NHS
Barnsley
Clinical Commissioning Group

A meeting of the NHS Barnsley Clinical Commissioning Group Governing Body will be held on Thursday 9 September 2021 at 9.30 am via Microsoft Teams

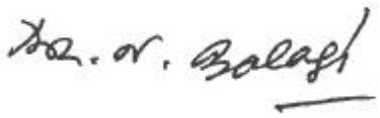
AGENDA
(Public)

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 21/09/05** Nick Balac	9.45 am 5 mins
6	Patient and Public Involvement Activity Report	Assurance	**GB/Pu 21/09/06** 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 8 July 2021	Approval	**GB/Pu 21/09/08** Nick Balac	10.05 am 5 mins
9	Matters Arising Report	Note	**GB/Pu 21/09/09** Nick Balac	10.10 am 5 mins
	Strategy			
10	Chief Officer's Report	Approval & Information	**GB/Pu 21/09/10** Chris Edwards	10.15 am 10 mins
11	Covid-19 Response and Recovery Reset update	Information & Assurance	**GB/Pu 21/09/11** Jamie Wike Jeremy Budd	10.25 am 10 mins
12	Barnsley Place Agreement	Approval	**GB/Pu 21/09/12** Jeremy Budd	10.35 am 10 mins
13	Barnsley Health and Social Care Plan	Information	**GB/Pu 21/09/13** Jeremy Budd	10.45 am 10 mins
14	Assurance Report – Cancer Update	Information &	**GB/Pu 21/09/14**	10.55 am

			Assurance	Hussain Kadarsha Mike Simms	10 mins
15	Assurance Report – Transforming Care Update		Information & Assurance	**GB/Pu 21/09/15** Patrick Otway	11.05 am 10 mins
	Quality and Governance				
16	Quality Highlights Report		Assurance	**GB/Pu 21/09/16** Jayne Sivakumar	11.15 am 10 mins
17	Risk & Governance Report		Assurance	**GB/Pu 21/09/17** Richard Walker	11.25 am 10 mins
	Finance and Performance				
18	Integrated Performance Report inc QIPP		Assurance and Information	**GB/Pu 21/09/18** Roxanna Naylor Jamie Wike	11.35 am 15 mins
	Committee Reports and Minutes				
19	19.1	Minutes of the Finance and Performance Committee held on 1 July 2021	Assurance	**GB/Pu 21/09/19.1** Nick Balac	11.55 am 10 mins
	19.2	Assurance Report of the Primary Care Commissioning Committee held on 5 August 2021 inc adopted minutes 27 May 2021	Assurance	**GB/Pu 21/09/19.2** Chris Millington	
	19.3	Minutes of the Quality and Patient Safety Committee held on 17 June 2021	Assurance	**GB/Pu 21/09/19.3** Jayne Sivakumar	
	19.4	Assurance Report of the Equality and Engagement Committee held on 12 August 2021 and adopted mins 20 May 2021	Assurance	**GB/Pu 21/09/19.4** Chris Millington	
	19.5	Unadopted Minutes of the Health and Wellbeing Board held on 10 June 2021.	Assurance	**GB/Pu 21/09/19.5** Nick Balac	
	General				
20	Reports Circulated in Advance for Noting: **From the SYB ICS Health Executive Group meeting held on 13 July 2021** • SYB ICS CEO Report (marked Enc B) **From the SYB ICS Health Executive Group held on 10 August 2021** • SYB ICS CEO Report (marked Enc B)		Information & Assurance	Nick Balac	12.05 pm 5 mins
21	Reflection on how well the meeting's		Assurance	Nick Balac	12.10 pm

	business has been conducted: • Conduct of meetings • Any areas for additional assurance • Any training needs identified			
22	**Date and Time of the Next Meeting:** Thursday 11 November 2021 at 09.30 am Via Microsoft Teams			12.15 pm Close

Signed



Dr Nick Balac – Chairman

Exclusion of the Public:

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

NHS
Barnsley
Clinical Commissioning Group

GOVERNING BODY

9 September 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 (ceased July 2021)
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
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Clinical Commissioning Group

GOVERNING BODY

9 September 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, engagement and equality

4. SUMMARY OF PREVIOUS GOVERNANCE

Group / Committee	Date	Outcome
CCG engagement and equality committee	12/8/2021	Noted

5. EXECUTIVE SUMMARY

Three areas of work are highlighted in this report. The period of engagement to support the re-procurement of GP services at Brierley Medical Centre has now concluded. 215 people gave their feedback as part of the engagement phase during August 2021. This provided considerable feedback to inform the questions forming part of the bidding process.

Work is due to start soon to better understand the experiences people have from the point of being referred for further tests or direct to hospital for a suspected cancer. This work, which is a collaboration between the CCG and Barnsley Healthcare Federation, aims to provide quality improvement insights for the group of people.

Finally, we have highlighted the publication of the National strategy for autistic children, young people and adults: 2021 to 2026. This will sit alongside and help inform the local all-age autism strategy.

6.	THE COMMITTEE IS ASKED TO:
	• Note the approach to engagement for the re-procurement of primary care services in Brierley.

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:	*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 3.2**	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?	***Yes***
	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	**Patient and public involvement in the re-procurement of primary care services at Brierley Medical Centre** Primary care medical services have been provided at Brierley Medical Centre by the current contract holders since December 2015 with a 5-year plus 1-year contract option. In 2020 agreement was reached by Barnsley CCG's Primary Care Commissioning committee to continue delivery of this service for the 1-year contract extension option. The re-procurement phase for a new contract is currently live with a view for a new contract term to commence from in December 2021. The CCG submitted a patient and public engagement proposal to support this work to the Barnsley Overview and Scrutiny committee in July 2021, which did not raise any request to alter the planned approach. A period of engagement was undertaken from 4 August 2021 to the 19 August 2021. Approximately 9% (215) of the adult practice population got involved with coverage from across all age groups. People were asked to provide feedback on what worked well for them at the current service and what could be improved. There was also a general question which asked if there was anything the CCG needed to consider more widely about GP services in that area, either now or in the future. The results from the feedback have been used to inform questions to bidders as part of the procurement process. Ways in which people could get involved were based on the profile of the practice population and using the equality impact assessment to inform the options: • Paper survey sent to every registered adult patient • Online survey • Face to face 1-1 at Brierley Methodist Church (few hundred metres from the GP practice) available on one day in the afternoon and into the early evening. These were promoted via: • Letter to every registered patient • Text message reminder half-way through via the practice with link to online survey • Briefing email to all key stakeholders working in and around that area (Cllrs; patient rep groups; care homes; voluntary groups, area council teams, etc) • Paid-for targeted advert on Facebook with link to survey • Media release to local press • CCG website • GP practice website The full engagement report is available as part of the procurement exercise and will be

	published on the CCG website afterwards. It will also be reported into the CCG Primary Care Commissioning Committee.
2	**Understanding people's experience of diagnostic services for suspected cancer** The CCG is working in partnership with Barnsley Healthcare Federation to better understand the experience of people who have recently visited their GP practice and following this a clinician has arranged for further tests for suspected cancer. We will be contacting people who have direct experience of the above to help us to understand, from their perspective, how this feels. Their feedback will help us to monitor local progress on cancer care at this stage of the process. It will also provide information to drive local quality improvements and improve the experience for anyone who has a suspected cancer and put on an urgent referral pathway.
3	**National strategy for autistic children, young people and adults: 2021 to 2026** On 21st July 2021, the new National strategy for autistic children, young people and adults: 2021 to 2026 was published. This is the government's national strategy for improving the lives of autistic people and their families and carers in England, and this is accompanied by an implementation plan. Over the next few months we will be working with partners from across the borough to develop a Barnsley All-Age Autism Strategy which will run alongside this. Further information will be provided on this work in a future report. .

NHS
Barnsley
Clinical Commissioning Group

Minutes of the meeting of the Barnsley Clinical Commissioning Group Governing Body (PUBLIC SESSION) held on Thursday 8 July 2021, 9.30 am via Microsoft Teams

MEMBERS PRESENT

Dr Nick Balac	Chairman
Nigel Bell	Lay Member for Governance
Chris Edwards	Chief Officer
Madhavi Guntamukkala	Medical Director & Member
Dr John Harban	Member (from Minute reference GB/Pu 21/07/12)
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
Jayne Sivakumar	Chief Nurse
Dr Mark Smith	Member

IN ATTENDANCE

Jeremy Budd	Director of Strategic Commissioning and Partnerships
Jo Harrison	Specialist Clinical Portfolio Manager (for minute reference GB/Pu GB/Pu 21/07/12 only)
Kay Morgan	Governance and Assurance Manager (Minutes)
Patrick Otway	Head of Commissioning (Mental Health, Children's, and Maternity) (for minute reference GB/Pu GB/Pu 21/07/13 only)
Kirsty Waknell	Head of Communications and Engagement
Richard Walker	Head of Governance and Assurance

APOLOGIES

Dr Adebowale Adekunle	Member
Mike Simms	Secondary Care Clinician

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

Agenda Item		Action	Deadline
GB/Pu 21/07/01	**HOUSEKEEPING**		
	Members noted the etiquette for meetings held via Microsoft Teams and to use the 'raised hand' function to raise questions.		
GB/Pu 21/07/02	**QUORACY**		

Agenda Item		Action	Deadline
	The meeting was declared quorate.		
GB/Pu 21/07/03	**PATIENT STORY**		
	The Chief Nurse introduced the Patient Story, reflecting a young man's experience of Covid 19 and his decision to have the Covid vaccination. The following comments in respect of the Patient Story were received from Governing Body Members. • A 'champion' voice of reason encouraging people to have the Covid vaccination is invaluable. People will have uncertainty and fears about Covid, and it is important to support people to stay safe and have the vaccine. • The staff and volunteers at vaccination centres are compassionate, answering all questions, putting people at ease, and non judgemental. If people turned down the initial offer of vaccine the offer is always there, and people are always welcomed. The Chairman concluded discussion advising that there is always a positive atmosphere at the vaccination hubs making it a pleasant experience for people attending.		
	The Governing Body noted the Patient Story.		
GB/Pu 21/07/04	**DECLARATIONS OF INTEREST, SPONSORSHIP, HOSPITALITY AND GIFTS RELEVANT TO THE AGENDA**		
	The Governing Body considered the Declarations of Interests Report. The Chairman advised that all Governing Body GP Members have a direct financial interest in agenda item 15 'PDA Schemes 2021/22. GP members are contracted through the PDA to deliver the schemes. The Chairman determined that GP members will be allowed to participate in discussion from a qualitative perspective improving outcomes for the People of Barnsley. It was noted that approval of the financial aspects is delegated to the Primary Care Commissioning Committee to facilitate the management of the declared conflict. No other new declarations were received.		

Agenda Item		Action	Deadline
	NB: Post meeting note: The following declaration from Dr John Harban was declared in the Governing Body private session held on 8 July 2021. The Chairman requested that this declaration also be recorded in the Governing Body public session minutes: Dr John Harban declared the following new non financial professional interest. • Chairman of the Barnsley Health Care Federation (BHF) Audit and Governance Committee. This is a temporary position until the appointment of a new lay member. The Chairman advised that Dr Harban will be conflicted with regard to any Governing Body discussions relating the BHF and these will be managed at the time of discussion.		
GB/Pu 21/07/05	**PATIENT AND PUBLIC INVOLVEMENT ACTIVITY REPORT**		
	The Head of Communications and Engagement introduced the Patient and Public Involvement Activity Report to the Governing Body. **Integrated Care Systems: Design Framework** The Head of Communications and Engagement referred Members to the recently published 'Integrated Care Systems: Design Framework'. The Framework determines that all parties in an ICS including place-based partnerships will be expected to agree how to listen and collectively act on the experience and aspirations of local people and communities. It was noted that the framework reflected the Barnsley partnership approach and guiding principles to engagement. In particular, working closely with and determining what matters to local communities, to drive commissioning work. **Involvement in CCG Meetings in Public Session** The Governing Body noted the public engagement in Governing Body meetings both pre and during the pandemic. The Head of Communications and Engagement advised that from engagement data the public are still interested in Governing Body meetings.		

Agenda Item		Action	Deadline
	The Chairman commented that although the report was positive, the face to face questions received at meetings facilitated a full response from the Governing Body. He proposed that whilst meetings are still being undertaken virtually (via Microsoft teams), any questions from the Patient Council via the Lay Member for Patient and Public Engagement & Primary Care Commissioning could be received at meetings and a live balanced response provided. The Lay Member for Patient and Public Engagement & Primary Care Commissioning advised that opportunities for wider public engagement with the local authority and other health and care partners are being considered. Face to face meetings are always positive and consideration to re-establish these will be undertaken once the CCG is able to return to working at Hillder House.		
	The Governing Body noted • **The approval of the CCG patient and public involvement strategy 2021/22** • **The expectations for working with communities and people as outlined in the Integrated Care Systems: Design Framework** • **The public involvement in CCG meetings in public during 2020/21** **Agreed Action** **To approach Patient Council regarding potential questions to be posed to the Governing Body.**	**CM**	
GB/Pu 21/07/06	**QUESTIONS FROM THE PUBLIC**		
	It was reported that the CCG had not received any questions from Members of the public.		
GB/Pu 21/07/07	**MINUTES OF THE MEETING HELD ON 13 MAY 2021 AND 10 JUNE 2021**		
	The minutes of the Governing Body meeting held on 13 May 2021 and 10 June were verified as a correct record of the proceedings.		
GB/Pu 21/07/08	**MATTERS ARISING REPORT**		

Agenda Item		Action	Deadline
	The Governing Body considered the Matters Arising Report and the following updates were noted: **Minute reference GB/Pu 21/05/16 Assurance Report Mental Health Update – GP referrals to CAMHS** The Chairman commented that the figures quoted regarding GP inappropriate referrals to CAMHS appeared negative and should be taken at face value. In reality, there is a demand for the service but simply rejecting referrals does not meet demand. It was noted that the single point of access (SPA) to the CAMHS Service will go live in September 2021. The SPA will manage all new referrals and signpost patients to appropriate services to best meet their needs. Two additional Mental Health Teams will provide more support in Primary Schools and children with high needs. ***Agreed action*** ***To schedule a review of CAMHS at a future BEST meeting.*** 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 BEST. Barnsley Education Support Time (BEST) was pioneered in Barnsley from 2002, by the former Primary Care Trust (PCT) Local Medical Committee (LMC) and clinical tutors and is now supported by the CCG. It provides protected learning time for Primary Care Staff to share best practice and guidance. **Minute reference GB/PU 19/11/03 Patient Story – Young Commissioners, OASIS – The voice of the Young Commissioners in the work of the Health and Wellbeing Board.** The Chairman reported that the meeting of the Health and Wellbeing Board in August 2021 and been deferred and this action will therefore be raised at the September 2021 meeting.	**JW (PO)**	
STRATEGY			
GB/Pu 21/07/09	**CHIEF OFFICER'S REPORT**		

Agenda Item		Action	Deadline
	The Chief Officer presented his report which provided the Governing Body with two recently published 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 and an update on the Covid Pandemic Inquiry.		
	Integrated Care Systems (ICS): Design Framework The Chief Officer explained that the ICS Design Framework sets out how NHS organisations should respond to the next phase of system development. The framework provides some 'guidelines' for NHS organisations as they develop their plans - reflecting the best ways of serving communities and patients in their specific local context. It was noted that Barnsley as a 'Place' is part of the South Yorkshire and Bassetlaw Integrated Care System (SY&B ICS) and is coterminous with the Local Authority area. Development work is in progress with Local Health and Social Care partners to ensure maximum delegation to the Barnsley Place, so that decisions about Barnsley continue to be made in Barnsley. The Chief Officer advised that the first reading of the draft Health Bill will be by week ending 10 July 2021 and the second reading before the parliament summer recess. Once the Bill is passed. it is expected that significant detailed guidance will be issued to ICSs in September 2021.		
	The Governing Body noted the report. ***Agreed action*** • ***To provide the Governing Body with NHS Confederation Briefing summary of the Health and Care Bill*** • ***To provide the Governing Body with a synopsis of Health and Care Bill, published w/c 5 July 2021. In particular, the main parts that are relevant to place based partnership***	**CE** **JB**	
GB/Pu 21/07/10	**COVID-19 RESPONSE AND RECOVERY RESET**		

Agenda Item		Action	Deadline
	The Director of Strategic Commissioning and Partnerships provided the Governing Body with an update in relation to the current situation and the CCG's response to the Coronavirus Disease (COVID19) pandemic. It was highlighted that Covid cases are continuing to rise both locally and nationally and restrictions are still in place until 19 July 2021. The numbers of staff isolating across all local Health and Social Care partners is increasing and this brings difficulties in addressing the increased demand for and backlog in health and care services. The Covid vaccination programme continues to be successful in Barnsley and is on target to achieve the national ambition to have 66% of adults double vaccinated by 19 July 2021. This is a huge achievement for everyone involved the Barnsley Health Care Federation, Primary Care vaccinators and all volunteers		
	The Chairman commented that eighteen months into Covid, and as more cases come along staff are suffering with post Covid fatigue and the health and social care workforce are tired and stressed. This will affect the recovery of services and impact on the post Covid reset plans. The vaccination programme is positive but there is a real need to encourage unvaccinated people to come forward. It was noted that guidance about the autumn booster vaccination campaign is awaited though emerging information suggests the over 50's and people designated at risk will be offered the booster vaccination.		
	The Governing Body noted the update provided including the priorities for the NHS and the progress in implementing the vaccination programme.		
GB/Pu 21/07/11	**ASSURANCE REPORT - INTEGRATED CARE AT BARNSLEY PLACE**		
	The Director of Strategic Commissioning and Partnerships provided the Governing Body with an assurance report on the development of integrated care at Barnsley place. It was highlighted that the legislative programme presents the Barnsley place with an opportunity to further build on health and Social Care partnership working and learning from shared experiences through COVID to improve health and care services for local people.		

Agenda Item		Action	Deadline
	The report provided Governing Body with assurance around: • The 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 • Strengthening joint commissioning between the CCG and Barnsley Council and agreement of a commissioning plan to support the delivery of the Barnsley Health and Care Plan. • Growing the workforce for the future – refreshing the Barnsley Integrated Workforce Strategy • Optimum use of the health and care estate across the borough and investment to facilitate shift of activity from hospital into community • Supporting and promoting the role of the community, voluntary and social enterprise sector in Barnsley in health and care • Principal threats to delivery and next steps		
	The Lay Member for Patient and Public Engagement & Primary Care Commissioning commented that a strength of the Barnsley Hospital NHS Foundation Trust is its local workforce and people within the borough wishing to work within the local health and social care services. The Chairman advised that the workforce group are progressing a number of initiatives to strengthen the local health and social care workforce base as an example 11 applications were received to develop as Practice Nurses.		
	The Governing Body noted the update for information and assurance. ***Dr John Harban GP Member joined the meeting***		
GB/Pu 21/07/12	**ASSURANCE REPORT LOCKED REHAB**		
	The Chief Nurse and Specialist Clinical Portfolio Manager introduced an assurance update report on Out of Area Locked Rehabilitation. The detailed report updated 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.		

Agenda Item		Action	Deadline
	The Chief Officer advised that there is increased demand for Out of Area Locked Rehabilitation, and this is a challenging area across the country. It is important to work at Barnsley place level and across the South Yorkshire and Bassetlaw ICS to generate solutions leading to improvement in the current service provision. In response to a question raised the Specialist Clinical Portfolio Manager clarified that the shortage of tier 4 beds is not quantified.		
	The Chief Nurse thanked the Specialist Clinical Portfolio Manager, Governing Body and Commissioning and Transformation Team for driving work towards improvement in Out of Area Locked Rehabilitation services.		
	The Governing Body • **Noted the updated position and progress made to initiate and develop mitigating actions to reduce risks.** • **Supported the recommendations** ***Agreed action*** ***To undertake a detailed review of Out of Area Locked Rehabilitation services at a future Governing Body Development Session.***	**JSiv** **JHari**	
GB/Pu 21/07/13	**ASSURANCE REPORT – MATERNITY**		
	The Head of Commissioning (Mental Health, Children's, and Maternity) presented an Assurance Report in respect of local maternity services to the Governing Body. The Governing Body noted the Progress made within the South Yorkshire and Bassetlaw Integrated Care System Local Maternity System (SYB ICS LMS) in transforming maternity services within the region to deliver the recommendations of 'Better Births – Improving Outcomes of Maternity Services in England – A Five Year Forward View for Maternity Care.		
	The Governing Body noted the report.		
GB/Pu 21/07/14	**PRACTICE DELIVERY AGREEMENT (PDA) SCHEMES**		

Agenda Item		Action	Deadline
	The Chairman advised that all Governing Body GP Members have a direct financial interest in this agenda item 'PDA Schemes. 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 and the approval of the financial aspects is delegated to the Primary Care Commissioning Committee to manage the declared conflict.		
	The Medical Director introduced the proposed Primary Care PDA Schemes 2021/22 to the Governing Body for approval. Discussion took place and the following comments were received: • Scheme 4 Evidence Based Commissioning Policies Where there are non evidenced based intervention such as tonsillectomies and in terms of patient expectations and, it is difficult for GPs to negotiate with patients regarding such interventions. • Scheme 3 staff training, The PCN can support provision of spirometry training and updating of equipment as required. Practices can also refer patients to the Barnsley REspiratory Assessment and THErapy (BREATHE) Service. During the Covid pandemic spirometry testing ceased in the community and at the Barnsley Hospital NHS Foundation Trust, resulting in a backlog risk for primary and secondary care and noted that if Primary Care do not recommence spirometry testing and support the hospital, this could further impact on the hospital workload. • Scheme 6 IT and Digital Projects A view was expressed that digital consultations are not preferred by all patients; many patients prefer face to face consultations. The Chairman advised that whatever medium of consultation is required, should be embraced, and utilised to address patient need.		
	It was noted that there had been a wide and inclusive involvement of Practices and the Local Medical Committee in the development of the PDA final Schemes presented to Governing Body.		

Agenda Item		Action	Deadline
	The Governing Body approved the proposed schemes for inclusion within the 2021/22 PDA.		
GB/Pu 21/07/15	**COMMISSIONING FOR OUTCOMES POLICY**		
	The Medical Director presented the revised South Yorkshire and Bassetlaw Commissioning for Outcomes Policy (v22) for approval. The Chief Finance Officer commented that from a secondary care perspective compliance with the Commissioning for Outcomes Policy will be monitored by the Clinical` Quality Board.		
	The Governing Body • **Approved 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.** • **Noted the local approach to implementation in primary and secondary care.** ***Agreed Actions*** ***To present the South Yorkshire and Bassetlaw Commissioning for Outcomes Policy to a future Barnsley Education Support Time (BEST) event.*** ***To submit the South Yorkshire and Bassetlaw Commissioning for Outcomes Policy to the Clinical Quality Board.***	**MS / MG** **MS / MG**	
QUALITY AND GOVERNANCE			
GB/Pu 21/07/16	**QUALITY HIGHLIGHTS REPORT**		
	The Chief Nurse introduced the Quality Highlights report with six rated quality issues to the Governing Body, With regard to Primary Care the Chairman advised that a Barnsley whole system health and social care performance dashboard is being developed and will include GP appointment data. The dashboard will show when the system is pressured i.e. in terms of demand and the		

Agenda Item		Action	Deadline
	Barnsley Integrated Partnership Group will look for system solutions to meet demand. The Governing Body noted the CQC unannounced inspection visit to the Barnsley Hospice. The Lay Member for Patient and Public Engagement & Primary Care Commissioning commented that Barnsley people are very proud and supportive of the Hospice.		
	The Governing Body noted the Quality Highlights Report for information and assurance. ***Agreed action*** ***To apprise the Patient Council about the unannounced CQC inspection visit to the Barnsley Hospice.***	**CM JS**	
GB/Pu 21/07/17	**RISK AND GOVERNANCE EXCEPTION REPORT**		
	The Head of Governance and Assurance introduced the Risk and Governance Exception Report to the Governing Body noting that the GBAF (Governing Body Assurance Framework) has been refreshed around the 2021/22 Planning Guidance.		
	The Governing Body • **Approved the refreshed Governing Body Assurance Framework 2021/22** • **Reviewed the Risk Register and determined that all risks are being appropriately managed** • **Did not Identify any potential new risks or risks for removal** • **Noted the removal of risks 20/02 and 19/03** • **Received the Governing Body work Plan & Agenda Timetable 2021/22**		
FINANCE AND PERFORMANCE			
GB/Pu 21/07/18	**INTEGRATED PERFORMANCE REPORT**		
	The Chief Finance Officer provided the Governing Body with an overview on the CCGs performance against key performance indicators and an overview of the financial performance up to 31 May 2021 or the latest available position.		

