21/02/11 - PEOPLE AND ORGANISATIONAL DEVELOPMENT (OD) STRATEGY 2021 TO 2022** • The head of governance and assurance to take the People and OD Strategy to the senior management team for consideration of how to embed this across the organisation**.** **Update: 20.5.21** RW discussing at SMT meeting on the 28 May 2021**.** RW to update CM when complete. **Actions closed and further updates will be brought to the committee as they arise.**	RW	
PATIENT AND PUBLIC ENGAGEMENT			
EEC 21/05/06	**PATIENT AND PUBLIC INVOLVEMENT STRATEGY**		
	The previous CCG Patient and Public Involvement Strategy came to an end this year. It was agreed at the previous committee meeting on 25th February to carry out a refresh of this with a view to bringing the draft document back for final comment/ approval at today's meeting. **Summary of changes made as part of the refresh** • The refreshed strategy takes into account the move to more joined-up partnership working both across South Yorkshire and Bassetlaw and in Barnsley and reflects the changing structures in health and care. • The guiding principles originally developed in partnership with Patient Council members for the previous strategy have been slightly refined and strengthened based on discussions that took place at the workshop with members held in April 2021. The format of the strategy has been changed to reflect feedback received from colleagues on which of the sections within the strategy should be prioritised and which of these should be included as part of the appendices. Comments from committee members. • CM delighted that no major amends were required which highlighted that the we got the document right in the first place • KW thanked all colleagues for their input in the refresh of the strategy document.		

Agenda Item	Note	Action	Deadline
	• This will help us as a guiding principal paper to take into the next phase of what our work will be as commissioners and also working across the wider partnership. • Think about strengthening the patient experience links with engagement. How do we join those two worlds up across the organisation. The committee was in agreement with the amends and The Chair approved the document.		
EEC 21/05/07	**INTEGRATED CARE DEVELOPMENT**		
	KW – updated colleagues on our CCG patient and public engagement and set out the CCG approach on national policy proposals which are changing regularly. The work that is taking place to support the national proposed legislation which will see CCG' s moving into single system of Integrated Care System is still moving at pace. Last time it was reported that there was no intention to do an additional piece of either consultation, or a proposal to do that and no proposal to go out and do any more engagement on business wide structure of what the future proposals will bring, due to carrying out so much work as part of the NHS long-term plan pre-covid so no need to do again. Over the next 6 months we will be able to drill down into the specifics i.e. digital - peoples appetite and interest to use different technologies to access healthcare. These will then be the areas that we will start to focus more on rather than governance structure should there be a Healthcare Partnership Board in Barnsley. This was proposed to the Overview and Scrutiny committee since our last meeting, who were very supportive of all the work that had taken place over the last 12 months and to share that message with all colleagues. Comments from committee members: • A lot of the work that has been done and also with the council has created a great amount of data and there is a need to ensure that this is not just left and forgotten about. • An important element in what we do going forward is required, clinical colleagues have said we cannot go back to how we used to be but in relation to how we do it, i.e.virtual and digitally, we still have a long way to go • A lot of people are not able to work digitally and there is a need to nurture and encourage them. The Chair thanked KW for the update. KW will bring back to the meeting when she has a full update.	**KW**	
EEC 21/05/08	**MINUTES OF THE PATIENT COUNCIL MEETINGS HELD ON FEBRUARY, MARCH AND APRIL 2021**		
	The Patient Council minutes were shared for information and the Chair highlighted the following:		