Agenda Item		Action	Deadline
	Performance 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 and waiting times for diagnostic waits and urgent care. Performance has continued to improve against the 19 week referral to treatment target and waits over 52 weeks continue to reduce. Performance on most of the cancer pathways is below national standards and the Barnsley Cancer Steering Board is working to improve performance. A Cancer Assurance Report will be submitted to the next meeting of the Governing Body on 8 September 2021. It was highlighted that the Barnsley Hospital NHS Foundation trust had its highest number (425) ever of patients attending A&E in one day. An action plan is in place to manage demand. The Chief Finance Officer advised the Governing Body of the National Accelerator Programme, bringing additional funding into the South Yorkshire and Bassetlaw Integrated Care System and Barnsley to reduce elective waiting lists and backlog initially in acute care. Work is also being undertaken to address waiting list issues as a result of Covid 19 within community and primary care.		
	Finance The Chief Finance Officer reported that at this early stage in the financial 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 CCG's Efficiency Programme Management Office (PMO) continues to monitor and review delivery of the CCGs £7.2m efficiency programme and work on plans to address the gap in the efficiency programme.		

Agenda Item		Action	Deadline
	There is a level of uncertainty of the current finance regime and lack of clarity on the funding regime from October 2021 (H2). 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. The Chief Finance Officer is attending a NHSE/I briefing for NHS Chief Finance Officers and Finance Directors on 8 July 2021 Re 21/22 Finances. The CCG will work with the Barnsley health and social care partners to reduce system costs i.e. high A&E attenders.		
	The Governing Body noted the contents of the report including: • Performance to date 2021/22 • Projected delivery of all financial duties predicated on the assumptions outline in the report and mitigations.		
COMMITTEE REPORTS AND MINUTES			
GB/Pu 21/07/19	**COMMITTEE REPORTS AND MINUTES**		
	The Governing Body received and noted the following Committee minutes & assurance reports: • Unadopted Minutes of the Audit Committee held on 10 June 2021. The Lay Member for Governance highlighted that the Audit Committee had reviewed the CCGs Annual Report and Accounts 2021/21 and recommended to the Governing Body that it approves and adopts the Annual Report and Accounts 2020/21. The Audit Committee had also discussed progress on the Internal Audit recommendations relating to Children's Continuing Care and S117 funding decisions and proposed that a task and finish group develop an action plan to ensure the recommendations are swiftly completed and to timescale. The Governing Body will receive a CHC assurance update on this work at a Governing Body Development Session on 22 July 2021 • Minutes of the Finance and Performance Committee held on 6 May 2021.		

Agenda Item		Action	Deadline
	• Assurance Report from the Primary Care Commissioning Committee held on 27 May 2021 including adopted minutes dated 25 March 2021. • Adopted Minutes of the Quality and Patient Safety Committee held on 15 April 202121. • Assurance Report from the Equality & Engagement Committee held on 20 May 2021 including adopted minutes dated 20 May 2021		
GB/Pu 21/07/20	**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 11 May 2021 • SYB ICS CEO Report (Enc B) From the SY&B ICS Health Executive Group held on 8 June 2021 • SYB ICS CEO Report (Enc B) .		
GB/Pu 21/07/21	**REFLECTION ON HOW WELL THE MEETING'S BUSINESS HAS BEEN CONDUCTED**		
	The Governing Body agreed that the business of the meeting had been achieved including good discussion on public involvement in future Governing Boy meetings.		
	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 21/07/22	**DATE AND TIME OF THE NEXT MEETING**		
	Thursday 9 September 2021 at 09.30 am via Microsoft Teams		

NHS
Barnsley
Clinical Commissioning Group

GOVERNING BODY
(Public session)

9 September 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 8 July 2021

Table 1

Minute Ref	Issue	Action	Outcome/Action
GB/Pu 21/07/16	**QUALITY HIGHLIGHTS REPORT** To apprise the Patient Council about the unannounced CQC inspection visit to the Barnsley Hospice	CM JS	**Complete** - CM discussed with JS
GB/Pu 21/07/15	**COMMISSIONING FOR OUTCOMES POLICY** To present the South Yorkshire and Bassetlaw Commissioning for Outcomes Policy to a future Barnsley Education Support Time (BEST) event. To submit the South Yorkshire and Bassetlaw Commissioning for Outcomes Policy to the Clinical Quality Board.	MSi MSi	
GB/Pu 21/07/12	**ASSURANCE REPORT LOCKED REHAB** To undertake a detailed review of Out of Area Locked Rehabilitation services at a future Governing Body Development Session	JS JHarri	GBDS provisionally scheduled 28 October 2021

GB/Pu 21/07/09	**CHIEF OFFICER'S REPORT** • To provide the Governing Body with NHS Confederation Briefing summary of the Health and Care Bill • To provide the Governing Body with a synopsis of Health and Care Bill, published w/c 5 July 2021. In particular, the main parts that are relevant to place based partnership	CE JB	**Complete** **Complete**
GB/Pu 21/07/05	**PATIENT AND PUBLIC INVOLVEMENT ACTIVITY REPORT** To approach Patient Council regarding potential questions to be posed to the Governing Body	CM	**Complete** - Scheduled agenda item for next meeting of the Patient Council 28 July 2021.

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 in September 2021.
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	**Complete** - The plan was submitted to 22 July Governing Body Development Session.
GB/Pu 21/01/15 & GB/Pu 21/05/08	**SUICIDE PREVENTION AND BEREAVEMENT SUPPORT UPDATE**		Ongoing - PO liaising with Public Health colleagues to see how the MH information can be best shared.
	To develop information for Primary Care detailing available services re Suicide Prevention and Bereavement support services.	PO MSm	Information sent out the practices on 23/2/21. Exploring possibility of putting MH information on single page on BEST site.
	To provide assurance that information re Suicide Prevention and Bereavement Support Services is relevant and available to practice staff	PO MSm	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 MSm	Work is progressing to ensure that the attempted suicide follow up service is part of the Single point of access (SPA). All of this will be considered within the Mental Health Investment paper that I am presenting to the private session of Governing Body on 9th September 2021

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	**Complete**
GB/Pu 21/05/16 & GB/Pu 21/07/08	**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 To pick up on GP referrals to CAHMS and report back to the Governing Body	PO PO	**Complete** - 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. **Complete** - 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.
	To schedule a review of CAMHS at a future BEST meeting.	PO	CAMHS has been a focus at a number of Governing Body Development sessions recently and future update sessions have already been agreed. A date for CAMHS to attend BEST is still to be determined.

NHS
Barnsley
Clinical Commissioning Group

GOVERNING BODY
Public Session

9 September 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:

- The NHSE/I Annual Assessment letter
- The Framework to support the Transition to Integrated Care Boards & guidance documents
- A Proposal to Expand the Scope of the Joint Committee Delegation

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

NHSE/I Annual Assessment letter

NHS England and NHS Improvement undertake an annual assessment of CCG performance. The approach to the 2020/21 assessment has been simplified due to the continued impact of Covid-19 and the change in priorities to respond. This approach means that CCGs will no longer be given an overall rating but replaced by a narrative assessment of CCG performance

The assessment letter provides narrative assessment against the 5 priority areas of:

- Improve the Quality of Service
- Reduce Health Inequalities
- Involve and Consult the public
- Comply with Finance Duties
- Leadership and Governance

I am very pleased to announce that Barnsley CCG has done really well this year, as demonstrated in the following overall final comment from the assessment letter:

"The CCG has played a key role in supporting the NHS in South Yorkshire and Bassetlaw to respond so effectively to the COVID-19 Pandemic; the effective leadership of the CCG is also fundamental to the local Place – and wider ICS – recovery plan. The CCG both provided strong leadership in Barnsley and at a system level through the year with a focus on leading joint commissioning, maternity services and, importantly, the development of the system business case for primary care estate".

The Framework to support the Transition to Integrated Care Boards & guidance documents

The HR Framework to support the transition to Integrated Care Boards has now been published, along with a range of other guidance, these are:

- **HR Framework for Developing Integrated Care Boards**
  The HR Framework provides national policy ambition and practical support for NHS organisations affected by the proposed legislative changes as they develop and transition towards the new statutory Integrated Care Boards (ICBs).

- **Building Strong Integrated Care Systems everywhere: guidance on the ICS people function**
  The ICS People Function guidance builds on the priorities set out in the People Plan. It is intended to help NHS system leaders and their partners support their 'one workforce' by delivering key outcome-based people functions from April 2022.

- **ICS Implementation guidance: ICB Readiness to operate statement (ROS) & checklist**
  This document provides a template ICB Readiness to Operate Statement (ROS) and accompanying ROS checklist. It describes how the checklist will be used to enable system leaders to assess progress and transition towards the establishment of ICBs.

- **ICS Implementation Guidance: Due Diligence, Transfer of people and property from CCGs to ICB and CCG Close Down**
  This guidance outlines the due diligence process which underpins the legal transfer of people (staff), property and liabilities to ICBs, the legal establishment of ICBs and abolition of CCGs, and close-down activity for CCGs.

	• **Interim Guidance on Functions & Governance** This interim guide covers the expected governance requirements for Integrated Care Boards as outlined in the Health and Care Bill and the ICS Design Framework. The guidance is designed for all ICS partners involved in the establishment of Integrated Care Boards, particularly ICS leads, CCG AOs and their teams as well as NHSEI regional teams.
	Proposal to CCG Governing Bodies to Supplement the JC CCG Manual to expand the Scope of the Joint Committee Delegation and put in place additional arrangements for the transition to ICBs 2021/22 (Schedule 3) The five CCGs and Integrated Care System (ICS) wish to put in place arrangements to ensure a smooth transition to the Integrated Care Board (ICB) in April 2022. It has been decided that the most practical way of doing this is for the Joint Committee of CCGs to co-ordinate the taking of preparatory steps for the transition to the ICS on behalf of the CCGs and for the ICS to have visibility of that work The proposal at appendix C sets out that the Joint Committee of the five CCGs is adapted for the transition to the South Yorkshire and Bassetlaw Integrated Care System ("ICS").
6.	**THE GOVERNING BODY IS ASKED TO:**
	1. **Note the NHSE/I Annual Assessment letter** 2. **Note the Framework to support the Transition to Integrated Care Boards & guidance documents** 3. **JCCG Joint Commissioning Committee Proposals** **Seeking agreement from the CCG members of the Joint Committee to the proposed approach and agreement for the Schedule (3) to be added to the JC CCG Manual Agreement / TOR and specifically approval of the following:** **a. Proposed amendment to the delegation of the Joint committee for the transition work but the Joint committee TOR (enclosed for reference) are unchanged** **b. Establishment of the Joint Committee sub-committee – the Change and Transition Board - to take forward the transition work between September and end March 2022**
7.	**APPENDICES / LINKS TO FURTHER INFORMATION**
	• Appendix A - NHSE/I Annual Assessment letter • Appendix B1 - HR Framework for Developing Integrated Care Boards - HR Framework for developing Integrated Care Boards • Appendix B2 - Building Strong Integrated Care Systems everywhere: guidance on the ICS people function - Building strong integrated care systems everywhere: guidance on the ICS people function • Appendix B3 - ICS Implementation guidance: ICB Readiness to operate

	statement (ROS) - ICS implementation guidance: ICB readiness to operate statement (ROS) and checklist • Appendix B4 - ICS Implementation Guidance: Due Diligence, Transfer of people and property from CCGs to ICB and CCG Close Down - ICS Implementation Guidance: Due Diligence, Transfer of People and Property from CCGs to ICBs and CCG Close Down • Appendix B5 - Interim Guidance on Functions & Governance - Interim guidance on the functions and governance of the integrated care board • Appendix C - Proposal to CCG Governing Bodies to Supplement the JC CCG Manual to expand the Scope of the Joint Committee Delegation and put in place additional arrangements for the transition to ICBs 2021/22 (Schedule 3) • Appendix C1 – Manual Agreement and Terms of reference of Joint Committee of Clinical Commissioning Groups SY&B 2019/20

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***

South Yorkshire and Bassetlaw Integrated Care System

722 Prince of Wales Road
Sheffield
S9 4EU
Becky Howard: 07876 851849

02 August 2021

Nick Balac, Chair - Barnsley CCG
Chris Edwards, Accountable Officer - Barnsley CCG

Dear Nick & Chris,

2020/21 CCG annual assessment

NHS England and NHS Improvement have a legal requirement to undertake an annual assessment of CCG performance. The approach to the 2020/21 assessment has been simplified due to the continued impact of Covid-19 and the change in priorities to respond. This approach means that CCGs will no longer be given an overall rating, as this has been replaced by a narrative assessment of CCG performance.

The 2020/21 narrative assessment is based on the operational priorities set out in July and December 2020, focussing on CCGs' contribution to local delivery of the overall system plan for recovery, with emphasis on the effectiveness of working relationships in local systems.

This letter summarises the key points of the discussion at the year-end assessment review meeting for Barnsley CCG, that focussed around the following five priority areas.

Improve the quality of service

Barnsley CCG has effectively supported the local Place, and wider South Yorkshire & Bassetlaw System throughout 20/21, and has:

- responded to Covid-19 demand including taking enabling actions to ensure the effective use of resources;

- supported the system to ensure a return to delivery of near-normal levels of non-Covid-19 health services;
- maintained systems and processes to ensure oversight of quality and patient experience;
- taken account of lessons learned during the first Covid-19 peak,
- supported the system to respond to other emergency demands and manage winter pressures; and
- taken effective action to support the health and wellbeing of its workforce

We have noted the strengthening of the partnership in Barnsley over the last 12 months. The pandemic demonstrated the strength of the "1 PCN" approach for Barnsley and the new leadership arrangements, including in the Health & Well-being Board, are making a real difference with a shift away from former competitive behaviours to collaboration and a sense of common purpose.

The provider collaborative is moving forward in Barnsley with agreement to shadow form from September and an alliance between the Federation and your community provider to provide important infrastructure support to general practice going forward.

Reduce health inequalities

Barnsley CCG has supported the delivery the eight urgent actions to address inequalities in NHS provision and outcomes – as identified in the Phase three response to Covid-19 pandemic.

The CCG has provided robust information on work done to protect the most vulnerable through enhanced analysis and have a named executive and steering group in place for tackling health inequalities.

Work underway in 21/22 to accelerate preventative programmes which proactively engage those at greatest risk of poor health outcomes is rightly a priority, as is the development of digitally enabled care.

A clear example of this was the establishment of the "Listening Ear" bereavement service which provided invaluable access to support at a time when access to face-to-face services was restricted.

Similarly, the Breathe Service was established as we went into 2020/21 and provided an important way to support residents from across all communities, including those

more geographically remote from the hospital, with access to respiratory support and care.

Involve and consult the public

The CCG has described how – working with partners to engage with communities in general, including Barnsley Reach (hosted by BMBC) and neighbourhood based work (working with statutory and voluntary partners working with local communities) - it identifies and engages with deprived communities, Black, Asian and Minority Ethnic communities, inclusion health populations and people with disabilities (people with Learning Disabilities/ autism or both, people experiencing mental ill health and people experiencing frailty) and the full diversity of the local population.

The CCG has used digital platforms to understand the insights from its communities, with a particular focus on areas of deprivation such as the Dearne Valley and BME communities. This has enabled you to receive rapid feedback allowing services to be shaped around the needs of specific communities.

Comply with financial duties

Barnsley CCG has delivered its break-even target in year and contributed to the reduction of system deficits, as confirmed in the CCG 20/21 Annual Accounts.

The CCG has delivered the Mental Health Investment Standard; and the CCG's administrative costs are within its running cost allocation.

Leadership and governance

Barnsley CCG continued to demonstrate effective leadership and governance throughout 20/21, including:

- effective systems and processes for monitoring, analysing and acting on a range of information about quality, performance and finance, from a variety of sources including patient feedback, analyses of access to services and experiences of service users, so that it can identify early warnings of a failing service;
- effective system leadership and progressed partnership working, underpinned by governance arrangements and information-sharing processes, including evidence of multi-professional leadership; and
- supported the streamlining of commissioning arrangements

South Yorkshire and Bassetlaw Integrated Care System

Overall

The CCG has played a key role in supporting the NHS in South Yorkshire and Bassetlaw to respond so effectively to the COVID-19 Pandemic; the effective leadership of the CCG is also fundamental to the local Place – and wider ICS – recovery plan.

Thank you for the whole CCG team's dedication and commitment throughout a period of unprecedented challenge.

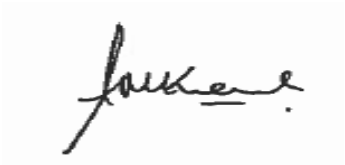
In addition to the wider team, you have both provided strong leadership in Barnsley and at a system level through the year with a focus on leading joint commissioning, maternity services and, importantly, the development of the system business case for primary care estate.

The CCG may also wish to publish a summary of the 2020/21 annual assessment.

We look forward to working with you and continuing to support your CCG through this transitional year, in improving healthcare for your local population and system.

Yours sincerely,

Sir Andrew Cash
System Leader
South Yorkshire & Bassetlaw
Integrated Care System



Alison Knowles

Locality Director – South Yorkshire & Bassetlaw

South Yorkshire and Bassetlaw Integrated Care System

Proposal to CCG Governing Bodies

to

Supplement the JC CCG Manual to expand the Scope of the Joint Committee Delegation and put in place additional arrangements for the transition to ICBs 2021/22 (SCHEDULE 3)

Barnsley CCG Governing Body Meeting

Public Session

9 September 2021

Author(s)	**Rob McGough - Hill Dickinson**
Sponsor	**SYB AOs and Joint Committee CCGs**
Is your report for Approval / Consideration / Noting	
Approval	
Background	

NHS Operational Planning Guidance for 2021/22 requires systems to start formally planning for the establishment of the statutory integrated care systems during Q1 of 2021, including setting out plans to operate in shadow form in Q4 of 2021/22. In summary this will involve the establishment of a statutory Integrated Care Board (ICB) and an Integrated Care Partnership (ICP) which together make the Integrated Care Systems (ICSs) of the future. Both statutory functions of current CCGs and some of NHS England will transfer to the ICB, along with existing non-statutory functions of ICSs, including strategic planning, transformation and oversight. The ICB is working towards operating in full shadow form from December 2021.

The five CCGs and ICS wish to put in place arrangements to ensure a smooth transition to the ICB in April 2022. It has been decided that the most practical way of doing this is for the Joint Committee of CCGs ("the Joint Committee") to co-ordinate the taking of preparatory steps for the transition to the ICS on behalf of the CCGs and for the ICS to have visibility of that work.

The boundaries of the ICS mean that NHS Bassetlaw will be moving from the ICS into Nottinghamshire and a neighbouring integrated care system on 1st April 2022. NHS Bassetlaw will continue to have an interest in many of the transitional issues within the remit of the Joint Committee. However, it is recognised that there may also be areas in which NHS Bassetlaw does not have a direct interest, and that NHS Bassetlaw may want to be less involved in discussions on such issues. The transitional operating arrangements take account of this.

Summary of key points

This proposed Schedule (3) sets out that the Joint Committee of the five CCGs is adapted for the transition to the South Yorkshire and Bassetlaw Integrated Care System by:

- Expanding the scope of its delegation to include transition work such as the carrying out of due diligence, development of corporate policies, development of the constitution for the new ICB and liaising with NHS England regarding the constitution;

- Inviting members of the ICB to its meetings, so that they have a full understanding of the preparatory work being done by the Joint Committee;

- Establishing a sub-committee to carry out this preparatory work; and

- Having a working arrangement with Bassetlaw CCG that the CCG may choose not to participate in parts of the meeting that are not directly relevant to Bassetlaw, following the move of Bassetlaw from South Yorkshire & Bassetlaw ICS to Nottinghamshire & Nottingham ICS on 1st April 2022.

- No changes are made to the Joint Committee's Terms of Reference. In particular, Bassetlaw CCG will continue to be a member of the Joint Committee and attendance of a representative from Bassetlaw CCG will still be required in order for meetings of the Joint Committee to be quorate. If a member from Bassetlaw CCG is in attendance at a Joint Committee meeting and decides not to actively participate in discussions on a particular topic, that will not mean that the meeting is inquorate.

- This paper has been supported by Barnsley CCG, Bassetlaw CCG, Doncaster CCG, Rotherham CCG, Sheffield CCG and Derbyshire CCG as a variation to the Manual and Delegation. If there is any difference between the provisions of this Schedule 3 and the remainder of the Manual or the Delegation, then the terms of this Paper will take precedence.

- As set out above, nothing in this Schedule 3 amends the Joint Committee Terms of Reference (ToR attached for reference).

Recommendations

This paper seeks agreement from the CCG members of the Joint Committee to this approach and agreement for the Schedule (3) enclosed to be added to the JC CCG Manual Agreement / TOR (attached for reference) and specifically approval of the following:

1. Proposed amendment to the delegation of the Joint committee for the transition work but the Joint committee TOR (enclosed for reference) are unchanged

2. Establishment of the Joint Committee sub-committee – the Change and Transition Board - to take forward the transition work between September and end March 2022

Joint Committee Transition 2021/22

Proposal to add as SCHEDULE 3 to

Joint Committee of CCGs Manual / Terms of Reference

Background

1 NHS Operational Planning Guidance for 2021/22 requires systems to start formally planning for the establishment of the statutory integrated care systems during Q1 of 2021, including setting out plans to operate in shadow form in Q4 of 2021/22. In summary this will involve the establishment of a statutory Integrated Care Board (**ICB**) and an Integrated Care Partnership (**ICP**) which together make the Integrated Care Systems (**ICSs**) of the future. Both statutory functions of current CCGs and some of NHS England will transfer to the ICB, along with existing non-statutory functions of ICSs, including strategic planning, transformation and oversight. The ICB is working towards operating in full shadow form from December 2021.

2 The five CCGs and ICS wish to put in place arrangements to ensure a smooth transition to the ICB in April 2022. It has been decided that the most practical way of doing this is for the Joint Committee of CCGs (**"the Joint Committee"**) to co-ordinate the taking of preparatory steps for the transition to the ICS on behalf of the CCGs and for the ICS to have visibility of that work.

3 The boundaries of the ICS mean that NHS Bassetlaw will be moving from the ICS into Nottinghamshire and a neighbouring integrated care system from the 1st April 2022. NHS Bassetlaw will continue to have an interest in many of the transitional issues within the remit of the Joint Committee. However, it is recognised that there may also be areas in which NHS Bassetlaw does not have a direct interest, and that NHS Bassetlaw may want to be less involved in discussions on such issues. The transitional operating arrangements take account of this.

4 It is anticipated that these arrangements will be in place between September 2021 and 1st April 2022, when CCGs will be dissolved, and ICSs formally established under legislation.

5 In this paper capitalised terms have the same meaning as in the Manual, unless otherwise defined. References to the ICB, ICP and ICS include those organisations operating in shadow form, prior to their legal establishment under the Health & Care Bill.

Transitional arrangements

6 The Joint Committee is adapted for the transition to the South Yorkshire Integrated Care System (**"ICS"**) by:

a. Expanding the scope of its delegation to include transition work such as the carrying out of due diligence, development of corporate policies, development of the constitution for the new ICB and liaising with NHS England regarding the constitution;

b. Inviting members of the ICB to its meetings, so that they have a full understanding of the preparatory work being done by the Joint Committee;

c. Establishing a sub-committee to carry out this preparatory work; and

d. Having a working arrangement with Bassetlaw CCG that the CCG may choose not to participate in parts of the meeting that are not directly relevant to Bassetlaw, following the move of Bassetlaw from South Yorkshire & Bassetlaw ICS to Nottinghamshire & Nottingham ICS on 1st April 2022.

7 No changes are made to the Joint Committee's Terms of Reference. In particular, Bassetlaw CCG will continue to be a core member of the Joint Committee and attendance of a representative from Bassetlaw CCG will still be required in order for meetings of the Joint Committee to be quorate. If a member from Bassetlaw CCG is in attendance at a Joint Committee meeting and decides not to actively participate in discussions on a particular topic, that will not mean that the meeting is inquorate.

8 This paper has been supported by Barnsley CCG, Bassetlaw CCG, Doncaster CCG, Rotherham CCG, Sheffield CCG and Derbyshire CCG as a variation to the Manual and Delegation. If there is any difference between the provisions of this Schedule 3 and the remainder of the Manual or the Delegation, then the terms of this Paper will take precedence. As set out above, nothing in this Schedule 3 amends the Joint Committee Terms of Reference.

Expanding the Delegation

9 The Delegation is expanded by adding the following paragraph to the end of section B:

*The delegated functions also relate to the preparation for the transition of commissioning responsibilities from CCGs and NHS England to Integrated Care Systems following the introduction of new legislation. The CCGs delegate these functions (regarding the preparation for the transition of commissioning responsibilities) to the Joint Committee, to enable consistent and effective decision-making. Such preparation for future commissioning to be carried out by Integrated Care Boards (**ICBs**) may include (but is not limited to):*

- *The development of draft corporate policies for consideration/ adoption by the ICB once it is formally established e.g. in the areas of HR, conflicts of interest, finance.*

- *Developing the ICB constitution and liaising as appropriate with NHS England to gain approval for the constitution; this may include overseeing support work carried out by the ICB, such as producing drafts of the constitution and co-ordinating engagement.*

- *Producing/ providing input into the transition schemes that will manage the move from CCGs to ICSs and liaising as appropriate with NHS England.*

- *Being the point of contact for any queries from the ICB while it operates in shadow form, including for the provision of information needed to support the ICB's work.*

The development of any ICB plans (such as the Forward Plan and the Capital Plan) will be carried out by the ICB operating in shadow form.

Developing the ICB constitution

10 Under the Health & Care Bill 2021 as currently drafted the CCGs are responsible for the consultation on and submission for approval of the ICB constitution. Under the updated delegation (see section above) this responsibility has been delegated to the Joint Committee.

11 The ICB has offered support to the Joint Committee regarding the constitution, including through preparation of a draft constitution for consideration by the Joint Committee and the co-ordination of any engagement exercise.

12 The Joint Committee may request and obtain assistance from the ICB regarding its responsibilities related to the constitution, in particular regarding any engagement exercise. This may include the ICB carrying out/ co-ordinating activities to support the Joint Committee. The Joint Committee shall be responsible for overseeing any such activity by the ICB and taking any final decisions regarding the CCGs' responsibilities relating to the ICB constitution.

Meeting arrangements for the Joint Committee during the transition period

13 The following arrangements will be put in place to ensure effective working between the Joint Committee and the ICB during the transition period.

<u>Attendance</u>

14 Under its terms of reference (paragraph 5.4) the Joint Committee can invite non-voting members to join the Joint Committee. Non-voting members are invited to all Joint Committee meetings but do not count towards the quorum. The Joint Committee invites the following post holders to join the Joint Committee as non-voting members:

- ICB Chair Designate
- Two individuals nominated by the ICB Chair Designate (the ICB Chair Designate may update these nominations from time to time through informing the Joint Committee Chair of the change)

15 It will be for these invitees to decide whether or not to attend the meeting, informed by the meeting agenda. If the Joint Committee particularly wants a representative from the ICB to attend, this should be highlighted to the ICB Point of Contact at the time that the agenda is circulated.

16 Each ICB non-voting member may nominate a deputy to attend in their place. Such nominations should be made at least three working days in advance of the meeting where possible and should be made by contacting the Joint Committee Point of Contact.

17 The Joint Committee may invite further post holders to join the Joint Committee. If the Joint Committee wishes further ICB officers to join, the Joint Committee Point of Contact should make a request to the ICB Point of Contact. If the ICB wishes further ICB officers to join, the ICB Point of Contact should make a request to the Joint Committee Point of Contact. The Joint Committee can then decide whether those individuals should be added as non-voting members and whether or

not they are able to appoint a deputy if they are unable to attend. To keep meetings manageable, it is envisaged that the total number of non-voting members from the ICB will not exceed four.

18 The Joint Committee can also invite additional experts to attend its meetings on an ad hoc basis. If the Joint Committee wishes an expert from the ICB to attend, then they should make this request to the ICB Point of Contact. If the ICB wishes an ad hoc expert to attend then the ICB Point of Contact should make a request to the Joint Committee Point of Contact at least five working days prior to the meeting.

Communications

19 To ensure clear lines of communication both the ICB and the Joint Committee will have a dedicated **Point of Contact**. The Chair of the Joint Committee will nominate the Joint Committee point of contact and the Chair Designate of the ICB will nominate the ICB point of contact. Nominations may be updated from time to time. At the time of writing the points of contact are:

Joint Committee Point of Contact – Lisa Kell, Director of Commissioning at the ICS,

lisa.kell@nhs.net

ICB Point of Contact – Will Cleary-Gray, Chief Operating Officer at the ICS,

will.cleary-gray@nhs.net

20 Communications regarding the administration of Joint Committee meetings should go through these points of contact.

Meeting administration

21 Administration of the meeting shall continue to be the responsibility of the Joint Committee. It will therefore be the responsibility of the Joint Committee to ensure that:

- Meeting invitations are sent out to the appropriate people (including non-voting members from the ICB)
- Meeting agendas and papers are circulated in advance
- Minutes of the meeting are taken.
- Minutes of the meeting are circulated

22 If the ICB wants a matter to be added to the Joint Committee meeting agenda then the ICB Point of Contact should notify the Joint Committee Point of Contact at least 5 working days before the meeting and provide any relevant papers within the timescales requested by the Joint Committee Point of Contact. The Joint Committee will then consider whether to include the item in accordance with its Terms of Reference.

Meeting papers

23 The agenda and minutes for each meeting will clearly set out:

23.1 The voting members from the Joint Committee who are attending

23.2 The non-voting members from the ICB who are attending

23.3 Any other non-voting members

23.4 Anyone attending as an ad hoc expert

23.5 Who is leading on each agenda item

24 Technically, the minutes will be approved by voting members of the Joint Committee attending the following meeting. However, the voting members will take account of the views of non-voting members in attendance at the relevant meeting before approving the minutes.

Establishing sub-committees

25 The Joint Committee establishes a sub-committee (the Change and Transition Board) to assist it with transition work.

26 The sub-committee will prepare proposals and carry out preparatory work for approval/ adoption by the Joint Committee. The sub-committee will not itself make decisions.

27 The Change and Transition Board sub-committee will operate in accordance with its terms of reference, set out below.

Terms of Reference	
Group or meeting	**Change and Transition Board sub-committee, a sub-committee of the Joint Committee of CCGs ("Joint Committee")**
Roles and responsibilities	To assist the Joint Committee with the preparation for the transition of commissioning responsibilities from the CCG and NHS England to the ICS. The Joint Committee will ask the sub-committee to complete particular tasks on a case by case basis. The sub-committee will make proposals to the Joint Committee. It will then be for the Joint Committee to discuss and adopt these as appropriate. The sub-committee cannot make any decisions on behalf of the Joint Committee.
Membership	**Voting members** One individual nominated by Barnsley CCG One individual nominated by Bassetlaw CCG One individual nominated by Doncaster CCG One individual nominated by Rotherham CCG One individual nominated by Sheffield CCG A CCG Director of Finance from one of the core member CCGs nominated by the Chair of the Joint Committee Each of these members may nominate a deputy to attend in their place. Each CCG may update their nominations from time to time through informing the sub-committee Chair of the change. **Observers** Four individuals nominated by the ICB Chair Designate (the ICB Chair Designate may update these nominations from time to time through informing the sub-committee Chair of the change). It is anticipated that the initial nominees will be the ICS Lead, the ICS Deputy Lead, the ICS Chief Operating Officer and the ICS Director of HR. The Joint Committee Point of Contact, as described in Schedule 3 of the Manual. Each of these observers may nominate a deputy to attend in their place.

	The voting members may invite such other observers to join the sub-committee provided the total number of observers does not exceed 7. The term **"Members"** refers to both voting members and observers of the sub-committee. **Other attendees** The voting members may invite other individuals with subject matter expertise to join its meetings on an ad hoc basis to inform discussions Note that the membership of the sub-committee may flex (through the CCGs and ICB updating their nominations) according to the subject matter of the sub-committee's work.
Sub-committee points of contact	The Point of Contact for the voting members shall be the Joint Committee Point of Contact; the Point of Contact for the observers is the ICB Point of Contact both Points of Contact as described in Schedule 3 of the Manual.
Chair	The sub-committee will be chaired jointly by two joint Chairs: (1) The Chair of the Joint Committee of CCGs; and (2) The ICB Chair Designate will select one of his nominees to be the other joint chair. It is anticipated that the ICS Lead will be the first such appointment. References to "Chair" in these terms of reference are to the two joint Chairs acting together.
Quorum	The sub-committee is considered quorate if there is at least one representative from Barnsley CCG, Bassetlaw CCG, Doncaster CCG, Rotherham CCG and Sheffield CCG present save that a meeting may be quorate without a representative from Bassetlaw CCG if Bassetlaw CCG has indicated that they do not want to participate in the relevant agenda item. If a meeting is not quorate it may continue but any work or decisions will need to be adopted by a subsequent quorate meeting before being referred to the Joint Committee.
Meetings	<u>Meeting schedule</u> The sub-committee will determine its schedule of meetings at its first meeting and may amend that schedule from time to time.

	The Chair may determine that the sub-committee needs to meet on an urgent basis, in which case the notice period shall be as specified by the Chair acting reasonably. Urgent meetings may be held virtually, using any of the means specified above. <u>Participation by video-link/ phone</u> The Chair may agree that Members may participate in meetings by means of telephone, video or computer link or other live and uninterrupted conferencing facilities provided every Member participating is able to be heard by every other Member. Participation in a meeting in this manner shall constitute presence in person at such meeting. <u>Meetings in private</u> Given that the sub-committee will not be making any decisions on behalf of the Joint Committee, it will meet in private.
Decision-making	Ideally, decisions made by the sub-committee should have the support of all voting members, save that the support of Bassetlaw CCG is not needed if it has stated that it does not have an interest in the matter. If this is not possible then decisions may be made by the majority of voting members present and voting. If the sub-committee refers a matter to the Joint Committee that does not have consensus support as outlined above, this should be made clear and reasons for the lack of consensus given. The Joint Committee shall also be informed of any concerns raised by observers.
Conduct of business	If a Member wishes to add an item to the agenda they must notify the Joint Committee Point of Contact. Requests for agenda items will be passed to the sub-committee Chair who will decide the content and order of the agenda. Circulation of the meeting agenda and papers via email will take place at least five working days prior to the meeting where possible. The sub-committee will have administrative support from the ICS Project Management Office to: - Collate items for the agenda - Circulate the agenda and any papers - take and circulate action points from meetings - maintain a record of actions and action owners
Conflicts of interest	The rules on conflicts of interest that apply to the Joint Committee shall also apply to the sub-committee.

	Observers will comply with their organisation's rules on conflicts of interest. Members will be transparent about any interest their organisation has in matters being discussed by the sub-committee. References to organisation include the ICB and Integrated Care Partnership operating in shadow form.
Accountability and reporting	The sub-committee is accountable to the Joint Committee. Action points from sub-committee meetings will be sent to Board Members within 10 working days of each meeting. Members are also accountable to their host organisation.
Review	It is not anticipated that these terms of reference will be reviewed as it is expected that CCGs will be dissolved in April 2022. However, the Joint Committee may review these Terms of Reference as it considers appropriate.

Manual Agreement and Terms Of Reference

Of

Joint Committee of Clinical Commissioning Groups

South Yorkshire and Bassetlaw

2019/20

Final Version

July 2019

Start Date: 24 July 2019

Review date: 1st December 2019

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

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

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

Chapter 1 - Introduction and Overview

1. Background

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

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

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

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

and Associate* Member CCG

- NHS Derby and Derbyshire Clinical Commissioning Group;

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

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

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

(2) The arrangements may provide for—

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

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

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

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

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

2. Purpose of the JC CCGs

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

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

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

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

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

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

2.6 Generally, the JC CCGs will work across the system to develop a strategic approach to commissioning sustainable, efficient services that are patient centred and focussed on

improving population health outcomes. Further, it will enable the development of integrated working with social care and wider community and voluntary sector partners so that the patients receive a more seamless service.

3. Role in local health and care system

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

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

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

4. Status of this Manual and Interpretation

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

5. Term

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

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

Chapter 2- Commissioning Intentions and Statutory Duties

6. System / local commissioning intentions

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

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

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

* *Consistent with Long Term Plan Requirements*

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

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

7. Any existing arrangements

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

8. Complying with the Statutory Duties of CCGs

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

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

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

8.4 The result of this is that:

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

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

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

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

9. **Governance**

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

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

Chapter 3 – Delegation

10. Purpose of delegation

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

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

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

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

11. The delegation

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

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

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

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

12. Terms of delegation in context of joint commissioning

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

Chapter 4 - Terms of reference of joint committee

13. Terms of Reference of the JC CCGs

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

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

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

14. Reserved Functions

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

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

14.3 **Exercise of the Joint Functions**

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

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

Chapter 5- Additional terms supplementing the Terms of Reference

15. Key Objectives and Guiding Principles for JC CCGs

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

15.2 The Key Objectives of the JC CCGs are:

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

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

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

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

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

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

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

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

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

15.2.1.9 ensuring equity of access to services collaboratively commissioned; and

15.2.1.10 To support ongoing effective working of the Member CCGs.

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

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

- To collaborate and co-operate. Do it once rather than repeating or duplicating actions and increasing cost across the CCGs. Establish and adhere to the governance structure set out in the Terms of Reference and in this Manual, to ensure that activities are delivered and actions taken as required;
- To be accountable. Take on, manage and account to each other for performance of the respective roles and responsibilities set out in the Terms of Reference and in this Manual;
- To be open. Communicate openly about major concerns, issues or opportunities relating to the functions delegated to the JC CCGs, as set out in Appendix 1 (*Delegation)*;
- To learn, develop and seek to achieve full potential. Share information, experience, materials and skills to learn from each other and develop effective working practices, work collaboratively to identify solutions, eliminate duplication of effort, mitigate risk and reduce cost whilst ensuring quality is maintained or improved across all the Member CCGs;
- To adopt a positive outlook. Behave in a positive, proactive manner;
- To adhere to statutory requirements and best practice. Comply with applicable laws and standards including EU procurement rules, data protection and freedom of information legislation.
- To act in a timely manner. Recognise the time-critical nature of the functions delegated to the JC CCGs as set out in Appendix 1 (*Delegation*), and respond accordingly to requests for support;
- To manage stakeholders effectively;
- To deploy appropriate resources. Ensure sufficient and appropriately qualified resources are available and authorised to fulfil the responsibilities set out in the Terms of Reference and in this Manual; and
- To act in good faith to support achievement of the Key Objectives and compliance with these Principles.
- The JC CCGs has a commitment to ensuring that in pursuing its Key Objectives it does not increase inequalities or worsen health outcomes for any local populations.
- Where one of the partners voted in a different way to others on any issue the committee would take the time to discuss and understand the reasons why.

16. Sub committees of the JC CCGs

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

16.1.1 **Joint Committee Sub Group**

17. Finances/ Pooled Funding

17.1 The Member CCGs may, for the purposes of exercising the Joint Functions under this Manual, establish and maintain a pooled fund in accordance with section 14Z3 of the

NHS Act 2006. Specifically, member CCGs may want to look at how to support the implementation of the decisions they make from service reconfiguration processes through to enabling strategic system change across the region. Pooling funds for use across the region for the overall benefit of all patients would ensure that best use of limited resources is achieved. It will also mean that implementation of decisions is less likely to stall due to financial challenges in that a pooled fund provides greater regional support options than CCGs seeking to implement change individually.

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

18. Secretariat

18.1 SYB ICS will provide the secretariat to the JC CCGs

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

19. Staffing

19.1 See 18 above

20. Conflicts of Interest.

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

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

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

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

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

21. General Data Protection Regulation (GDPR) 2018

21.1 The Member CCGs shall all comply with GDPR requirements.

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

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

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

21.3.1 all relevant Information Law requirements including the common law duty of confidence and other legal obligations in relation to information sharing including those set out in the NHS Act 2006 and the Human Rights Act 1998;

21.3.2 Good Practice; and

21.3.3 relevant Guidance (including guidance given by the Information Commissioner).

22. IT inter-operability

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

23. Confidentiality

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

24. Freedom of Information

24.1 Each Member CCG acknowledges that the other Member CCGs are a public authority for the purposes of the Freedom of Information Act 2000 (**"FOIA"**) and the Environmental Information Regulations 2004 (**"EIR"**).

24.2 Each Member CCG may be statutorily required to disclose information about the Agreement and the information shared or generated by the Member CCGs pursuant to this Agreement and the Terms of Reference, in response to a specific request under FOIA or EIR, in which case:

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

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

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

25. Procurement

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

The real procurement objective is to -

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

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

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

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

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

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

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

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

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

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

25.3 Advertisements and expressions of interest

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

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

25.4 Award of a new contract without a competition

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

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

25.5 Conflict of Interests

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

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

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

25.6 Anti-competitive behaviour

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

- Are you acting in an anticompetitive manner – for instance have you prevented new providers from entering the market or caused a provider to exit the market?
- If so, is it objectively justifiable as being in the interests of users and stakeholders? What evidence do you have to support this?

26 Competition Issues

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

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

26.2 Merger control rules

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

26.3 Jurisdictional Tests

The CMA has jurisdiction to examine a merger where:

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

26.3.2 and either

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

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

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

26.4 Competition test

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

26.5 SLC assessment

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

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

26.6 CMA merger assessment timetable

The process is divided into two stages:

- Phase I: an initial 40 working day investigation; and

- Phase II: a possible 24 weeks in-depth investigation, which can be extended if the CMA considers it necessary.

27 Liability and indemnities.

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

28 Breach of this Manual and Remedies

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

29 Dispute Resolution

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

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

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

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

30 Leaving the JC CCGs

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

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

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

31 Termination of the Manual

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

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

32 Notices

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

32.2 Notices sent:

32.2.1 by hand will be effective upon delivery;

32.2.2 by post will be effective upon the earlier of actual receipt or five (5) working days after mailing; or

32.2.3 by email will be effective when sent (subject to no automated response being received).

33 Variations

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

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

34 Counterparts

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

35 Applicable Law

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

Schedule 1
Definitions and Interpretation

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

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

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

Schedule 2
Member CCGs

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

Appendix 1

Delegation by CCGs to JC CCGs

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

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

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

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

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

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

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

- Consistency with current and prospective patient choice.

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

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

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

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

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

Appendix 2

JC CCGs Terms of Reference

1. Introduction

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

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

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

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

(1) NHS Barnsley Clinical Commissioning Group;

(2) NHS Bassetlaw Clinical Commissioning Group;

(3) NHS Doncaster Clinical Commissioning Group;

(4) NHS Rotherham Clinical Commissioning Group;

(5) NHS Sheffield Clinical Commissioning Group;

(6) NHS England Specialised Commissioning; Non voting

And *Associate CCG members:

(6) NHS Derby and Derbyshire Clinical Commissioning Group;

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

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

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

1.6 Guiding principles:

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

2. Statutory Framework

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

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

3. Role of the JC CCGs

3.1 The role of the JC CCGs shall be:

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

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

4. Geographical coverage

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

5. Membership

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

5.2 Voting members:

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

5.3 Non-voting attendees:

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

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

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

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

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

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

6. Meetings

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

a) notice of meetings;

b) handling of meetings;

c) agendas;

d) circulation of papers; and

e) conflicts of interest.

7. Voting

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

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

8. Quorum

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

9. Frequency of meetings

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

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

10 Meetings of the JC CCGs

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

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

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

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

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

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

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

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

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

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

10.11 Answers to submitted questions relating to the agenda received in advance of the meeting will be published on the JCCCG section of the South Yorkshire and Bassetlaw Integrated Care System website prior to the meeting. Up to 15 minutes will be set aside at the beginning of the meeting in public for questions and/or statements to be made by members of the public. The chair reserves the right to not answer questions or statements that are not deemed appropriate to the JC CCGs agenda.

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

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

11. Secretariat provisions

The secretariat to the JC CCGs will:

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

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

12. Reporting to CCGs

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

13. Decisions

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

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

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

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

15. Attendance

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

15. Review of Terms of Reference

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

15. Withdrawal from the JC CCGs

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

16. List of Members from each CCG and non-voting members

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

Appendix 3

Checklist of Statutory Duties and Protocols

Public Law Issues (including for service change)

1. Case For Change

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

2. Engagement with Public and Patients

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

3. Four Key Tests

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

(i) strong public and patient engagement;

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

(iii) a clear clinical evidence base; and

(iv) support for proposals from clinical commissioners.

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

4. Equality

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

5. Statutory obligations

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

- 14P – Duty to promote NHS Constitution
- 14Q – Duty as to effectiveness, efficiency etc
- 14R – Duty as to improvement in quality of services
- 14T – Duty as to reducing inequalities

- 14V – Duty as to patient choice
- 14X - Duty to promote innovation
- 14Z1 – Duty as to promoting integration
- 14Z2 – Public involvement and consultation by CCGs (see above)

6. Government Consultation Principles Updated 2018

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

7. Principles for consultation (2018)

- **Consultations should be clear and concise**

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

- **Consultations should have a purpose**

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

- **Consultations should be informative**

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

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

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

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

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

- **Consultations should be targeted**

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

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

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

- **Consultations should be agreed before publication**

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

- **Consultation should facilitate scrutiny**

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

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

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

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

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

8. Governance

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

9. Local authorities

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

10. Clear plan

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

11. Analysis and report

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

12. Compliance with statutory obligations and four Key Tests

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

13. IRP

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

Procurement Issues

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

1. Procurement objective

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

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

2. Three general requirements

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

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

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

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

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

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

3. Advertisements and expressions of interest

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

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

4. Award of a new contract without a competition

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

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

5. Conflict of Interests

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

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

6. Anti-competitive behaviour

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

- Are you acting in an anticompetitive manner – for instance have you prevented new providers from entering the market or caused a provider to exit the market?
- If so, is it objectively justifiable as being in the interests of users and stakeholders? What evidence do you have to support this?