Agenda Item	Note	Action	Deadline
	The Chair refreshed the committee on February's patient council meeting whereby a presentation was given on "My Best Life" by Joe Hill, Service Manager from South Yorkshire Housing who are responsible for running our My best life programme. Patient Council MBL Presentation Feb 202 Comments from committee members: • Some really impressive performance data for the social prescribing service and wondered if they have shared how the pandemic has changed the way they have provided the service and also the services they are able to refer into. How have the f2f changes in services effected the outcomes. • My Best Life Contract service did change its approach in how they reached out to people due to the pandemic. They did lots of telephone and video contact in place of f2f. They also adopted a slightly different approach within A&E but still managed to reach out and support and help. Not as many numbers as previously but did offer quite a comprehensive service with good outcomes through the pandemic. They are now picking up and reinstating f2f offers where it is safe and practical to do so. • We are very proud of My Best Life service as it has made a significant difference to people who have had contact with this service. It is a credit that this service has added a bit of a national blue print for social prescribing. Very happy and confident that they responded as well and effectively as they could during the pandemic. • It was very difficult at times but they found their way through and they did find routes to get the support and kept their link workers connected with people for slightly longer where it was much more difficult to access some of the services more readily. • Given the year we have had and the circumstances we have had, they have done a tremendously sterling job. Pleased that they managed to do what they did and offer that support. • Currently working with Adult social care in the local authorities to see how we can bring back working together in terms of referral to make it smoother and efficient. Also to try and capture those people that do not fall in to social care definitions but may not get picked up through other health routes. This will strengthen that offer. • CBB has been doing some physiological debriefings for different cohorts of the hospital i.e. Band 6's in ED and confirmed that everything that My Best Life service are doing is gratefully received. • Part of the plan with social prescribing is to look at that high intensity user element and see if we could use some of the additional roles funding. • As a CCG we are increasingly proud of this service and have		

Agenda Item	Note	Action	Deadline
	thanked them at every opportunity for their professional help and service. Chair asked AA what he had seen with his own f2f personal experience of My Best Life service. AA confirmed that they still regularly refer into social prescribing those that think will benefit from it. They are doing a lot of very good work to support people to be able to manage their non-medical problems ie. housing, finances etc. that makes people unwell because they cannot get the access to those things. In terms of the impact on whether it has reduced f2f contact, it has not made a lot of impact on appointments, however it is good to be able to hand over to another service to help them. The figures we are still seeing coming out of lockdown are still tremendously much higher which reflects on what happens in ED just that they are busy in a different way. In GP's a lot of talk taking place on the telephone and those patients that need to bring in will do. People in the first lock down who were unable to attend ED they looked after themselves and we are trying to encourage people to carry on looking after themselves and only attend ED if an emergency. Chair commented that one lesson that we have learnt or should have learnt is looking after our own bodies in a much better way than we have done in the past. RW – left the meeting. <u>March 2021 Patient Council.</u>  Patient Council Presentation Cancer : Chair refreshed committee on the March Patient Council meeting on Cancer Recovery Programme from Siobhan Lendzionowski around Behavioural Science. Comments from the committee members: • agreed and backed up what behavioural science is and it's important to use as much as possible it is a marvellous tool that we have. • important for organisations to put out positive messages to staff • messages can get diluted and important to back up with positive messages from corporate comms and senior managers		

Agenda Item	Note	Action	Deadline
	• positive messages from comms have a much bigger effect in transforming the experience of the people on the shop floor i.e. values and behaviour • if they see managers living by the same values and supplement by organisational communications it is powerful in changing the culture of the organisation • passion gets results • really pleased to see the behavioural science tool being used again. Having previously had a person in the CCG who championed this but since left the behavioural change has lost its way, there was a lot of merit in the programme. • delighted to see that it is back and perhaps how do we stop it from losing its way again in the future when people perhaps do not see it has being quite tangible.		
QUALITY GOVERNANCE			
EEC 21/05/09	**CCG Risk Register and Assurance Framework**		
	Chair acknowledged that RW was not in the meeting to update the risk register. The committee reviewed and agreed that the risks are being appropriately managed and scored and they are assured. CBB to amend the heading of the Risk Register document to remove Test comment KW highlighted that as part of the partnership work that we have been doing in Barnsley throughout the pandemic there has been a risk register, of which a risk that we do not communicate effectively with the local communities on a whole range of topics and sits there as a risk for all partners, NHS, Council etc. There is also a risk on there that we do not engage with communities and understand the needs of communities and therefore meet their needs. So the risk register of our committee does not sit in isolation and there is a risk on the Barnsley wide risk register, which is about ensuring that we do meet the needs of local people and do through good engagement in all its forms.	**CBB**	
EQUALITY			
EEC 21/05/10	**EQUALITY OBJECTIVES ACTION PLAN 2019 – 2021 PERFORMANCE**		
	The Equality & Engagement Committee Annual Assurance report was submitted to the committee for approval. The report is to provide assurance that we are discharging the terms of reference of the committee and manging any risks. The audit committee and governing body receive this assurance report as part of year end processes.		