Competition Issues

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

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

2. Merger control rules

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

3. Jurisdictional Tests

The CMA has jurisdiction to examine a merger where:

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

2. and either

- the UK turnover of the acquired enterprise exceeds £70 million; or

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

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

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

4. Competition test

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

5. SLC assessment

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

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

6. CMA merger assessment timetable

The process is divided into two stages:

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

Appendix 4

South Yorkshire and Bassetlaw JC CCGs Clinical Engagement and Assurance Process

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

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

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

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

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

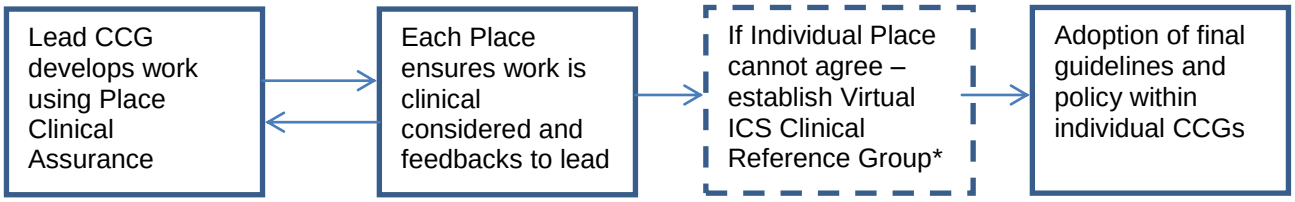
These respective groups all have the remit to ensure clinical debate and assurance is undertaken at place enabling a clinical consensus in each place for SYB system commissioning priorities throughout the work that cover the following requirements:

- Patient centred and quality driven decision making
- Local ownership and implementation of recommendations

- Consistency of guidelines and clinical pathways across the ICS
- Timely decision making to ensure implementation within agreed timeframes

SYB Clinical Engagement and Assurance Process:

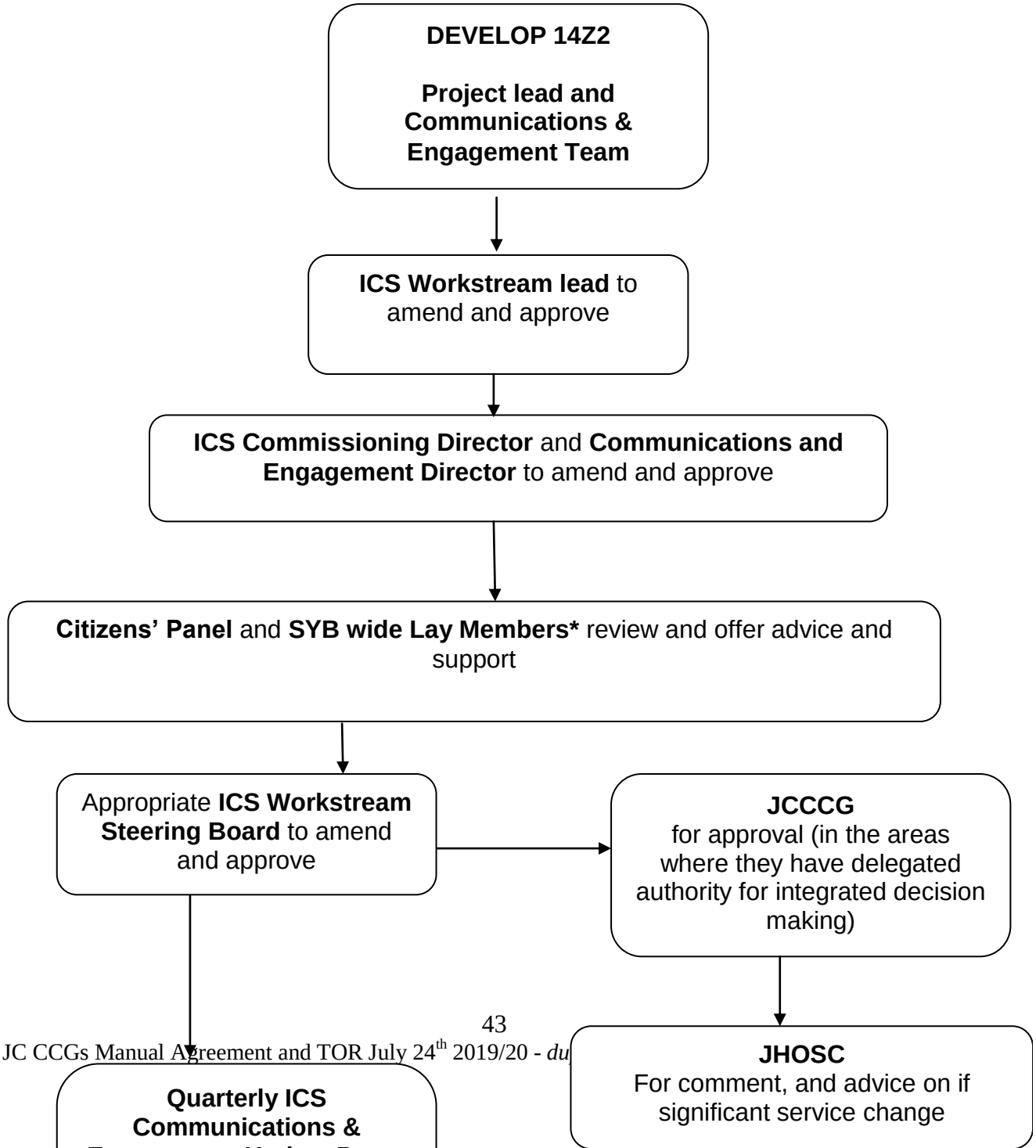
Lead CCG liaises with individual places to ensure clinical reference and agreement takes place during development of work:



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

Appendix 5

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



NHS
Barnsley
Clinical Commissioning Group

GOVERNING BODY

9 September 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 8 July, information was provided on the latest intelligence, guidance 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 that the COVID19 outbreak be classified as a pandemic and the introduction of 'lock down' restrictions on 23 March, 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 was 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, 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 was set around 4 key steps with indicative dates for moving through these steps however all the dates were indicative and subject to change if there were any factors that could put recovery at risk. These were:

- 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.

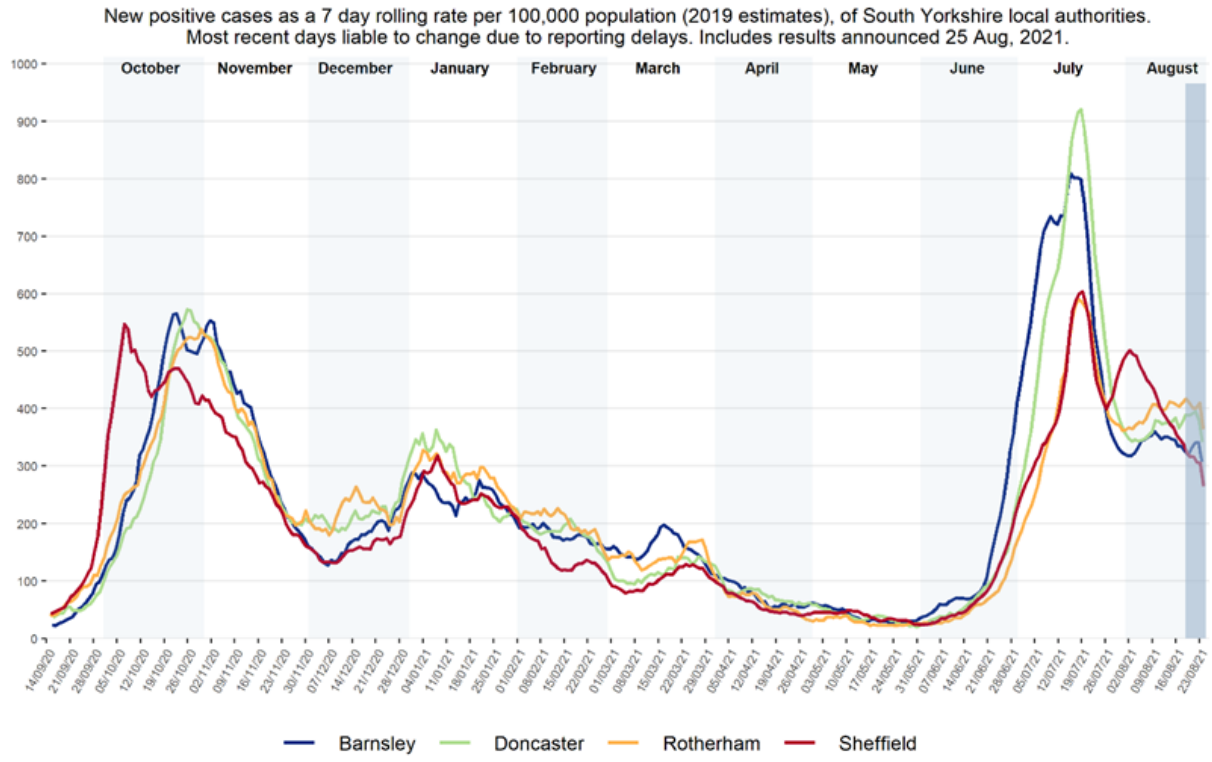
* Due to increasing infection rates and an increased spread of the delta variant, Step 4 was delayed by 4 weeks to 19 July 2021.

Monitoring of Covid levels continues to be monitored to inform planning and future response with the latest summary (as at 25 August) included in the table below:

TEST	MEASURE	VALUE	DIRECTION
INFECTIONS & TREND	Seven day case rate Seven day rate in over 60s Positivity rate	319.7 189.1 10.6	THE RATE HAS REMAINED LARGELY LEVEL AT THIS HIGH BASELINE AND IS NOT EXPECTED TO DROP BELOW 300 BEFORE SCHOOLS REOPEN. OUR RATES ARE SIMILAR TO THE NATIONAL AVERAGE.
GENERAL DISRUPTION	Service, sector and organisational issues	***Clusters***: there are no significant new or active clusters ***Staff absence***: this continues to be an issue across all services with a slight recent increase	
VACCINE PROGRESS	Number with 1st dose (2nd dose) % of population with 1st dose (2nd)	175,330 (158,162) 84.3% (76.9%)	THERE IS GROWING TALK OF COMMENCING THE VACCINE BOOSTER PROGRAMME IN SEPTEMBER AND CONSIDERATION OF EXPANDING CHILDHOOD VACCINATION.
IMPACT OF VACCINE / SEVERITY OF DISEASE	Number of people in hospital Number of people in ITU/HDU CEV people in hospital	34 6 1	OF THOSE IN HOSPITAL WITH COVID ... 19 ARE FULLY VACCINATED (8/19 WERE ADMITTED FOR COVID). 7 HAVE NOT BEEN VACCINATED (4/7 HAVE BEEN ADMITTED FOR COVID). 8 HAVE AN UNKNOWN VACCINE STATUS.
IMPACT OF VARIANTS	Predominant variant Variants Of Concern	Delta predominant with no other local transmission of VOCs / VUI	THERE ARE SMALL NUMBERS OF VUIs BEING DETECTED IN YH, BUT THESE ARE MOSTLY IMPORTED AND NOT SPREADING.

As can be seen in the chart below, the infection rate in Barnsley has reduced following an increase in June and July and whilst still significantly above the low levels seen in May, is stable and continuing to slowly reduce.

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



The impact of the new school year commencing has not yet been seen, however it is anticipated that this could lead to an increase in infection rates and therefore the CCG will continue to work with local partners in Barnsley and across the South Yorkshire and Bassetlaw Integrated Care System to ensure appropriate action and response and 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 250,000 vaccines. Including activity delivered for Health and Care workers in hospital hubs and vaccination at pharmacy and large-scale sites this number increases to over 350,000 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 (92.5% of the cohort) having received

	both doses. Vaccination continues for cohorts 10-12 (under 50's) and around 73% of this group have received their first dose and 60% have now received a second dose. The eligible cohorts for the vaccine were extended during August to include all 16 & 17 year olds and 12-15 year olds with certain medical conditions or who are household contacts of people who are immunosuppressed. As at the end of August, over 40% of this group had received a first vaccine. To maximise overall uptake of the vaccination programme, the Barnsley Local Vaccination Service are continuing to offer a range of options for accessing the vaccine including bookable appointments, walk in clinics and pop-up clinics to target populations with lower uptake. Recent examples include vaccination within the maternity unit for pregnant mothers (with additional advice and guidance provided) and a pop-up at ASOS, a large employer in Barnsley. 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. As the programme moves into the next phase, planning is taking place for a potential booster campaign and for a childhood vaccination programme for all children aged 12-15. The Joint Committee on Vaccination and Immunisation (JCVI) have not approved either programme at this point however planning is taking place, working with all partners, to be in a position to begin delivery as soon as the details of any programme are confirmed.
6.	**THE GOVERNING BODY IS ASKED TO:**
	• Note the update provided in this paper including 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

PUBLIC GOVERNING BODY

9 September 2021

Barnsley Place Agreement

PART 1A – SUMMARY REPORT

1.	**THIS PAPER IS FOR**						
	Decision		*Approval*	x	*Assurance*		*Information*	
2.	**PURPOSE AND EXECUTIVE SUMMARY**						
	The purpose of this report is to provide an update to NHS Barnsley CCG on the proposed arrangements for the development of the Barnsley Integrated Care Partnership (ICP) including a collaborative agreement for the ICP (referred to as the "**Place Agreement**"). The Place Agreement has been co-produced, and work on it has been led on behalf of the Integrated Care Partnership Group (ICPG) by its sub-committee, the Place Design Team. ICPG approved the Place Agreement on the 29th July 2021, subject to a clarification amendment re-emphasising our commitment as a place to equality and diversity. The Place Agreement is before Governing Body for approval and is a key step towards the successful delivery of a Place Based Partnership for Barnsley as part of South Yorkshire ICS from 1 April 2022.						
3.	**REPORT OF**						

	Name	**Designation**
Executive / Clinical Lead	Jeremy Budd	Director Strategic Commissioning and Partnership
Authors	Jeremy Budd Hill Dickinson	Director Strategic Commissioning and Partnership

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
Barnsley Integrated Care Partnership Group	29/07/21	Approved, subject to amendment re commitment to Equality and Diversity
Barnsley Design Team	01/09/21	Amendment re Equality and Diversity in the Principles approved

5. EXECUTIVE SUMMARY

Purpose

1. The purpose of this report is to provide an update to NHS Barnsley CCG on the proposed arrangements for the development of the Barnsley Integrated Care Partnership (ICP) including a collaborative agreement for the ICP (referred to as the "**Place Agreement**").

2. The **Health and Care Compact** has been developed by an overarching Steering Group of the ICS to set out the commitment of the ICS health and care partners to focus on the shared purpose of the ICS to deliver the quadruple aim (better health, care, value and reduced inequalities) to improve population health outcomes and reduce health inequalities. Governing Body approved the Compact in its May meeting. The Place Agreement mirrors the principles embodied in the Health and Care Compact.

3. The **Place Agreement** is intended to facilitate further progress towards an ICP model for Barnsley, in line with the policy direction set out in the DHSC White Paper – *Integrating Care* – and as outlined in the Health & Care Bill, which has now had its second reading in Parliament. The Place Agreement is being developed by Hill Dickinson LLP with input from Partner representatives forming a 'Design Team' which reports into the Barnsley ICP Group (BICPG).

4. The proposal is that the Place Agreement is entered into by NHS Barnsley CCG, Barnsley Metropolitan Borough Council, Barnsley Hospital NHS Foundation Trust, South West Yorkshire Partnership NHS Foundation Trust, Barnsley Healthcare Federation, Barnsley Hospice and Barnsley Community and Voluntary Services (referred to in the Place Agreement as the Partners). Barnsley Healthwatch will continue to play a key role in the ICP through continued attendance at BICPG and Barnsley ICP Delivery Group (BICPDG) meetings.

Development of the Barnsley Integrated Care Partnership

5. The Partners have, for a number of years, been working collaboratively across Barnsley to integrate services and provide care closer to home for local people. The Partners established the ICPG in 2018 through which to

collaborate, reporting into Partner organisations.

6. It is clear from the Health and Care Bill that a formal place-based partnership will need to be in place in Barnsley from April 2022 and that the Partners will need to undertake a programme of work in 2021/22 to prepare for the transition. The development of the ICP will be undertaken in parallel with, and linked to, the further development of the SYB ICS. The ICS is expected to become a statutory entity in its own right in April 2022, with the CCG being dissolved and its functions transferred to the ICS.

The Place Agreement

7. The Place Agreement is intended to document the existing governance arrangements in Barnsley and incorporates an outline development plan for the ICP which the Partners will sign up to. The Place Agreement documents the agreed vision and objectives of the Partners for the ICP and the shared principles of the Partners in developing a place-based health and care operating model for the people of Barnsley ultimately using a population health management approach and focusing on a number of 'priority programmes' as set out in the Barnsley Health and Care Plan. The principles set out in the Place Agreement will broadly align with those set out in the Health and Care Compact as noted above.

8. The Place Agreement should work alongside and facilitate the development of provider collaborative arrangements. There will need to be a programme of work to develop both the place-based partnership for Barnsley through the ICP governance structures, as well as a provider collaborative at place.

9. To this end, the Partners have nominated representatives to form a 'Design Team', reporting into the ICPG, which is leading on the development of the Place Agreement and a development plan for 2021/22, with input from Hill Dickinson. The development plan will identify key areas of development for the ICP and link into programmes of work to be undertaken during 2021/22 in readiness for shadow operation from Q3 2021/22.

Key features of the Place Agreement

10. The Place Agreement is a collaborative agreement similar to other such agreements already in place in a number of other systems. Key examples include Bradford District & Craven, Collaborative Newcastle and St Helens Cares.

11. The Place Agreement sets out the:

- vision and core objectives of the Partners for the development and delivery of the ICP;
- key collaborative principles that the Partners will comply with in working together to achieve the common vision and objectives (in line with the Health and Care Compact);
- the governance structures underpinning the ICP;

- the priority programmes and key enabling programmes which the Partners agree to deliver together (The Barnsley Health and Care Plan);
- the ICP development plan (in outline – and which will be refined considerably once full guidance has been released to support the implementation of the Health and Care Bill) as referred to above; and
- other standard provisions for agreements of this nature, including dealing with conflicts of interest, confidentiality and a dispute resolution process.

12. Each Partner who signs up to the Place Agreement agrees to collaborate with the other Partners to deliver the vision, objectives and priorities and to act in accordance with the agreed collaborative principles. The Place Agreement provides a framework for the Partners to make aligned decisions respecting existing statutory duties and functions of the Partners. As a framework, the Place Agreement is designed to be flexible and to evolve over time; this is particularly important because of the upcoming period of transition in 2021/22 to formalise the place-based partnership for Barnsley.

13. It is important to note that the Place Agreement will <u>not</u>:

- override the existing statutory requirements / duties or governance arrangements of the Partner organisations;
- change or replace any existing service contracts;
- pool any funds; or
- transfer any staff.

14. The current thinking of the Design Team is that the Place Agreement should have a duration of 2 years from 1 June 2021, with a review taking place by Q4 2021/22 and at intervals as agreed thereafter (to reflect the transition period in 2021/22) so that it can be updated as agreed between the Partners. Subject to approval of the Partners, the Place Agreement will not be legally binding in its entirety, with limited clauses such as confidentiality being legally binding.

15. From a governance perspective, the Place Agreement will document the existing governance groups (the ICPG and the ICPDG) and their terms of reference, with the ICPG continuing to report to individual Partner boards (through Partner representatives) and providing updates to the Health and Wellbeing Board.

16. The future governance arrangements are to be developed and will need to take into account guidance issued by NHS England & Improvement (some now received, al lot more expected shortly), the Health & Care Bill (currently in Committee Stage in Parliament) and the approach developed by the ICS with Partners. It is anticipated, however, that the Health and Wellbeing Board would continue to play a central role in the ICP approach and the shift to a population health management model for Barnsley. The

	White Paper sets this out in broad terms and we expect further guidance on how the Health and Wellbeing Board will work together with the ICS and as part of a place-based partnership to be published in the coming months. **Timetable and Next Steps** 17. The **Compact** has been previously circulated to all partners, including the CCG GB, where it was accepted unchanged. 18. The draft Place Agreement is before GB today for approval, having been already approved by ICPG in July. 19. The CCG GB will be kept informed of developments in relation to the ICS and the ICP generally, including the implications for Barnsley of any guidance published centrally on place-based partnerships and the Health & Care Bill itself, in due course. •
6.	**THE GOVERNING BODY / COMMITTEE IS ASKED TO:**
	Recommendation 20. The CCG GB is asked to: • approve the draft Place Agreement, as a key stepping stone towards the establishment of a Place Based Partnership as part of South Yorkshire ICS from 1 April 2022.
7.	**APPENDICES / LINKS TO FURTHER INFORMATION**
	• Appendix 1 – Barnsley Place Agreement

Agenda time allocation for report:	

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	**X**	6.1 Efficiency Plans	X
2.1 Primary Care	**X**	7.1 Transforming Care for people with LD	X
3.1 Cancer	**X**	8.1 Maternity	X
3.2 Maximising Elective Activity	**X**	9.1 Digital and Technology	X
4.1 Mental Health	**X**	10.1 Compliance with statutory duties	X
5.1 Integrated Care @ System	**X**	11.1 Delivery of Enhanced Health in Care Homes	X
5.2 Integrated Care @ Place	**X**	12.1 Delivering The Covid Vaccination Programme & Meeting The Needs of Patients with Covid-19	X
5.3 Implementing Population Health Management And Personalised Care	**X**		

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 3.2**	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***
GB clinical commissioners contributed to Barnsley 2030 and the integrated care outcomes framework that informed the plan. GP clinical commissioners have been involved in the joint commissioning review and are members of the transformation board and enabler groups that contributed to the plan. The clinical Chair is a member of ICPG that formerly endorsed the plan.	

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***
The Chief Finance Officer is a member of the Efficiencies Executive is part of the Governance of the integrated care partnership and has responsibility for ensuring that service transformation delivers productivity gains for the system.	

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***
Quality assurance and improvement is one of the five cross-cutting themes of the plan. A QIA will be completed for each area of service transformation/development as appropriate in accordance with organisational policies and procedures.	

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***
Tackling health inequalities is one of the five cross-cutting themes of the plan. An EIA will be completed for each area of service transformation/development as appropriate in accordance with organisational policies and procedures.	

3.6 Public Involvement & Consultation (s14Z2)

Has a s14Z2: Patient and Public Participation Form been completed if relevant?	***Y***
Have any issues or risks identified been appropriately addressed having taken advice from the Head of Comms & Engagement if appropriate?	***Y***
The engagement and equality leads group has reviewed the plan and identified implications for public involvement and consultation. A report will be taken to ICDG for assurance and information and the transformation delivery groups for action in due course. Appropriate engagement and involvement will be completed for each area of service transformation/development as appropriate in accordance with organisational policies and procedures and principles agreed by the partnership. It is the ambition of the partnership to have more and better conversations with people to shape services and co-create health and wellbeing.	

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***
An Open Data Information Sharing group has been established involving information governance leads from across the partnership and will advise the partnership on related issues as required. A DPIA will produced for each relevant initiative and will be managed in accordance with organisational policy, procedures and best practice.	

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,	***NA***

	networks or Federations may be a bidder for a procurement opportunity?	
3.9	**Human Resources**	
	Have any significant HR implications been identified and managed appropriately, having taken advice from the HR Lead if appropriate?	***NA***
	The Barnsley Integrated Workforce Development Group comprises HR/workforce and professional leads from across the partnership and advises the partnership on related issues as required.	
3.10	**Environmental Sustainability**	
	Have any significant (positive or negative) impacts on the environment or the CCG's carbon footprint been identified?	***NA***
	An appropriate impact assessment will be undertake for each service development initiative in the plan and managed in accordance with relevant organisational policies and procedures.	

BARNSLEY PLACE AGREEMENT

DATE **2021**

1. NHS BARNSLEY CLINICAL COMMISSIONING GROUP

2. BARNSLEY METROPOLITAN BOROUGH COUNCIL

3. BARNSLEY HOSPITAL NHS FOUNDATION TRUST

4. SOUTH WEST YORKSHIRE PARTNERSHIP NHS FOUNDATION TRUST

5. BARNSLEY HEALTHCARE FEDERATION

6. BARNSLEY HOSPICE

7. BARNSLEY COMMUNITY AND VOLUNTARY SERVICES

BARNSLEY PLACE AGREEMENT

No	Date	Version Number	Author
1	09.03.21	1	Hill Dickinson
2	29.03.21	2	Hill Dickinson – following Design Team meetings 11.03.21 / 23.03.21
3	12.04.21	3	Hill Dickinson – minor updates to drafting plus incorporating comments from Wendy Lowder and Andrew Osborn
4	26.04.21	4	Hill Dickinson – updated diagram and governance Clause 12
5	17.05.21	5	Hill Dickinson – update to Clause 7
6	19.05.21	6	Hill Dickinson – update to incorporate provider collaboration wording and minor amendments from Design Team meeting 19.05.21
7	10.06.21	7	BNHFT mark up
8	18.06.21	8	Hill Dickinson – following BHNFT mark up
9	16.07.21	9	Hill Dickinson – insertion of footnote at 10.4; refs to Health and Care Plan and removal of Priority Programmes, and remit of ICDG included in line with TORs.
10	31.08.21	10	Addition of principle (section 7.3.15) to reflect feedback from July ICPG around Equality & Diversity.

BARNSLEY PLACE AGREEMENT

Contents

Overarching Note – Barnsley Place Agreement

This Agreement provides an overarching framework for the continued development of an integrated care partnership for Barnsley. The arrangements set out are intended to build on the existing integrated governance structures between the health and care partners in Barnsley, including the Integrated Care Partnership Group and the Integrated Care Delivery Group, and further strengthen relationships between the Partners for the benefit of the Barnsley population.

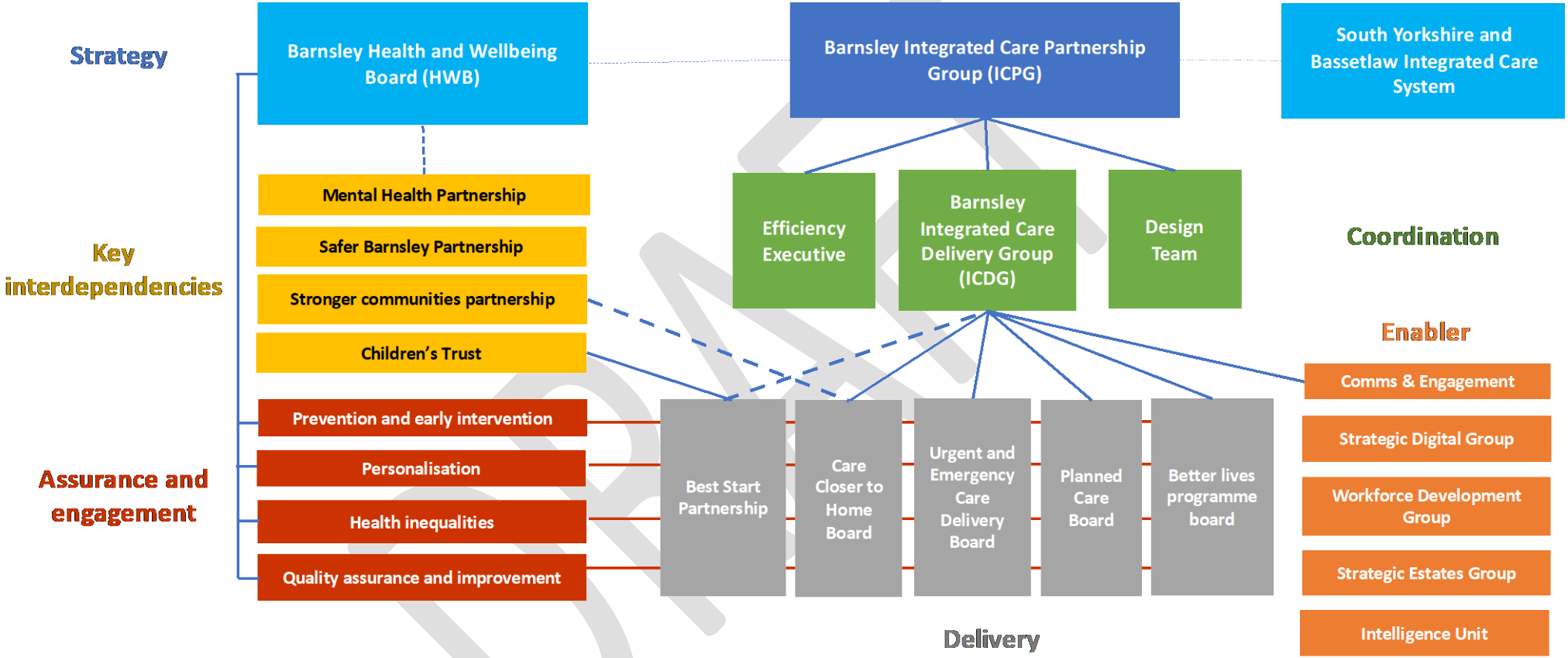
Figure 1 below includes a diagram illustrating the governance arrangements for Barnsley Integrated Care Partnership ("ICP") as at the Commencement Date.

This Agreement is designed to work alongside existing NHS Standard Contracts (commonly the Services Contract) and arrangements for the delivery of non-NHS care, support and community services via the Council to the extent such services are within the scope of the Agreement. The Agreement is only intended to be legally binding for specific elements, which are identified, such as confidentiality and intellectual property.

The Partners intend to work together under the governance framework set out in this Agreement to embed and further develop the ICP approach to ultimately include requirements in relation to population health outcomes, risk/gain share, and financial and contract management and regulatory requirements, as may be agreed between the Partners. The Partners acknowledge that 2021/22 will be a transitional year during which they will work together through this Agreement to implement a development plan (the ICP Development Plan – set out in Schedule 2) to create a thriving ICP for Barnsley which enables provider collaboration where this aligns with the ICP vision and objectives, and the Barnsley Health and Care Plan. The Partners intend to work towards documenting such arrangements as may be agreed in a formal legally binding agreement for April 2022, in line with the policy direction in respect of the development of Integrated Care Systems and place-based partnership set out in the White Paper, *"Integration and Innovation: working together to improve health and social care for all"* (February 2021).

The Partners will review progress made against the ICP Development Plan and the terms of this Agreement no later than September 2021 and at such intervals as the Partners may agree thereafter. The Partners may agree to either vary the Agreement to reflect developments or enter into a new agreement for April 2022.

FIGURE 1 – BARNSLEY INTEGRATED CARE PARTNERSHIP



BARNSLEY PLACE AGREEMENT

DATE: **2021**

This Place Agreement (the **Agreement**) is made between:

1. **NHS BARNSLEY CLINICAL COMMISSIONING GROUP** of 49, 51 Gawber Road, Barnsley, S75 2PY ("**CCG**");

2. **BARNSLEY METROPOLITAN BOROUGH COUNCIL** of 1 Westgate, Western Street, Barnsley, S70 2DR ("**Council**");

3. **BARNSLEY HOSPITAL NHS FOUNDATION TRUST** of Gawber Road, Barnsley, S75 2EP ("**BHNFT**");

4. **SOUTH WEST YORKSHIRE PARTNERSHIP NHS FOUNDATION TRUST** of Ouchthorpe Lane, Wakefield, WF1 3SP ("**SWYPFT**");

5. **BARNSLEY HEALTHCARE FEDERATION COMMUNITY INTEREST COMPANY** (Registered Company No: 09651047) of Oaks Park Primary Care Centre, Thornton Road, Barnsley, S70 3NE ("**BHF**");

6. **BARNSLEY HOSPICE** (Registered Charity No: 700586) of Church Street, Barnsley, S75 2RL ("**BH**"); and

7. **BARNSLEY COMMUNITY AND VOLUNTARY SERVICES** of Pontefract Road, Barnsley S71 5PN ("**CVS**");

together referred to in this Agreement as the "**Partners**".

The CCG and the Council (in its role as commissioner of social care and public health services) are together referred to in this Agreement as the "**Commissioners**".

BHFT, SWYPFT, BHF, BH, CVS and the Council (in its role as provider of social care services, whether directly or through contracting arrangements with third party providers) are together referred to in this Agreement as the "**Providers**".

BACKGROUND

(A) The NHS Five Year Forward View set out a clear goal that "*the NHS will take decisive steps to break down the barriers in how care is provided between family doctors and hospitals, between physical and mental health, between health and social care*". The NHS Long Term Plan, published in January 2019, provided a vision of health and care joined up locally around population needs.

(B) The white paper published by the Department of Health and Social Care in February

2021[1] (the "White Paper") builds on the NHS Long Term Plan vision and sets out the key components of an integrated care system ("ICS"). One of these components is "*strong and effective place-based partnerships*" in local places between the NHS, local government and key local partners, interfacing with a statutory ICS for South Yorkshire & Bassetlaw and provider collaboratives established both at Place and on a broader sector-based footprint.

(C) In addition, as at the Commencement Date, the Covid-19 pandemic is continuing, and the Partners acknowledge that they will need to continue to support each other and work in partnership through this Agreement to address the significant health and care challenges, including health inequalities, facing the people of Barnsley.

(D) The Partners have been working collaboratively across Barnsley to integrate services and provide care closer to home for local people for some time. This Agreement sets out the vision, objectives and shared principles of the Partners in supporting the further development of place-based health and care provision for the people of Barnsley using a population health management approach, building on the progress achieved by the Partners to date.

(E) The Partners will focus on delivery of the Barnsley Health and Care Plan to work towards specific outcomes over the term. Changes or additions to the Health and Care Plan may be identified by the Partners during the term of this Agreement as required to further the collaborative work of the Partners for the benefit of the population of Barnsley. The ICP governance framework will enable the Providers to collaborate in order to identify opportunities for service improvement or redesign in relation to the Health and Care Plan where such opportunities align with the Barnsley ICP vision and objectives.

(F) In light of the White Paper, the Partners recognise that from the Commencement Date until April 2022 they will need to undertake a programme of work through the governance arrangements set out in this Agreement to further develop their place arrangements to become a thriving ICP ready to manage Barnsley resources together for the benefit of the Barnsley population. This programme of work is set out, in initial outline terms, in the ICP Development Plan in Schedule 2 to this Agreement.

(G) The Commissioners are the statutory bodies responsible for planning, organising and buying social care, NHS-funded healthcare, support and community services for people who live in Barnsley.

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[1] *Integration and Innovation: working together to improve health and social care for all* (Integration and Innovation: working together to improve health and social care for all (publishing.service.gov.uk)

(H) The Providers (including the Council in its provider role) are together providers of social care, public health and education services, NHS funded healthcare services including primary care services, community and support services to the population of Barnsley.

(I) The Partners acknowledge that the delivery and development of the ICP will rely on both Commissioners and Providers working collaboratively rather than separately to plan financially sustainable methods of delivering integrated, population-focused services in furtherance of the Health and Care Plan and the ICP Development Plan.

(J) The Partners acknowledge that the Council has a dual role within the Barnsley health and care system as both a commissioner of social care and public health services but also as a provider of social care services either through direct delivery or through contracts with third party providers. In its role as commissioner of social care services the Council shall work in conjunction with the CCG and in its role as a provider of social care services the Council shall work in conjunction with the Providers. The Council recognises the need to and will ensure that any potential conflicts of interest arising from its dual role are appropriately identified and managed.

(K) This Agreement is intended to work alongside:

a) the Services Contracts; and

b) the Section 75 Agreement between the CCG and the Council.

IT IS AGREED AS FOLLOWS:

1. DEFINITIONS AND INTERPRETATION

1.1 In this Agreement, capitalised words and expressions shall have the meanings given to them in Schedule 1.

1.2 In this Agreement, unless the context requires otherwise, the following rules of construction shall apply:

1.2.1 a person includes a natural person, corporate or unincorporated body (whether or not having separate legal personality);

1.2.2 unless the context otherwise requires, words in the singular shall include the plural and in the plural shall include the singular;

1.2.3 a reference to a “Provider” or a “Commissioner” or any Partner includes its personal representatives, successors or permitted assigns;

1.2.4 a reference to a statute or statutory provision is a reference to such statute or provision as amended or re-enacted. A reference to a statute or statutory

provision includes any subordinate legislation made under that statute or statutory provision, as amended or re-enacted; and

1.2.5 any phrase introduced by the terms "**including**", "**include**", "**in particular**" or any similar expression shall be construed as illustrative and shall not limit the sense of the words preceding those terms.

2. STATUS AND PURPOSE OF THIS AGREEMENT

2.1 The Partners have agreed to work together on behalf of the people of Barnsley to further develop the ICP through which to identify and respond to the health and care needs of the Barnsley population, and deliver integrated health, support and community care to develop and ultimately deliver improved health and care outcomes for the people of Barnsley.

2.2 This Agreement sets out the key terms that the Partners have agreed, including:

2.2.1 the vision of the Partners, and key objectives for the development and delivery of integrated services in Barnsley and the Health and Care Plan;

2.2.2 the key principles that the Partners will comply with in working together through the ICP;

2.2.3 the governance structures underpinning the ICP; and

2.2.4 the initial Development Plan for the ICP for 2021/22, which the Partners will work together to implement through this Agreement.

2.3 Notwithstanding the good faith consideration that each Partner has afforded the terms set out in this Agreement, the Partners agree that, save as provided in Clause 2.4 below, this Agreement shall not be legally binding. The Partners each enter into this Agreement intending to honour all of their respective obligations.

2.4 This Clause 2.4, Clauses 10 (*Transparency*), 18 (*Liability*), 20 (*Confidentiality and FOIA*), 21 (*Intellectual Property*), 22.4 (*Counterparts*) and 22.5 (*Governing Law and Jurisdiction*) shall come into force from the date of this Agreement and shall give rise to legally binding commitments between the Partners.

2.5 Each of the Providers has one or more individual Services Contracts (or where appropriate combined Services Contracts) with the CCG or the Council. This Agreement will work alongside these Services Contracts and the Section 75 Agreement as appropriate.

2.6 Each of the Commissioners and the Providers agree to work together in a collaborative and integrated way on a Best for Barnsley basis and the Services Contracts set out how

the Providers provide Services to the Population. This Agreement is not intended to conflict with or take precedence over the terms of the Services Contracts or the Section 75 Agreement unless expressly agreed by the Partners.

3. APPROVALS

Each Partner acknowledges and confirms that as at the date of this Agreement, it has obtained all necessary authorisations to enter into this Agreement and that its own organisational leadership body has approved the terms of this Agreement.

4. DURATION AND REVIEW

4.1 This Agreement shall take effect on the Commencement Date and will continue in full force and effect and will expire on 31 March 2023 (the "**Initial Term**"), unless and until terminated in accordance with the terms of this Agreement.

4.2 At the expiry of the Initial Term this Agreement shall expire automatically without notice unless, no later than 3 months before the end of the Initial Term, the Partners agree in writing that the term of the Agreement shall be extended for a further term to be agreed between the Partners (the "**Extended Term**").

4.3 The Partners will review progress made against the ICP Development Plan and the terms of this Agreement by September 2021 and at such intervals thereafter as the Partners may agree. The Partners may agree to vary the Agreement to reflect developments as appropriate in accordance with Clause 19 (*Variations*).

SECTION A: VISION, OBJECTIVES AND PRINCIPLES

5. THE VISION

5.1 The Partners have agreed to work towards a common vision for the ICP as follows:

> *People of Barnsley are enabled to take control of their health and wellbeing and enjoy happy, healthy and longer lives, in safer and stronger communities, regardless of who they are and wherever they live.*

6. THE OBJECTIVES

6.1 The Partners have agreed to work together and to perform their duties under this Agreement in order to achieve the following Objectives:

6.1.1 Develop an integrated joined up health and care system where the people of Barnsley experience continuity of care – each Partner delivering their part without duplication;

6.1.2 Individuals, families and communities are empowered to take control wherever possible of their own health and wellbeing;

6.1.3 Shift the focus on treating patients with health problems to supporting the community to remain healthy in the first instance;

6.1.4 Embed integrated care that delivers the best value for the Barnsley pound;

6.1.5 Develop population health management approaches to improve health and wellbeing and reduce health inequalities;

6.1.6 Work towards becoming a thriving ICP in accordance with the ICP Development Plan for 2021/22 and beyond; and

6.1.7 Play a pivotal role in delivering our shared vision for Barnsley: a place of possibilities, set out in Barnsley 2030. A healthy, learning, growing and sustainable Barnsley.

6.2 The Partners acknowledge that they will have to make decisions together in order for the ICP arrangements to work effectively. The Partners agree that they will work together and make decisions on a Best for Barnsley basis in order to achieve the Objectives, save for the Reserved Matters listed at Clause 9.

7. THE PRINCIPLES

7.1 These Principles underpin the delivery of the Partners' obligations under this Agreement and set out key factors for a successful relationship between the Partners for the delivery of the ICP.

7.2 The Partners agree that the successful delivery of the ICP operating model will depend on their ability to effectively co-ordinate and combine their expertise and resources in order to deliver an integrated approach to the planning, provision and use of community assets and services across the Partners.

7.3 The Partners will work together in good faith and, unless the provisions in this Agreement state otherwise, the Partners will:

7.3.1 Aim for better health and wellbeing for the whole population, better quality care for all patients and sustainable services for the taxpayer alongside the reduction of health inequalities (the "quadruple aim");

7.3.2 Play our part in social and economic development and environmental sustainability of Barnsley and the wider South Yorkshire and Bassetlaw region;

7.3.3 Commit to making decisions at the right level and with the relevant partners at the ICP level to deliver the ICP vision and the Shared Purpose and benefit the population of Barnsley and the wider South Yorkshire and Bassetlaw region. Decisions should not adversely affect the outcomes or equity for populations within Barnsley or the ICS;

7.3.4 Ensure that the children's, young people and families' agenda is a key element of the ICP's work;

7.3.5 Support each other and work collaboratively to take decisions at the most local level as close as possible to the communities that we affect whether that be system, place or neighbourhood (subsidiarity);

7.3.6 Develop collaborative system leadership encompassing health, social care and wider system partners to deliver the ICP vision and the Shared Purpose, and a culture and values to support transformation. All members are respected and valued. They understand their own contribution and support the contributions of other members to the ICP vision and the Shared Purpose;

7.3.7 Strengthen clinical and professional leadership including general practitioners as expert generalists with the patient;

7.3.8 Enable the leadership role of citizens, communities and voluntary sector;

7.3.9 Strengthen the links between neighbourhoods, Place and the ICS and demonstrate inclusivity and shared ownership;

7.3.10 Make time and other resources available to develop the ICP and deepen working relationships between the Partners at all levels;

7.3.11 Be transparent with each other and the people of Barnsley and the wider South Yorkshire and Bassetlaw area around decisions and appointments;

7.3.12 Use the best available data to inform priorities and decision-making;

7.3.13 Look for simplicity and effectiveness in any ICP structures and governance and follow the rule of form following function;

7.3.14 Act with honesty and integrity and trust that each other will do the same. This includes each Partner being open about the interests of their organisation and any disagreement they have with a proposal or analysis. The Partners will assume that each acts with good intentions;

7.3.15 Value individuals, celebrate equality & diversity and be inclusive in all that we do;

7.3.16 Work to understand the perspective and impacts of their decisions on other parts of the health and social care system;

7.3.17 Adopt an asset based approach that is citizen-led, relationship orientated, asset based, place-based and inclusion focussed;

7.3.18 Provide a proactive and person-centred approach that empowers patients and addresses people's needs;

7.3.19 Improve quality and efficiency of services through sharing records, data and information including integrated information management and technology;

7.3.20 Support the delivery of more enhanced and specialised services in the community where appropriate;

7.3.21 Neighbourhood focus for delivery of services whilst ensuring services are wrapped around patients and aligned to GP practices;

7.3.22 Focus on self-care to promote independence and reduce pressures on the health and care system;

7.3.23 Focus on prevention including the wider determinants of health and understanding the perspective and impacts of our decision on other parts of the health and social care system

7.3.24 Maximise the agreed outcomes within the resources available to deliver best possible value for the Barnsley pound,

7.3.25 Promote and strive to adhere to the Nolan Principles of public life (selflessness, integrity, objectivity, accountability, openness, honesty and leadership) including:

7.3.26 Being accountable to each other for the performance of respective roles and responsibilities for the ICP and the ICS, in particular where there is an interface with other Partners;

7.3.27 Communicating openly about major concerns, issues or opportunities relating to this Agreement and adopt transparency as a core value, including through open book reporting and accounting, subject always to appropriate treatment of Commercially Sensitive Information if applicable;

7.3.28 Having conversations about supporting the wider health and care system, not just furthering our own organisation's interests;

7.3.29 Undertaking more aligned decision-making across the Partners and trying to commission and deliver services in an integrated way wherever reasonably possible;

7.3.30 Using insights from data to inform decision making;

7.3.31 Engaging positively with other partners in other geographies in pursuit of the aim described at 7.3.1 and effective planning and delivery;

7.3.32 Ensuring that problems are resolved where possible rather than being moved around the system; and

7.3.33 Acting promptly. Recognising the importance of integrated working and the ICP and responding to requests for support from other Partners,

and these are the "**Principles**".

8. PROBLEM RESOLUTION AND ESCALATION

8.1 The Partners agree to adopt a systematic approach to problem resolution which recognises the Objectives and the Principles set out in Clauses 6 and 7 above and which:

8.1.1 seeks solutions without apportioning blame;

8.1.2 is based on mutually beneficial outcomes;

8.1.3 treats the Partners as equal parties in the dispute resolution process; and

8.1.4 contains a mutual acceptance that adversarial attitudes waste time and money.

8.2 If a problem, issue, concern or complaint comes to the attention of a Partner in relation to the Objectives, Principles or any matter in this Agreement and is appropriate for resolution between the Commissioners and the Providers such Partner shall notify the other Partners and the Partners each acknowledge and confirm that they shall then seek to resolve the issue by a process of discussion within 20 Operational Days of such matter being notified.

8.3 Any Dispute arising between the Partners which is not resolved under Clause 8.2 above will be resolved in accordance with Schedule 4 (*Dispute Resolution Procedure*).

8.4 If any Partner receives any formal enquiry, complaint, claim or threat of action from a third party relating to this Agreement (including, but not limited to, claims made by a supplier or requests for information made under the FOIA relating to this Agreement) the receiving Partner will liaise with the Integrated Care Partnership Group as to the contents of any response before a response is issued.

SECTION B: OPERATION OF AND ROLES IN THE SYSTEM

9. RESERVED MATTERS

9.1 The Partners acknowledge that each of the Commissioners is required to comply with certain statutory duties as statutory commissioners. Consequently, the Commissioners each reserve the matters set out in Clause 9.2 for their respective determination as they see fit in accordance with Clause 9.3.