Agenda Item	Note	Action	Deadline
	Committee members approved the report. A RAG rating has now been introduced to the action plan. Updates given to the risk register and all to review and check. KW thanked CBB for completing the RAG rating. Emotional objectives – bring wording to next committee	**ALL** **CBB**	
GENERAL			
EEC 21/05/11	**HR Policies**		
	RW returned to the meeting. ES updated the members on the amended policy as follows: The committee was asked to approve the proposed changes to the following policies as summarised below: • Working Time regulations Policy • Alcohol and Substance Misuse Policy • Induction, Mandatory and Statutory Training Given that we are approaching a period of possible organisational change it is our intention to make amendments to HR policies only where there is a change to legislation or significant change in best practice. This is a process that CCGs locally (NHS Doncaster CCG, NHS Sheffield CCG, NHS Bassetlaw CCG and NHS Rotherham CCG) are also adopting. Only amendments to dates and any typos have been made to the above mentioned policies with the exception of the Induction, Mandatory and Statutory Training Policy. Section 2.3 of this policy has been changed in response to comments from Internal Audit who have asked that we explicitly highlight the need for Data Security Awareness Training to be completed in week one of employment, with all other Mandatory & Statutory Training completed within the first month. **Next Steps** Once the changes are approved by the Committee the policies will be updated, placed on the CCG's external website and the changes notified to staff via the weekly communication update. Comments from Committee members: • It was felt that it was a big ask for new staff to complete the mandatory training within the first month. • Should have the time to go though as not fully in the role in first weeks so have the spare capacity to complete and as we are measured on it, we need to ensure it is completed asap. • Induction and the things doing prior to commencement in post. It		

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	was felt that it does not reflect the home working context that we currently find ourselves in now and in the future because that way of working is not reflected in this and should link across to that working policy. • Need to be clear how we can support staff in induction and new in post to be clear what expectations are. • It has been difficult with new starters to be able to set the expectations for the job and fitting in with the team. But credit to the team and new starters that have adapted to the change. • Felt we should reflect the health and well being information, hard for new people to come into teams and only see virtually. • Need to be mindful going forward that what you seen on screen of a person is not always how they are feeling and more prompts generally on how staff are going on to be asked how to work. ES accepted all points given but asked members to remember that this was an emergency response to working at home. We do now have the home working policy in place for when life is back to normal which we did not have before. ES to review the induction part/list and cross reference with home working policy to ensure clear that the two link together. ES to send a slightly revised version out by email rather than wait for next meeting.	**ES**	
EEC 21/05/12	**ANY OTHER BUSINESS**		
	Reciprocal mentoring – to be put on the plan. Discussed at ICS, CCG and Trust pairing up (established leaders with aspiring leaders) to encourage aspiring leaders to know what is happening. The challenge is to get aspiring leaders to take part. The CCG have 2 established leaders but the programme has not been released to aspiring leaders yet. Need all to raise awareness of attending the programme. A request for aspiring leaders to join will be going out shortly to volunteer and participate. Chair asked RW who was not present in the meeting when discussing the Risk Register, if he had any further additions that needed highlighting. RW confirmed he had nothing further to add to the risk register.	**ALL**	
EEC 21/05/13	**ITEMS TO HIGHLIGHT IN THE GOVERNING BODY ASSURANCE REPORT**		
	Committee members agreed to highlight the following areas: • To take some sort of summary of the Equality objectives as these have not gone previously to GB.	**KW**	
EEC 20/05/14	**REFLECTION ON HOW WELL THE MEETING'S BUSINESS HAD BEEN CONDUCTED**		
	The Chair thanked members for their input, good quality and content of papers and a good meeting. Committee members feel assured by the ongoing activities in relation to equality and engagement and no training needs were identified.		

Agenda Item	Note	Action	Deadline
	Chair thanked everyone for being prompt, being supportive and thanked all for their discussion. KW advised that Sue Womack, Manager, Healthwatch, Barnsley who had sent her apologies for today's meeting and that she is leaving her post at HWB. Chair expressed on behalf of the Committee SW's support and thanked her for her input at this committee. No replacement has been identified as yet, the post is out currently to advert. No training needs. Closed at 10.26am		
EEC 21/05/15	**DATE AND TIME OF THE NEXT MEETING**		
	The next meeting of the Equality and Engagement Committee will be held on Thursday 12 August 2021 at 1pm – 3pm via Microsoft Teams.		