9.2 Each of the Commissioners shall be free to determine the following Reserved Matters:

9.2.1 making any decision or action where necessary to ensure compliance with their respective statutory duties, including the powers and responsibilities conferred on each of the Commissioners respectively by Law, its constitution or the Section 75 Agreement; or

9.2.2 any matter upon which they may be required to submit to public consultation or in relation to which they may be required to respond to or liaise with a local Healthwatch organisation.

9.3 The Partners agree that:

9.3.1 the Reserved Matters are limited to the express terms of Clause 9.2 above; and

9.3.2 the Integrated Care Partnership Group may not make a final recommendation on any of the matters set out in Clause 9.2 above, which are reserved for determination by either Commissioner respectively.

9.4 Where determining a Reserved Matter, subject to any need for urgency because to act otherwise would result in the relevant Commissioner breaching their statutory obligations, the relevant Commissioner will first consult with the Integrated Care Partnership Group in respect of their proposed determination of a Reserved Matter in line with the Objectives and the Principles.

9.5 Nothing in this Agreement obliges any Commissioner or Provider to act contrary to its respective statutory or regulatory obligations.

10. TRANSPARENCY

10.1 Subject to Clause 10.4, the Partners will provide to each other all information that is reasonably required in order to deliver the Health and Care Plan and implement the ICP Development Plan in line with the Objectives.

10.2 The Partners have responsibilities to comply with Law (including Competition Law). The Partners will make sure that they share information, and in particular Competition Sensitive Information, in such a way that is compliant with Competition Law and, accordingly, the Integrated Care Partnership Group and the Integrated Care Delivery Group will each ensure that the exchange of Competition Sensitive Information will be restricted to circumstances where:

10.2.1 it is essential;

10.2.2 it is not exchanged more widely than necessary;

10.2.3 it is subject to suitable non-disclosure or confidentiality agreements which include a requirement for the recipient to destroy or return it on request or on termination or expiry of this Agreement; and

10.2.4 it may not be used other than to achieve the Objectives in accordance with the Principles.

10.3 The Commissioners will make sure that the Integrated Care Delivery Group establishes appropriate information barriers between and within the Providers so as to ensure that Competition Sensitive Information and Confidential Information are only available to those Providers who need to see it to achieve the Objectives and for no other purpose whatsoever so that the Partners do not breach Competition Law.

10.4 It is accepted by the Partners that the involvement of the Providers in the governance arrangements for the ICP is likely to give rise to situations where information will be generated and made available to the Providers which could give the Providers an unfair advantage in competitions or which may be capable of distorting such competitions (for example, disclosure of pricing information or approach to risk may provide one Provider with a commercial advantage over a separate Provider). Any Provider will have the opportunity to demonstrate to the reasonable satisfaction of the CCG and/or the Council (where acting as a commissioner) in relation to any competitive procurements that the information it has acquired as a result of its participation in the ICP, other than as a result of a breach of this Agreement, does not preclude the CCG and the Council (where acting as a commissioner) from running a fair competitive procurement in accordance with their legal obligations. A Provider shall not be obliged to provide any

information which in its reasonable opinion would provide any other Partner with an unfair advantage in any competition or would distort competition.[2]

10.5 Notwithstanding Clause 10.4 above, the Commissioners may take such measures as they consider necessary in relation to such competitive procurements in order to comply with their obligations under Law which may include excluding any potential bidder from the competitive procurement in accordance with the Law governing that competitive procurement.

11. OBLIGATIONS AND ROLES OF THE PARTIES

Commissioners' obligations and role

11.1 Each Commissioner will:

11.1.1 help to maintain and further develop an environment that encourages collaboration between the Providers;

11.1.2 provide clarity on the resources available for Barnsley from their organisations clearly articulating health, care and support outcomes for the Providers, performance standards, scope of services and technical requirements;

11.1.3 support the Providers in developing links to other relevant services;

11.1.4 comply with their statutory duties;

11.1.5 seek to commission the services within the Health and Care Plan in an integrated, effective and streamlined way to meet the Objectives and in accordance with the Principles; and

11.1.6 work collaboratively with the Providers to develop the ICP approach for the Health and Care Plan and implement the ICP Development Plan.

Providers' obligations and role

11.2 Each Provider will:

11.2.1 act collaboratively and in good faith with each other in accordance with the Law and Good Practice to achieve the Objectives, having at all times regard to the best interests of the Population;

[2] This clause was discussed by the Partners at the ICPG meeting on 24th June 2021, and agreed following consideration of advice from Hill Dickinson.

11.2.2 co-operate fully and liaise appropriately with each other Provider in order to ensure a co-ordinated approach to promoting the quality of patient care and so as to achieve continuity in the provision of services within the Health and Care Plan that avoids inconvenience to, or risk to the health and safety of, Service Users, employees of the Providers or members of the public;

11.2.3 work collaboratively with any or all of the other Providers to identify and develop opportunities for service improvement/ redesign in line with the Objectives, including where such opportunities are identified by the Partners through the ICPG; and

11.2.4 through high performance and collaboration, unlock and generate enhanced innovation and better outcomes and value for the Population in line with the Objectives.

Commissioners' and Providers' obligations and role

11.3 Each of the Partners acknowledges and confirms that:

11.3.1 it remains responsible for performing its obligations in accordance with the Services Contracts to which it is party;

11.3.2 it will be separately and solely liable to the relevant counterparty or counterparties under its own Services Contracts;

11.3.3 it remains responsible for its own compliance with all relevant regulatory requirements and remains accountable to its board/cabinet and all applicable regulatory bodies; and

11.3.4 it will work collaboratively with the other Partners to develop the ICP approach for the Health and Care Plan and implement the ICP Development Plan.

SECTION C: GOVERNANCE ARRANGEMENTS

12. BARNSLEY INTEGRATED CARE PARTNERSHIP GOVERNANCE

12.1 In addition to the Partners' own Boards / Cabinet / Governing Body, which shall remain accountable for the exercise of each of the Partners' respective functions, the governance structure for the ICP arrangements will comprise:

12.1.1 the Barnsley Integrated Care Partnership Group (ICPG); and

12.1.2 the Barnsley Integrated Care Delivery Group (ICDG).

12.2 The diagram in Schedule 3 (*Governance*) sets out the governance structure and the links between the various groups in more detail.

Barnsley Integrated Care Partnership Group (ICPG)

12.3 The ICPG reports to Partner organisation boards and is the group responsible for:

12.3.1 overseeing the ICP arrangements under this Agreement;

12.3.2 reporting to Partner organisations on progress against the Objectives; and

12.3.3 liaising where appropriate with:

(a) national stakeholders (including NHS England and NHS Improvement); and

(b) South Yorkshire & Bassetlaw ICS,

to communicate the views of the ICP on matters relating to integrated care in Barnsley.

12.4 The ICPG will act in accordance with its terms of reference set out in Schedule 3 Part 1 and will:

12.4.1 provide visible leadership, direction and commitment to the Vision and Objectives for developing integrated care in Barnsley and ensuring effective governance, communication and delivery of the Objectives;

12.4.2 work together to achieve the Objectives through providing strategic and operational oversight, developing new models of joined up services including through referring specific opportunities for service improvement /redesign to collaboratives of some or all of the Providers (dependent on the opportunity);

12.4.3 providing shared responses to the South Yorkshire & Bassetlaw ICS on strategic developments including through nomination of ICP representatives to attend governance groups at ICS level as required;

12.4.4 produce shared communications;

12.4.5 develop shared strategies to enable the achievement of the Vision and Objectives;

12.4.6 develop a shared understanding of collective finances across the Partners with the ultimate aim of shared management of financial risk, and consider investment decisions across the ICP;

12.4.7 oversee and inform the work of the ICDG; and

12.4.8 have regard to the strategy developed by the Barnsley Health and Wellbeing Board; and

12.4.9 discharge the functions set out in its terms of reference, to the extent that they are not set out in this Clause 12.4.

12.5 Where the ICPG refers opportunities to a collaborative group of some or all of the Providers pursuant to Clause 12.4.2, the Providers involved may collaborate through existing governance groups (e.g. the ICDG), or set up specific task and finish groups, in either case aligning with the work of the ICDG and reporting into the ICPG. The scope and detail of delivery by the Providers of any such opportunities will be agreed by the relevant Partners through the ICPG and appended to this Agreement.

Barnsley Integrated Care Delivery Group

12.6 The ICDG is the group responsible for the oversight and delivery of the Health and Care Plan and the ICP Development Plan. The ICDG will report to the ICPG, acting in accordance with its Terms of Reference set out in Schedule 3 (*Governance*) Part 2 and will:

12.6.1 oversee and deliver the Health and Care Plan and the ICP Development Plan and report regularly to the ICPG and Partner organisation boards on progress;

12.6.2 ensure all risk is assessed and assure that mitigating actions are in place;

12.6.3 manage and utilise resources across the ICP to optimise service delivery;

12.6.4 work within the overall scope of the ICP, recognising that changes will be agreed during the course of its development and introduction. Where relevant make recommendations to the ICPG for changes to the Health and Care Plan and/or ICP Development Plan;

12.6.5 support programme boards to deliver their objectives and milestones as set out in the Health and Care Plan; and

12.6.6 discharge the functions set out in its terms of reference, to the extent that they are not set out in this Clause 12.6.

12.7 The Partners will communicate with each other clearly, directly and in a timely manner to ensure that the Partners (and their representatives) present at the ICPG and the ICDG are able to represent their nominating organisations to enable effective and timely recommendations to be made in relation to the Health and Care Plan and the ICP Development Plan.

12.8 Each Partner must ensure that its appointed members of the ICPG and the ICDG (or their appointed deputies/alternatives) attend all of the meetings of the relevant group and participate fully and exercise their rights on a Best for Barnsley basis and in accordance with Clause 5 (*Objectives*) and Clause 7 (*Principles*).

12.9 The Partners agree that, in line with the ICP Development Plan, the governance arrangements set out in this Clause 12 will be further refined over the Initial Term. A key principle agreed by the Partners is that the chair of the place-based partnership board (whether the ICPG or otherwise) for Barnsley in place by April 2022 will rotate between the Partner organisations.

13. CONFLICTS OF INTEREST

13.1 Subject to compliance with Law (including without limitation Competition Law) and contractual obligations of confidentiality the Partners agree to share all information relevant to the achievement of the Objectives in an honest, open and timely manner.

13.2 The Partners will:

13.2.1 disclose to each other the full particulars of any real or apparent conflict of interest which arises or may arise in connection with this Agreement or the operation of the ICPG or the ICDG immediately upon becoming aware of the conflict of interest whether that conflict concerns the Partner or any person employed or retained by them for or in connection with the performance of this Agreement;

13.2.2 not allow themselves to be placed in a position of conflict of interest in regard to any of their rights or obligations under this Agreement (without the prior consent of the other Partners) before they participate in any decision in respect of that matter; and

13.2.3 use best endeavours to ensure that their representatives on the ICPG and the ICDG also comply with the requirements of this Clause 13 when acting in connection with this Agreement.

SECTION D: FINANCIAL PLANNING

14. PAYMENTS

14.1 The Providers will continue to be paid in accordance with the mechanism set out in their respective Services Contracts.

14.2 The Partners have not agreed as at the Commencement Date to share risk or reward.

14.3 The Partners will work together during the Initial Term to consider the further development of system financial principles in accordance with the principles contained within the terms of reference of the Efficiency Executive (as set out in Part 3 of Schedule 3), including potential risk/reward sharing mechanisms.

SECTION E: FUTURE DEVELOPMENT OF THE ICP

15. ICP DEVELOPMENT PLAN

15.1 The Partners have agreed to work together to further develop, and implement, the ICP Development Plan using the South Yorkshire and Bassetlaw ICS ICP Development Matrix to enable maximum delegation to a weight-bearing Barnsley ICP able to receive and make decisions about Barnsley's resource allocation, the initial draft of which is set out in Schedule 2 (*ICP Development Plan*). The areas for development set out in the ICP Development Plan have been identified by the Partners as priorities for 2021/22 in order to ensure that the ICP is ready to transition to the new model of health and care planning and delivery in Barnsley by April 2022. The Partners will keep the ICP Development Plan under review through the governance structures set out in this Agreement and may agree to amend the ICP Development Plan as required during the Initial Term, in line with policy direction and legislative developments.

SECTION F: GENERAL PROVISIONS

16. EXCLUSION AND TERMINATION

16.1 A Partner may be excluded from this Agreement on notice from the other Partners (acting in consensus) in the event of:

16.1.1 the termination of their Services Contract; or

16.1.2 an event of Insolvency affecting them.

16.2 A Partner may withdraw from this Agreement by giving not less than 6 months' written notice to each of the other Partners' representatives.

16.3 A Partner may be excluded from this Agreement on written notice from all of the remaining Partners in the event of a material or a persistent breach of the terms of this Agreement by the relevant Partner which has not been rectified within 30 days of notification issued by the remaining Partners (acting in consensus) or which is not reasonably capable of remedy. In such circumstances this Agreement shall be partially terminated in respect of the excluded Partner.

16.4 The ICPG may resolve to terminate this Agreement in whole where:

16.4.1 a Dispute cannot be resolved pursuant to the Dispute Resolution Procedure; or

16.4.2 where the Partners agree for this Agreement to be replaced by a formal legally binding agreement between them.

16.5 Where a Partner is excluded from this Agreement, or withdraws from it, the excluded or withdrawing (as relevant) Partner shall procure that all data and other material belonging to any other Partner shall be delivered back to the relevant Partner or deleted or destroyed (as instructed by the relevant Partner) as soon as reasonably practicable.

17. INTRODUCING NEW PROVIDERS

Additional parties may become parties to this Agreement on such terms as the Partners shall jointly agree in writing, acting at all times on a Best for Barnsley basis. Any new Partner will be required to agree in writing to the terms of this Agreement before admission.

18. LIABILITY

The Partners' respective responsibilities and liabilities in the event that things go wrong with the Services will be allocated under their respective Services Contracts and not this Agreement.

19. VARIATIONS

Any amendment to this Agreement will not be binding unless set out in writing and signed by or on behalf of each of the Partners.

20. CONFIDENTIALITY AND FOIA

20.1 Each Partner shall keep confidential all Confidential Information that it receives from the other Partners except to extent such Confidential Information is required by Law to be disclosed or is already in the public domain or comes into the public domain otherwise than through an unauthorised disclosure by a Partner to this Agreement.

20.2 To the extent that any Confidential Information is covered or protected by legal privilege, then disclosing such Confidential Information to any Partner or otherwise permitting disclosure of such Confidential Information does not constitute a waiver of privilege or of any other rights which a Partner may have in respect of such Confidential Information.

20.3 The Partners agree to procure, as far as is reasonably practicable, that the terms of this Clause 20 (*Confidentiality and FOIA*) are observed by any of their respective successors, assigns or transferees of respective businesses or interests or any part thereof as if they had been party to this Agreement.

20.4 Nothing in this Clause 20 (*Confidentiality and FOIA*) will affect any of the Partners' regulatory or statutory obligations, including but not limited to competition law of any applicable jurisdiction.

20.5 The Partners acknowledge that some of them are subject to the requirements of the FOIA and will facilitate each other's compliance with their information disclosure requirements, including the submission of requests for information and handling any such requests in a prompt manner and so as to ensure that any Partner which is subject to FOIA is able to comply with their statutory obligations.

21. INTELLECTUAL PROPERTY

21.1 In order to develop and deliver the arrangements under this Agreement in accordance with the Principles each Partner grants each of the other Partners a fully paid up, non-exclusive licence to use its existing Intellectual Property insofar as is reasonably required for the sole purpose of the fulfilment of that Partner's obligations under this Agreement.

21.2 If any Partner creates any new Intellectual Property through the development and delivery of the arrangements under this Agreement, the Partner which creates the new Intellectual Property will grant to the other Partners a fully paid up, non-exclusive licence to use the new Intellectual Property for the sole purpose of the fulfilment of that Partner's obligations and the development and delivery of the arrangements under this Agreement.

22. GENERAL

22.1 Any notice or other communication given to a Partner under or in connection with this Agreement shall be in writing, addressed to that Partner at its principal place of business or such other address as that Partner may have specified to the other Partner in writing in accordance with this Clause, and shall be delivered personally, or sent by pre-paid first class post, recorded delivery or commercial courier.

22.2 A notice or other communication shall be deemed to have been received: if delivered personally, when left at the address referred to in Clause 22.1 above; if sent by pre-paid first class post or recorded delivery, at 9.00 am on the second Operational Day after posting; or if delivered by commercial courier, on the date and at the time that the courier's delivery receipt is signed.

22.3 Nothing in this Agreement is intended to, or shall be deemed to, establish any partnership between any of the Partners, constitute any Partner the agent of another Partner, nor authorise any Partner to make or enter into any commitments for or on behalf of any other Partner except as expressly provided in this Agreement.

22.4 This Agreement may be executed in any number of counterparts, each of which when executed and delivered shall constitute an original of this Agreement, but all the counterparts shall together constitute the same agreement. The expression "counterpart" shall include any executed copy of this Agreement scanned into printable PDF, JPEG, or other agreed digital format and transmitted as an e-mail attachment. No counterpart shall be effective until each Partner has executed at least one counterpart.

22.5 This Agreement, and any dispute or claim arising out of or in connection with it or its subject matter or formation (including non-contractual disputes or claims), shall be governed by, and construed in accordance with, English law, and where applicable, the Partners irrevocably submit to the exclusive jurisdiction of the courts of England and Wales.

22.6 A person who is not a Partner to this Agreement shall not have any rights under or in connection with it.

This Agreement has been entered into on the date stated at the beginning of it.

Signed by [insert] .....

for and on behalf of **NHS BARNSLEY CLINICAL COMMISSIONING GROUP** [ ]

Signed by [insert] .....

for and on behalf of **BARNSLEY METROPOLITAN BOROUGH COUNCIL** [ ]

Signed by [insert] .....

for and on behalf of **BARNSLEY HOSPITAL NHS FOUNDATION TRUST** [ ]

Signed by [insert] .....

for and on behalf of **SOUTH WEST YORKSHIRE PARTNERSHIP NHS FOUNDATION TRUST** [ ]

Signed by [insert]

for and on behalf of **BARNSLEY HEALTHCARE FEDERATION** .....

[ ]

Signed by [insert] .....

for and on behalf of **BARNSLEY HOSPICE** [ ]

Signed by [insert] .....

for and on behalf of **BARNSLEY COMMUNITY AND VOLUNTARY SERVICES** [ ]

Healthwatch Barnsley *is the independent consumer champion created to gather and represent the views of the public in Barnsley. As it does not exist as a separate legal entity, it is not a Party to this Agreement and cannot be bound by the terms of this Agreement, but signs this Agreement below to confirm its support for the ICP, its vision, objectives and principles, and agrees to participate in the ICP governance structure.*

Signed by [insert] .....

for and on behalf of **HEALTHWATCH BARNSLEY** [ ]

SCHEDULE 1

Definitions and Interpretation

1. The following words and phrases have the following meanings:

Agreement	this agreement incorporating the Schedules.
Best for Barnsley	best for the achievement of the Objectives and the Outcomes for the Barnsley population on the basis of the Principles.
Commencement Date	the date entered on page one (1) of this Agreement.
Commercially Sensitive Information	Confidential Information which is of a commercially sensitive nature relating to a Partner, its intellectual property rights or its business or which a Partner has indicated would cause that Partner significant commercial disadvantage or material financial loss.
Competition Law	the Competition Act 1998 and the Enterprise Act 2002, as amended by the Enterprise and Regulatory Reform Act 2013 and as applied to the healthcare sector by Monitor in accordance with the Health and Social Care Act 2012.
Competition Sensitive Information	Confidential information which is owned, produced and marked as Competition Sensitive Information by one of the Partners and which that Partner properly considers is of such a nature that it cannot be exchanged with the other Partners without a breach or potential breach of Competition Law. Competition Sensitive Information may include, by way of illustration, trade secrets, confidential financial information and confidential commercial information, including without limitation, information relating to the terms of actual or proposed contracts or sub-contract arrangements (including bids received under competitive tendering), future pricing, business strategy and costs data, as may be utilised, produced or recorded by any Partner, the publication of which an organisation in the same business would reasonably be able to expect to protect by virtue of business confidentiality provisions.
Confidential Information	the provisions of this Agreement and all information which is secret or otherwise not publicly available (in both cases in its entirety or in part) including commercial, financial, marketing or technical information, know-how, trade secrets or business methods, in all cases whether disclosed orally or in writing before or after the date of this Agreement, including

	Commercially Sensitive Information and Competition Sensitive Information.
Dispute	any dispute arising between two or more of the Partners in connection with this Agreement or their respective rights and obligations under it.
Dispute Resolution Procedure	the procedure set out in Schedule 4 for the resolution of disputes which are not capable of resolution under Clause 8 (*Problem Resolution and Escalation*).
Efficiency Executive	the Efficiency Executive, the terms of reference for which are set out in Part 3 of Schedule 3 (Governance).
Extended Term	has the meaning set out in Clause 4.2.
FOIA	the Freedom of Information Act 2000 and any subordinate legislation (as defined in section 84 of the Freedom of Information Act 2000) from time to time together with any guidance and/or codes of practice issued by the Information Commissioner or relevant Government department in relation to such Act.
Good Practice	Good Clinical Practice and/or Good Health and/or Social Care Practice (each as defined in the Services Contracts), as appropriate.
Health and Care Plan	the Barnsley Health and Care Plan, available at: https://www.barnsleyccg.nhs.uk/barnsley-integrated-health-and-care-plan
ICDG	the Integrated Care Partnership Delivery Group, the terms of reference for which are set out in Part 2 of Schedule 3 (*Governance*).
ICP	Integrated Care Partnership.
ICPG	the Barnsley Integrated Care Partnership Group, the terms of reference for which are set out in Part 1 of Schedule 3 (Governance).
ICP Development Plan	the initial ICP Development Plan set out in Schedule 2 (*ICP Development Plan*).
ICS	Integrated Care System.
Initial Term	the period from and including the Commencement Date until 31 March 2023.
Insolvency	(as may be applicable to each Partner) a Partner taking any step or action in connection with its entering administration, provisional

	liquidation or any composition or arrangement with its creditors (other than in relation to a solvent restructuring), being wound up (whether voluntarily or by order of the court, unless for the purpose of a solvent restructuring), having a receiver appointed to any of its assets or ceasing to carry on business.
Intellectual Property	patents, rights to inventions, copyright and related rights, trade marks, business names and domain names, goodwill, rights in designs, rights in computer software, database rights, rights to use, and protect the confidentiality of, Confidential Information and all other intellectual property rights, in each case whether registered or unregistered and including all applications and rights to apply for and be granted, renewals or extensions of, and rights to claim priority from, such rights and all similar or equivalent rights or forms of protection which subsist or will subsist now or in the future in any part of the world.
Law	a) any applicable statute or proclamation or any delegated or subordinate legislation or regulation; b) any applicable judgment of a relevant court of law which is a binding precedent in England and Wales; c) Guidance (as defined in the NHS Standard Contract); d) National Standards (as defined in the NHS Standard Contract); and e) any applicable code.
NHS Standard Contract	the NHS Standard Contract for NHS healthcare services as published by NHS England from time to time.
Objectives	the objectives for the ICP set out in Clause 6.1.
Operational Days	a day other than a Saturday, Sunday or bank holiday in England.
Population	the population of Barnsley covered by each of the Commissioners.
Principles	the principles for the ICP set out in Clause 7.
Reserved Matter	has the meaning set out in Clause 9.2.
Section 75 Agreement	the agreement entered into by the Commissioners under section 75 of the National Health Service Act 2006 to commission the services listed in the Schedules to that agreement.
Service Users	people within the Barnsley population served by the Commissioners and who are in receipt of the Services.

Services	the services provided, or to be provided, by each Provider to Service Users pursuant to its respective Services Contract.
Services Contract	a contract entered into by one of the CCG or the Council and a Provider for the provision of Services, and references to a Services Contract include all or any one of those contracts as the context requires.
Shared Purpose	the shared purpose of the South Yorkshire & Bassetlaw ICS to deliver the quadruple aim (better health, care, value and reduced inequalities) in order to: improve population health outcomes; and reduce health inequalities for the population of South Yorkshire & Bassetlaw.

SCHEDULE 2

ICP Development Plan 2021/22

1. The Partners will work together, through the governance structures set out in this Agreement to develop the ICP during the Initial Term in line with the specific areas of focus set out in the outline ICP Development Plan set out below:

Development area	Proposed focus / Must Do's
Governance	Development of the current Barnsley integrated governance arrangements to include: • Develop proposals for a weight-bearing partnership structure (function then form) that can receive a delegated budget from the ICS and make collective decisions about resource allocation from the future ICS and other sources • Define and agree a place provider collaborative(s) with defined scope of services/pathway, resources and governance arrangements • Develop detailed place operating model for agreed weight bearing structure to include Governance, Infrastructure/Functions, Resources/Skills, Systems and Processes. • Develop ICP implementation rollout plan to transition to new weight bearing structure • Determine place based leadership team in accordance with agreed weight bearing model, with roles/responsibilities clearly articulated • Establish a clinal and professional forum/senate that is incorporated into the revised place based governance structure
Workforce / HR	• Develop an integrated organisational development programme • Investment by Partners in the development of the relationships between Partners that underpin working at Place, at all levels of seniority. Including investment of staff time and possibly also external resource to support organisational development. • Plans to improve flexibility of movement between organisations and development of joint appointments • Workforce resources that can be utilised by Place (e.g. former CCG staff now at the ICS and or staff employed by Partners)

Development area	Proposed focus / Must Do's
	have been identified and consideration given to the practicalities of line management/ secondments etc. • Skills mapping exercise and developing a plan to ensure that workforce needs are aligned to population health needs.
Shared functions across the ICP	Identifying functions which could be more integrated, shared and managed by the ICP across place (e.g. BI, safeguarding, quality)
Financial framework	• Consider how the financial flow and allocation mechanism will work within the ICP and to operate in shadow form a place P&L from September 21. (in accordance with ICS design framework and subsequent guidance). • Clear financial principles have been developed and will need to be tested against the initial priority areas where possible and link into the governance and delegation work described above.
Contracting	• Develop a clear contracting model from the ICP to provider parties. Link this to the development of the finance, governance and delegation processes at ICP and discussions with the ICS in terms of the proposed model of delegation. • Identify the elements which will be picked up at ICS level and work through how the ICP based arrangements should operate from April 2022.
Quality	Consider the quality principles for the ICP and bring the process for consideration of quality into line with finance for a linked process when making/taking decisions.
Population Health & BI	• Further development and embedding of the integrated dashboard, that supports the delivery of the Barnsley health and care plan. • Developing capacity to have a joint approach to data infrastructure, sharing and governance to enable: the forecasting of the population risk profile for the Place footprint • Develop approach to ensure there is a clear understanding across Place / Provider Collaborative of the population health needs and this is driving the delivery of strategy / plans and approach
Public and patient engagement	• Development of an integrated engagement strategy/framework • Engagement built in to emerging governance structures. • Engagement carried out regarding the new ways of working and used to inform service development

SCHEDULE 3

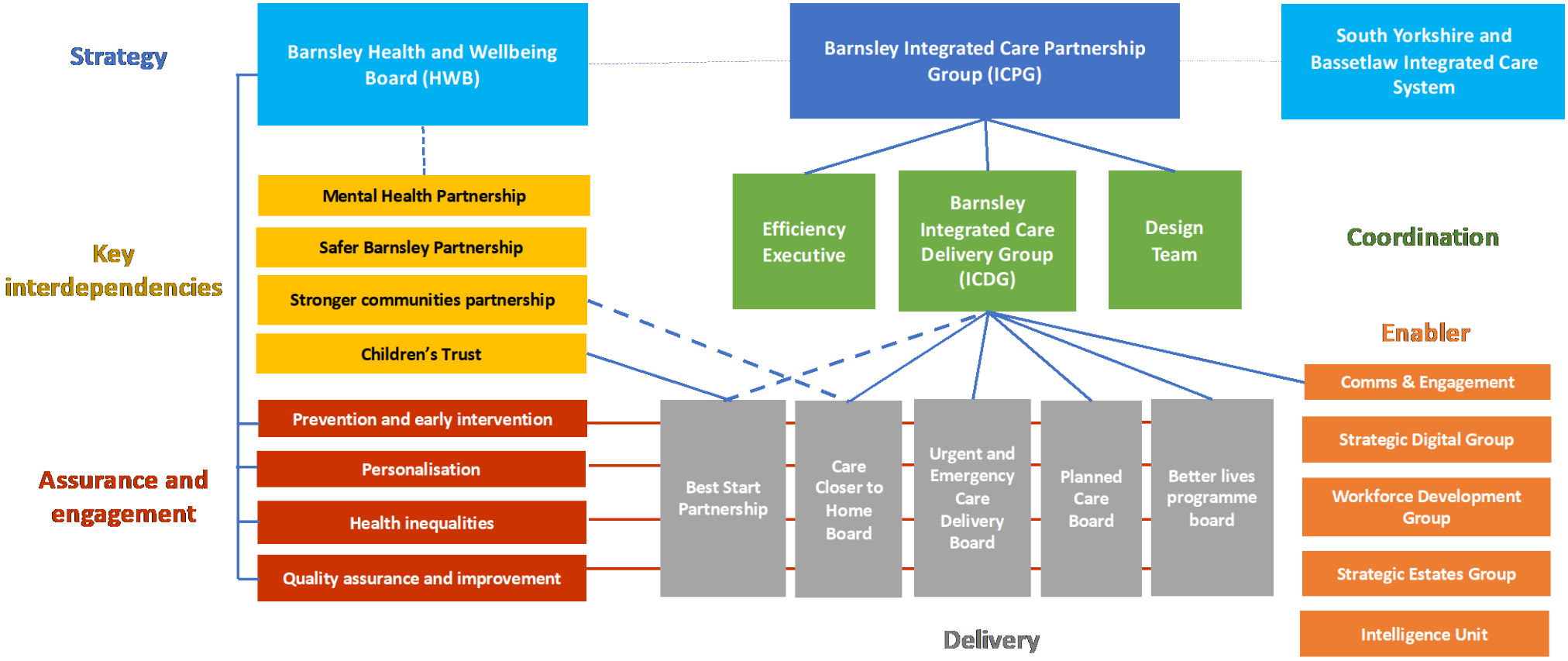
Governance

This Schedule 3 sets out the governance arrangements for the ICP under this Agreement.

The diagram below summarises the governance structure which the Partners have agreed to establish and operate from the Commencement Date, to provide oversight of the development and implementation of the ICP approach and the arrangements under this Agreement.

This Schedule also contains the terms of reference for the ICPG and the ICDG.

Overview of the Barnsley ICP governance model



Part 1 – Barnsley Integrated Care Partnership Group - Terms of Reference

Part 2 – Barnsley Integrated Care Delivery Group – Terms of Reference

Part 3 – Barnsley Efficiency Executive – Terms of Reference

SCHEDULE 4

Dispute Resolution Procedure

1. Avoiding and Solving Disputes

1.1 The Partners commit to working cooperatively to identify and resolve issues to the Partners' mutual satisfaction so as to avoid all forms of dispute or conflict in performing their obligations under this Agreement. Accordingly the Partners will look to collaborate and resolve differences under Clause 8 (*Problem Resolution and Escalation)* of this Agreement prior to commencing this procedure.

1.2 The Partners believe that by focusing on their agreed Objectives and Principles they are reinforcing their commitment to avoiding disputes and conflicts arising out of or in connection with the ICP arrangements set out in this Agreement.

1.3 The Partners shall promptly notify each other of any dispute or claim or any potential dispute or claim in relation to this Agreement or the operation of the ICP (each a '**Dispute**') when it arises.

1.4 In the first instance the relevant Partners' representatives shall meet with the aim of resolving the Dispute to the mutual satisfaction of the relevant Partners. If the Dispute cannot be resolved by the relevant Partners' representatives within 10 Operational Days of the Dispute being referred to them, the Dispute shall be referred to senior officers of the relevant Partners, such senior officers not to have had direct day-to-day involvement in the matter and having the authority to settle the Dispute. The senior officers shall deal proactively with any Dispute on a Best for Barnsley basis in accordance with this Agreement so as to seek to reach a unanimous decision.

1.5 The Partners agree that the senior officers may, on a Best for Barnsley basis, determine whatever action it believes is necessary including the following:

1.5.1 If the senior officers cannot resolve a Dispute, they may agree by consensus to select an independent facilitator to assist with resolving the Dispute; and

1.5.2 The independent facilitator shall:

(i) be provided with any information he or she requests about the Dispute;

(ii) assist the senior officers to work towards a consensus decision in respect of the Dispute;

(iii) regulate his or her own procedure;

(iv) determine the number of facilitated discussions, provided that there will be not less than three and not more than six facilitated discussions, which must take place within 20 Operational Days of the independent facilitator being appointed or such longer period as may be agreed between the Partners in Dispute; and

(v) have its costs and disbursements met by the Partners in Dispute equally.

1.5.3 If the independent facilitator cannot resolve the Dispute, the Dispute must be considered afresh in accordance with this Schedule 4 and only after such further consideration again fails to resolve the Dispute, the Partners may agree to:

(i) terminate this Agreement in accordance with Clause 16.1.1; or

(ii) agree that the Dispute need not be resolved.

Barnsley Integrated Care Partnership Group

Terms of Reference

Barnsley Integrated Care Partnership Group

1.	**Introduction**	
	1.1	Barnsley Metropolitan Borough Council (BMBC), Barnsley Hospital NHS Foundation Trust (BHNFT), South West Yorkshire Partnership NHS Foundation Trust (SWYPFT), Barnsley Healthcare Federation (BHF) and Barnsley Clinical Commissioning Group (BCCG) have, as partners, agreed to explore and develop an integrated system of health and social care in Barnsley working with other partners including Barnsley CVS, Healthwatch Barnsley and Barnsley Hospice.
	1.2	Together we will develop a model for integrated services that joins up care around the mental, physical and social needs of people. In doing so, we will help deliver the Barnsley health and care plan and ICP development plan.
	1.3	Partners have agreed to work towards a common vision for the Integrated Care Partnership (ICP) as follows: *People of Barnsley are enabled to take control of their health and wellbeing and enjoy happy, healthy and longer lives, in safer and stronger communities, regardless of who they are and wherever they live.*
	1.4	The Partners have agreed to work together and to perform their duties under a place agreement in order to achieve the following objectives: • Develop an integrated joined up health and care system where the people of Barnsley experience continuity of care – each Partner delivering their part without duplication; • Individuals, families and communities are empowered to take control wherever possible of their own health and wellbeing; • Shift the focus on treating patients with health problems to supporting the community to remain healthy in the first instance; • Embed integrated care that delivers the best value for the Barnsley pound; • Develop population health management approaches to improve health and wellbeing and reduce health inequalities; • Work towards becoming a thriving ICP in accordance with the ICP Development Plan for 2021/22 and beyond; and • Play a pivotal role in delivering our shared vision for Barnsley: a place of possibilities, set out in Barnsley 2030. A healthy, learning, growing and sustainable Barnsley.
2.	**Purpose**	
	2.1	Provide visible leadership, direction and commitment to the Vision and Objectives for developing integrated care in Barnsley and ensuring effective governance, communication and delivery of the Objectives.

	2.2	Work together to achieve the Vision and Objectives of the partnership through:
		• providing strategic and operational oversight
		• developing new models of joined up services in communities that:
		  ○ set out a new relationship with residents in neighbourhoods
		  ○ are person centred, with a focus on supported self-care, prevention and asset based
		  ○ ensure that services developed in neighbourhoods and new primary care networks are complementary in both services and governance.
		  ○ take a 'one public sector – one borough - one team' approach
		• providing shared responses to the South Yorkshire & Bassetlaw Integrated Care System (SYBICS) strategic developments on primary care networks and other associated integration requirements, including the horizontal provider collaboratives
		• producing shared communications
		• developing shared information governance and record keeping
		• developing a shared workforce strategy
		• developing a shared understanding of collective finances with the aim of a shared management of financial risk
		• considering investment decisions across the partnership
		• having regard to the strategy developed by the Barnsley Health and Wellbeing Board
		Ultimately this will ensure that we work together to drive efficiencies and better outcomes for the residents of Barnsley, in line with the Barnsley Plan.

	2.3	Provide mutual assurance to the constituent bodies through regular reports to the Boards of the constituent bodies.
	2.4	Oversee and inform the work of the ICDG providing support and strategic decision making either directly, within their scope of delegated authority, or by making recommendations to sovereign organisation Boards/relevant decision making bodies.
	2.5	Review and if appropriate, adapt the Programmes objectives, milestones and governance in light of internal or external strategic changes.
3.	**Responsibilities**	
	3.1	Operate within the authority delegated to it by the constituent governing bodies/Boards
	3.2	Provide mutual assurance to the constituent bodies through regular reports to the Boards of the constituent bodies/boards
	3.3	Reflect the underlying principles as set out within the Barnsley place agreement.
	3.4	To review progress and guide the Programme (health and care plan and

		ICP development plan) towards the overall agreed objectives and benefits.	
	3.5	Ensure all risk is assessed and assure that mitigating actions are in place.	
	3.6	Make best use of the Barnsley £ putting Barnsley people first ahead of the needs of individual partner organisations. In doing so, to collectively manage risk through effective arrangements between partner organisations that meet regulatory requirements and develop a collective voice in managing our position with the SYBICS.	
	3.7	Work within the overall scope of the Programme, recognising that changes will be agreed during the course of its development and introduction.	
	3.8	Support the ICDG to deliver the Programme objectives in line with the agreed Integrated Care Operating Principles.	
	3.9	Strategic decision making for issues raised by the ICDG within the scope of delegated authority.	
	3.10	The ICPG will help to develop clinical models and partnership priorities in line with mature partnership arrangements. For the avoidance of doubt, the ICPG will not have the final decision on clinical/operational models or the commissioning intentions of the CCG, as the CCG is not legally allowed to delegate its commissioning decisions.	
4.	**Membership**		
	4.1	The membership of the ICP will be:	
		4.1.1	Partner organisation rotation - Chair
		4.1.2	BHNFT – Chief Executive
		4.1.3	BHNFT – Chair
		4.1.4	BMBC – Leader of the Council (or delegated councillor)
		4.1.5	BMBC Chief Executive (or delegated Director)
		4.1.6	BHF – Chief Executive
		4.1.7	BHF – Chair
		4.1.8	SWYPFT – Chair
		4.1.9	SWYPFT – Chief Executive Officer
		4.1.10	Barnsley Hospice- Chief Executive
		4.1.11	Barnsley Voluntary Services- Chief Executive
		4.1.12	Barnsley Clinical Commissioning Group- Chair
		4.1.13	Barnsley Clinical Commissioning Group- Accountable Officer
		4.1.14	Barnsley PCN -Chair or Chief Executive
	4.2	In attendance of the ICP will be:	
		4.2.1	Healthwatch – Chair
		4.2.2	Integrated Care Delivery Group executive members
	4.3	Membership will be reviewed and adjusted as necessary to ensure the ICP meets its responsibilities. All members (as set out in 4.1) are voting members.	
	4.4	With effect from 1 April 2022, the role of Chair of the ICPG will be rotated to another member of the ICPG as agreed by the members in accordance with paragraph 5.1 below. This will be undertaken on an annual basis at the beginning of every financial year.	
	4.5	The same organisation cannot hold the chair position in both the ICPG and the ICDG at the same time.	
5.	**Voting and Quorum:**		
	5.1	The Board will operate through the development of a consensus and within its delegated authority.	

	5.2	The Board will be quorate when at least half of the membership is present.
	5.3	Deputies may be nominated to attend, although there should be a clear and consistent intention to attend by each appointed member.
	5.4	Any organisation failing to send a representative for two consecutive meetings will be asked to confirm their commitment.
6.	**Reporting Arrangements**	
	6.1	Formal minutes will be completed from the meeting. This is a private meeting between member organisations. However in the interests of good governance and promoting transparency the minutes relevant to a wider public audience can be taken in the public section of the member organisation' sovereign Boards.
	6.2	The constituent members of the ICPG are responsible for providing feedback on a regular basis to their member organisations' Boards/ relevant decision making bodies.
7.	**Administration**	
	7.1	The ICPG will be administered by the organisation of the chair.
8.	**Frequency**	
	8.1	The ICPG will meet on a monthly basis.
9.	**Code of Conduct**	
	9.1	The ICPG shall conduct its business in accordance with national guidance, and relevant codes of practice including the Nolan Principles.
10.	**Review**	
	10.1	The ICPG should review on a regular basis its own performance, membership and terms of reference. These ToR and any resulting changes to the terms of reference or membership should be approved by the member organisations' Boards/relevant decision making bodies.

Barnsley Efficiency Executive

Terms of Reference

Barnsley Efficiency Executive

1. Introduction

1.1. Delivering against the principles agreed by the Barnsley Health and Care Partnership which include:

1.1.1. Improved outcomes for Barnsley people

1.1.2. Care closer to home where appropriate and supporting the left shift in investment to enable this

1.1.3. Ensuring value for money in how we agree to use the Barnsley £

1.1.4. Collective commitment to meeting all of the investment standards set out in the Long Term Plan.

1.1.5. Taking mutual accountability and responsibility to support each other to deliver the 2020/21 plan for local people

1.1.6. A population health management approach to develop strategies to improve the health and wellbeing of the population

1.1.7. Acknowledging the risks our plan may pose to individual organisations throughout the year and working collectively to mitigate these.

1.2. In an increasingly challenging financial environment, it is important that the partnership has a robust mechanism for identifying and implementing opportunities to maximise the value (in terms of health outcomes) of its resources and ensuring that expenditure does not exceed the Barnsley place health and care financial allocation.

1.3. QIPP/CIP is the term commonly used to describe cost-improvement programmes that aim to improve or maintain quality of care at the same time as delivering efficiencies. (QIPP- quality, innovation, productivity, and prevention/CIP – Cost improvement programme).

2. Purpose

2.1. The Efficiency Executive will be the focal point for managing the PMO process ensuring a collective approach and responsibility for delivery. It will both support and hold to account clinical leads, management and project leads responsible for the delivery of efficiency projects and provide assurance to the partnership on the delivery of these programmes.

3. Responsibilities

3.1. The Efficiency Executive will manage projects in stages, following PRINCE2 methodology applied proportionately according to the scale, complexity and level of risk involved in the delivery of individual projects.

Key responsibilities are:

3.2. To review plans for proposed projects and, if appropriate, authorise the development of project initiation documents (PID), privacy impact assessment (PIA), quality impact assessment (QIA), equality impact assessment (EIA), risk and issues logs and a project plan.

3.3. To ensure each project has clear data to support delivery of efficiency using all data sources available such as NHS RightCare packs, Model Hospital. Patient Level Information Costing systems and other finance systems will also be utilised to ensure cost information is linked through to cash releasing efficiency appropriately.

3.4. To ensure transparency and open book principles across organisations to deliver the best outcome for the people of Barnsley.

3.5. To ensure that any agreed actions are taken forward and any changes to project documentation amended as appropriate.

3.6. To routinely monitor live projects against the delivery milestones through the receipt of regular (usually monthly) highlight reports developed and submitted by the project team.

3.7. To receive and review ad hoc exception reports from the project team when significant issues are likely to affect the delivery of a project, or the premise upon which the business case for the project is called into question. Only issues that cannot be reasonably managed locally within the project environment should be escalated to the Efficiency Executive.

3.8. To give direction to projects as required, with clear timescales and objective agreed at the start of each programme of work.

3.9. To authorise the closure of a project once all milestones are completed and the benefits are being realised or exceptional circumstances invalidate the premise upon which the business case for the project is based.

3.10. To review and approve a programme dashboard that summarises the progress of projects within the programme both in terms of meeting milestones and realising benefits.

3.11. To report progress to the partnership and within individual organisations.

3.12. To ensure that lessons learnt through the development and implementation of projects are appropriately responded to and fed back across the partnership as a whole.

4. Membership

4.1. Core members:

- Directors of Finance from each partner organisation (CCG, BHNFT, BMBC, SWYPFT)
- Director of Strategic Planning and Performance (CCG)
- Chief Delivery Officer (BHNFT)
- Director of Strategy (SWYPFT)
- Executive Director – Adults and Communities (BMBC)
- Chief Operating Officer (BHF)

4.2. Required members (as required)

- PMO support
- Programme leads
- Project Managers
- Other officers as required

5. Quorum

5.1. Quorum is four core members, one of whom should be a representative from each organisation. At the discretion of the chair or their nominated representative, meetings may proceed without quorum being reached in order for the group to fulfil its responsibilities in monitoring the progress of projects. If quorum is not reached, then significant decisions such as to authorise the commencement of a project should be deferred to the next meeting or decisions shared virtually with members of the group.

6. Reporting arrangements

6.1. A programme dashboard will be developed and submitted to the partnership.

6.2. Details of each programme will be reported consistently across each partner organisation boards as appropriate.

7. Relationships

7.1. The Efficiency Executive will ensure appropriate clinical engagement to the development or implementation of any project will ensure that any feedback from Clinical professionals is taken into account.

8. Administration

8.1. The Efficiency Executive will be supported by the CCG's programme management office (PMO) overseen by the Director of Strategic Planning and Performance.

9. Frequency

9.1. The Efficiency Executive will meet at least monthly and more frequently when required, as determined by the group.

10. Code of conduct

10.1. The group will conduct its business in accordance with national guidance, relevant codes of practice including the Nolan Principles. It will operate with transparency and open book accounting across organisations to ensure maximum efficiency can be achieved.

11. Review

11.1. The terms of reference will be reviewed in 3 months and annually thereafter.

Review date: October 2020

Barnsley Integrated Care Delivery Group

Terms of Reference

Barnsley Integrated Care Delivery Group

1.	Introduction	
	1.1	Barnsley Metropolitan Borough Council (BMBC), Barnsley Hospital NHS Foundation Trust (BHNFT), South West Yorkshire Partnership NHS Foundation Trust (SWYPFT), Barnsley Healthcare Federation (BHF) and Barnsley Clinical Commissioning Group (BCCG) have, as partners, agreed to develop an integrated system of health and social care in Barnsley working with other partners including Barnsley CVS, Healthwatch Barnsley and Barnsley Hospice. This integrated system is referred to in these terms of reference, and in the Place Agreement that the above partners have signed up to, as an "Integrated Care Partnership" or "ICP". The Integrated Care Delivery Group (ICDG) will oversee and deliver the Priority Programmes as agreed by the Partners, in accordance with vision and objectives set out below and in the Place Agreement, and report to the Integrated Care Partnership Group (ICPG) on progress.
	1.2	Together we will develop a model for integrated services that joins up care around the mental, physical and social needs of people. In doing so, we will help deliver the Barnsley health and care plan and ICP development plan.
	1.3	The Partners have agreed to work towards a common Vision for the Integrated Care Partnership (ICP) as follows: *People of Barnsley are enabled to take control of their health and wellbeing and enjoy happy, healthy and longer lives, in safer and stronger communities, regardless of who they are and wherever they live.*
	1.4	The Partners have agreed to work together in accordance with the Place Agreement in order to achieve the following Objectives: • Develop an integrated joined up health and care system where the people of Barnsley experience continuity of care – each Partner delivering their part without duplication; • Individuals, families and communities are empowered to take control wherever possible of their own health and wellbeing; • Shift the focus on treating patients with health problems to supporting the community to remain healthy in the first instance; • Embed integrated care that delivers the best value for the Barnsley pound; • Develop population health management approaches to improve health and wellbeing and reduce health inequalities; • Work towards becoming a thriving ICP in accordance with the ICP Development Plan for 2021/22 and beyond; and • Play a pivotal role in delivering our shared vision for Barnsley: a

		place of possibilities, set out in Barnsley 2030. A healthy, learning, growing and sustainable Barnsley.	
2.	**Purpose**		
	2.1	The purpose of the ICDG is to oversee and deliver the ICP priority programmes as agreed within Barnsley health and care plan and also overseeing delivery of the ICP development plan. Ensuring there is operational ownership of the agreed programme of work, agreeing where changes to the workplan need to made and reporting progress and risks to delivery to ICPG.	
3.	**Responsibilities**		
	3.1	Overseeing and delivering the ICP health and care plan and the ICP Development Plan.	
	3.2	Regular reporting to Partner organisation boards on progress against the ICP health and care plan and the ICP Development Plan.	
	3.3	Regular reporting to the ICPG on progress against the ICP health and care plan and the ICP Development Plan.	
	3.4	Operating in accordance with the principles as set out within the Barnsley Place Agreement.	
	3.5	Ensuring all risk is assessed and assuring that mitigating actions are in place.	
	3.6	Managing and utilising resources across the ICP to optimise service delivery.	
	3.7	Working within the overall scope of the ICP, recognising that changes will be agreed during the course of its development and introduction. Where relevant make recommendations to the ICPG for changes to the plan.	
	3.8	Supporting the Transformation and Enabling Programme boards to deliver their objectives and milestones as set out within the Barnsley health and care plan.	
	3.9	Considering and agree issues raised by the programme boards within the remit of the ICDG.	
	3.10	Overseeing and co-ordinating dependencies which exist across the ICP health and care plan.	
4.	**Membership**		
	4.1	The membership of the ICDG will be:	
		4.1.1	Partner organisation rotation - Chair of the ICDG
		4.1.2	BHNFT - Deputy CEO and Chief Delivery Officer
		4.1.4	BMBC - Director of Public Health,
		4.1.5	BMBC – Executive Director of Adults & Communities
		4.1.6	BMBC – Director of Children's Services
		4.1.8	BHF - CEO
		4.1.10	SWYPFT - Director of Strategy
		4.1.11	Healthwatch – CEO
		4.1.12	Barnsley Hospice - CEO
		4.1.13	Barnsley Community & Voluntary Services – CEO
		4.1.14	Barnsley Clinical Commissioning Group - Director of Strategic Commissioning & Partnerships, NHS Barnsley CCG
		4.1.15	Barnsley Clinical Commissioning Group - Chief Operating Officer
	4.2	Membership will be reviewed and adjusted by agreement of the members	

		as necessary to ensure the ICP meets its responsibilities. Every effort will be made to seek consensus.
	4.3	With effect from 1 April 2022, the role of Chair of the ICDG will be rotated to another member of the ICDG as agreed by the members in accordance with paragraph 5.1 below. This will be undertaken on an annual basis at the beginning of every financial year.
	4.4	The chair of ICDG cannot come from the same organisation as the chair of ICPG.
5.	**Decision making and Quorum:**	
	5.1	The ICDG will operate as a forum for discussion with the aim of reaching consensus among the Partners. The ICDG is neither a separate legal entity, nor a joint committee of the Partners, and is therefore unable to take decisions separately to its Partner members or bind any one of them; nor can one Partner organisation 'overrule' another on any matter.
	5.2	Each Partner organisation will delegate to its representative on the ICDG such authority as is agreed to be necessary in order for the ICDG to function effectively in discharging the responsibilities set out in these terms of reference.
	5.3	Each Partner organisation will ensure that their representatives understand the status of the ICDG and the limits of the authority delegated to them.
	5.4	The Board will be quorate when at least half of the membership is present.
	5.5	Deputies may be nominated to attend, although there should be a clear and consistent intention to attend by each appointed member.
	5.6	Any organisation failing to send a representative for two consecutive meetings will be asked to confirm their commitment.
	5.7	If ICDG is unable to reach consensus and make a decision it will refer to ICPG for resolution.
6.	**Reporting Arrangements**	
	6.1	Formal minutes will be completed from the meeting. This is a private meeting between member organisations. However in the interests of good governance and promoting transparency the minutes relevant to a wider public audience can be taken in the public section of the member organisation' sovereign Boards.
	6.2	The members of the ICDG are responsible for providing feedback on a regular basis to their member organisations' Boards/ relevant decision making bodies.
	6.3	ICDG will report on its activities monthly to ICPG.
7.	**Administration**	
	7.1	The ICDG will be administered by the Partner organisation of the current Chair.
8.	**Frequency**	
	8.1	The ICDG will meet on a monthly basis at minimum.
9.	**Code of Conduct**	
	9.1	The ICDG shall conduct its business in accordance with national guidance, and relevant codes of practice including the Nolan Principles.
	9.2	All members are required to notify the Chair of any actual, potential or perceived conflict of interest in advance of the meeting to enable

		appropriate management arrangements to be put in place.
10.	**Review**	
	10.1	The ICDG will review on a regular basis its own performance, membership and terms of reference. These terms of reference and any resulting changes to the terms of reference or membership will be approved by the member organisations' Boards/relevant decision making bodies.

NHS
Barnsley
Clinical Commissioning Group

PUBLIC GOVERNING BODY

9 September 2021

Barnsley Health and Care Plan 2021/22

PART 1A – SUMMARY REPORT

1.	**THIS PAPER IS FOR**						
	Decision		*Approval*		*Assurance*		*Information*	x
2.	**PURPOSE**						
	The Barnsley Health and Care Plan 2021/22 sets out the ambitions of the Integrated Care Partnership to improve health and wellbeing outcomes for the people of Barnsley. The plan has been developed in partnership. It is not intended to cover all planned activities of Barnsley health and care partners; its intention is to focus on activities where outcomes can be better delivered through partnership working together. Over the coming weeks it will be presented to the Boards of each partner organisation for their full endorsement. The Plan has already been presented to and endorsed by the CCG GB at a development session on the 22nd July. It has also been endorsed by the Barnsley Integrated Care Partnership Group on the 29th July. The Plan has also been approved and endorsed by BMBC at Purple Cabinet on the 14th July. The Plan is a 'live' document and will be refreshed during the course of 21/22 as we move to agree our 22/23 and beyond plan for Barnsley.						
3.	**REPORT OF**						

	Name	**Designation**
Executive / Clinical Lead	Jeremy Budd	Director Strategic Commissioning and Partnership
Authors	Joe Minton Andrew Osborn	Professional Manager Interim Service Director, BMBC

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
Barnsley Governing Body Development Session	22/07/21	Approved and Endorsed
Barnsley Integrated Care Partnership Group	29/07/21	Approved and Endorsed
Barnsley Integrated Care Delivery Group	22/06/21	Recommended for Approval by ICPG

5. EXECUTIVE SUMMARY

Health and care commissioners and provider organisations have been working collaboratively across Barnsley to integrate services and provide more care closer to home for local people for some time. Our goal is to dismantle boundaries at the point of delivery of care. We want people who use our services to be supported and empowered by what feels like 'one team', each delivering their part without duplication along common pathways of care. One team that is responsible to the people of Barnsley.

Our priorities for 2021/22 have been shaped by several policy initiatives and developments across health and care locally and nationally. These are –

1. Look after our people including their mental health and wellbeing
2. Deliver the COVID vaccination programme
3. Accelerate recovery of planned care services for physical and mental health and transform delivery
4. Increase uptake of early help for children and young families.
5. Joining up care and support in thriving communities
6. Responsive and accessible care in a crisis
7. Strengthen our partnership
8. Make mental health everybody's business

As partners to Barnsley 2030 we hope that our priorities and plans will help to promote Barnsley as a place of opportunity and realise the vision the local ambition for a health, learning, growing and sustainable borough.

6. THE GOVERNING BODY / COMMITTEE IS ASKED TO:

Endorse the Barnsley Health and Care Plan 2021/22

7. APPENDICES / LINKS TO FURTHER INFORMATION

- Appendix A – Barnsley Health and Care Plan 2021/22 (summary)
- Appendix B – Barnsley Health and Care Plan 2021/22 (full)

Agenda time allocation for report:	

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	**X**	6.1 Efficiency Plans	X
2.1 Primary Care	**X**	7.1 Transforming Care for people with LD	X
3.1 Cancer	**X**	8.1 Maternity	X
3.2 Maximising Elective Activity	**X**	9.1 Digital and Technology	X
4.1 Mental Health	**X**	10.1 Compliance with statutory duties	X
5.1 Integrated Care @ System	**X**	11.1 Delivery of Enhanced Health in Care Homes	X
5.2 Integrated Care @ Place	**X**	12.1 Delivering The Covid Vaccination Programme & Meeting The Needs of Patients with Covid-19	X
5.3 Implementing Population Health Management And Personalised Care	**X**		

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 3.2**	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***
GB clinical commissioners contributed to Barnsley 2030 and the integrated care outcomes framework that informed the plan. GP clinical commissioners have been involved in the joint commissioning review and are members of the transformation board and enabler groups that contributed to the plan. The clinical Chair is a member of ICPG that formerly endorsed the plan.	

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***
The Chief Finance Officer is a member of the Efficiencies Executive is part of the Governance of the integrated care partnership and has responsibility for ensuring that service transformation delivers productivity gains for the system.	

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***
Quality assurance and improvement is one of the five cross-cutting themes of the plan. A QIA will be completed for each area of service transformation/development as appropriate in accordance with organisational policies and procedures.	

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***
Tackling health inequalities is one of the five cross-cutting themes of the plan. An EIA will be completed for each area of service transformation/development as appropriate in accordance with organisational policies and procedures.	

3.6 Public Involvement & Consultation (s14Z2)

Has a s14Z2: Patient and Public Participation Form been completed if relevant?	***Y***
Have any issues or risks identified been appropriately addressed having taken advice from the Head of Comms & Engagement if appropriate?	***Y***
The engagement and equality leads group has reviewed the plan and identified implications for public involvement and consultation. A report will be taken to ICDG for assurance and information and the transformation delivery groups for action in due course. Appropriate engagement and involvement will be completed for each area of service transformation/development as appropriate in accordance with organisational policies and procedures and principles agreed by the partnership. It is the ambition of the partnership to have more and better conversations with people to shape services and co-create health and wellbeing.	

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***
An Open Data Information Sharing group has been established involving information governance leads from across the partnership and will advise the partnership on related issues as required. A DPIA will produced for each relevant initiative and will be managed in accordance with organisational policy, procedures and best practice.	

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,	***NA***

	networks or Federations may be a bidder for a procurement opportunity?	
3.9	**Human Resources**	
	Have any significant HR implications been identified and managed appropriately, having taken advice from the HR Lead if appropriate?	***NA***
	The Barnsley Integrated Workforce Development Group comprises HR/workforce and professional leads from across the partnership and advises the partnership on related issues as required.	
3.10	**Environmental Sustainability**	
	Have any significant (positive or negative) impacts on the environment or the CCG's carbon footprint been identified?	***NA***
	An appropriate impact assessment will be undertake for each service development initiative in the plan and managed in accordance with relevant organisational policies and procedures.	

BARNSLEY HEALTH & CARE

SUMMARY PLAN 2021/2022

The NHS Long Term plan is improving the way people experience health and care services. Hand-in-hand with Barnsley 2030, these plans will help focus our collective efforts for, and with, local communities.

At a regional level we've shaped these plans as the South Yorkshire and Bassetlaw Integrated Care system. In Barnsley we do this through the Integrated Care Partnership Group (ICPG) - health and care organisations across the NHS, council and voluntary and community sector working together with local communities.

The shared commitment of the ICPG partnership has supported organisations to see beyond their boundaries, freeing up teams to work together in a more joined-up, seamless and effective way.

BETTER TOGETHER: THE BARNSLEY APPROACH

TEAMWORK

"Working in an integrated way isn't about being based in a building or working on a patch together; it's been about how we interact and support each other to improve things for people."

We know that when we work best, we work as a team - we focus on the ask and we come together to get things sorted. We also look out for and after each other.

The emergency contact centre response during the pandemic; the roll out of the COVID-19 vaccine; getting the best and timely support for people leaving hospital - none of these are easy but they've worked really well in Barnsley because of the commitment to work in a joined-up way.

REMOVING BARRIERS

"What really strikes me is how fantastic people are at working together across Barnsley and coming up with solutions to improve things- they just get stuff done. We've got a real opportunity here to support them to build on that."

There are things in the way that our organisations are set up and run that can add barriers to the improvements we want to make.

This plan will address some of those things, freeing up staff from across and within the NHS, the council, the voluntary and community sector and the care sector to work more seamlessly together.

THRIVING COMMUNITIES

"We want to talk to local communities more about the types of health and wellbeing concerns they have and the opportunities they can see - we can't expect a good reception if we turn up with new services when they're not what people want - it can be like an unwanted birthday gift: Despite best intentions, if it doesn't fit the bill neither the person receiving it, nor the person giving it, gets a good experience."

Working with a range of organisations and the local community in the Dearne, we found that what mattered to the local community wasn't always the same as the things we'd anticipated. We also saw that improving health and wellbeing is much more than local services. it's about the assets in that community and the way they support and grow local people's wellbeing and resilience.

Having multi-disciplinary teams, working in and alongside the local community, has brought real benefits in the Dearne and it is part of our plans to bring care closer to people's homes.

BETTER TOGETHER PRIORITIES

SUMMARY PLAN 2021/2022

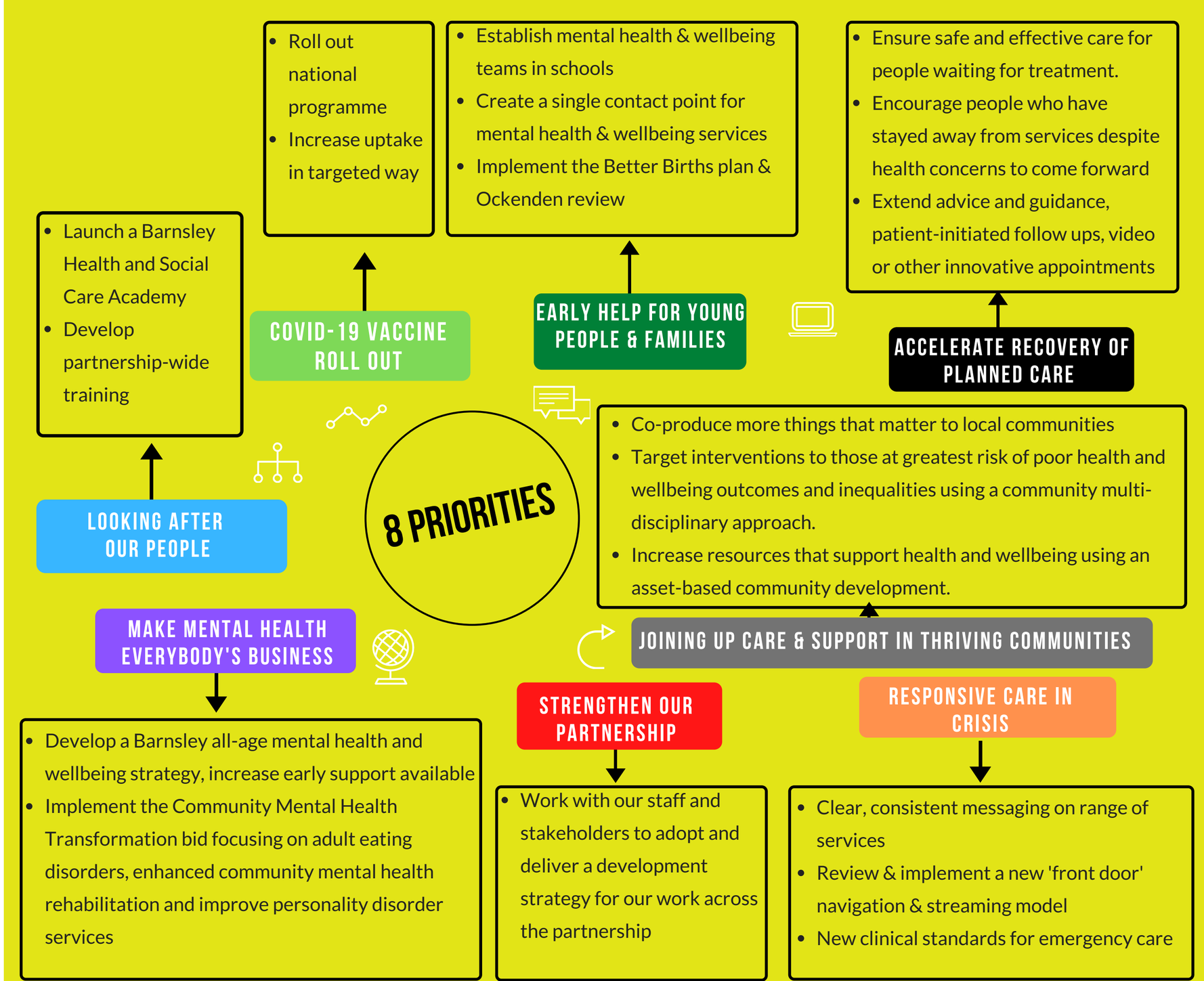
Our eight priorities for 2021/22 have been shaped by The NHS Long Term plan and the operational planning guidance sets out those that are must dos over the coming months.

Importantly, our priorities reflect those things which require or would benefit from collective effort from across our partnership.

They sit alongside the work of the Barnsley Mental Health Partnership.

Running throughout these priorities are some cross-cutting themes:

- Prevention and early intervention.
- Personalised care.
- Tackling inequalities.
- Quality assurance and improvement.
- Efficiency and value for money.



BETTER TOGETHER INVOLVING PEOPLE

SUMMARY PLAN 2021/2022

Listening to local communities about their ambitions and concerns for their own health and wellbeing, and that of their communities, is the basis of the work we want to do as a partnership.

Valuing their voice, alongside that of our staff and other stakeholders, is vital.

These guiding principles have been developed using feedback from local residents and people and carers who have used local services.

We will use the principles as we work through the Barnsley Health & Care Plan.

BETTER TOGETHER: PRINCIPLES OF INVOLVEMENT

- Have a strong local focus and work on both strengths and solutions with local communities
- Value equality and the diversity of local communities
- Make sure information is accessible and jargon free
- Ensure that everyone has a voice and we listen and learn from our staff and communities
- Involve the right people, at the right time and come to you
- Keep it simple and be honest about what you can influence
- Avoid repeating the same conversations
- Be open and transparent with what we know and what we have done and why

BETTER TOGETHER PARTNERS

SUMMARY PLAN 2021/2022

Health and care organisations have a strong history of working together in Barnsley. This has been highlighted and strengthened during the response to the COVID-19 pandemic.

This plan builds on these foundation and puts Barnsley in a good place as we move towards proposed changes set out in '*Integration and innovation: working together to improve health and social care for all'* legislation.

The Barnsley Integrated Care Partnership Group is made up of partners from across the health and care sector, including the voluntary and community sector and the independent voice of Healthwatch Barnsley.

This plan sits alongside the work of all the partners and has clear interdependencies.

BETTER TOGETHER: PARTNER MEMBERS

- Barnsley Clinical Commissioning Group
- Barnsley Community and Voluntary Services
- Barnsley Council
- Barnsley Healthcare Federation
- Barnsley Hospice
- Barnsley Hospital NHS Foundation Trust
- Healthwatch Barnsley
- South West Yorkshire Partnership NHS Foundation Trust

Barnsley Health and Care Plan 2021/22

Barnsley Integrated Care Partnership

BARNSLEY HEALTH & CARE

SUMMARY PLAN 2021/2022

The NHS Long Term plan is improving the way people experience health and care services. Hand-in-hand with Barnsley 2030, these plans will help focus our collective efforts for, and with, local communities.

At a regional level we've shaped these plans as the South Yorkshire and Bassetlaw Integrated Care system. In Barnsley we do this through the Integrated Care Partnership Group (ICPG) - health and care organisations across the NHS, council and voluntary and community sector working together with local communities.

The shared commitment of the ICPG partnership has supported organisations to see beyond their boundaries, freeing up teams to work together in a more joined-up, seamless and effective way.

BETTER TOGETHER: THE BARNSLEY APPROACH

TEAMWORK

"Working in an integrated way isn't about being based in a building or working on a patch together; it's been about how we interact and support each other to improve things for people."

We know that when we work best, we work as a team - we focus on the ask and we come together to get things sorted. We also look out for and after each other.

The emergency contact centre response during the pandemic; the roll out of the COVID-19 vaccine; getting the best and timely support for people leaving hospital - none of these are easy but they've worked really well in Barnsley because of the commitment to work in a joined-up way.

REMOVING BARRIERS

"What really strikes me is how fantastic people are at working together across Barnsley and coming up with solutions to improve things- they just get stuff done. We've got a real opportunity here to support them to build on that."

There are things in the way that our organisations are set up and run that can add barriers to the improvements we want to make.

This plan will address some of those things, freeing up staff from across and within the NHS, the council, the voluntary and community sector and the care sector to work more seamlessly together.

THRIVING COMMUNITIES

"We want to talk to local communities more about the types of health and wellbeing concerns they have and the opportunities they can see - we can't expect a good reception if we turn up with new services when they're not what people want - it can be like an unwanted birthday gift: Despite best intentions, if it doesn't fit the bill neither the person receiving it, nor the person giving it, gets a good experience."

Working with a range of organisations and the local community in the Dearne, we found that what mattered to the local community wasn't always the same as the things we'd anticipated. We also saw that improving health and wellbeing is much more than local services. it's about the assets in that community and the way they support and grow local people's wellbeing and resilience.

Having multi-disciplinary teams, working in and alongside the local community, has brought real benefits in the Dearne and it is part of our plans to bring care closer to people's homes.

Introduction

The last year has been incredibly difficult for everyone. For health and care services it has been a period like no other. Services have and continue to be under significant strain. During the early part of the pandemic back in spring 2020 the pressure was to prepare for a likely surge in illness, maintain essential services and protect staff and service users from exposure to the virus. During the summer and Autumn staff worked tirelessly to restore services, accelerate treatment for people who had experienced delays and to encourage those people who chose to stay away from services to return if they had concerns about there health. This was done with a backdrop of social distancing measures severely impacting on capacity in many areas and relatively high rates of infection and illness in Barnsley and the wider region. During the early winter Barnsley was one of the areas hit hardest by COVID with the hospital seeing one of the highest levels of COVID bed occupancy in the country and reaching the highest level of operational pressure. Over the Christmas holiday period the alpha variant that emerged in the South East moved the national focus and the approval of the early vaccines brought renewed hope that the virus could be brought under control again.

The COVID vaccination programme has been a great success across the country and in Barnsley. It has involved an extraordinary effort locally by all partners but especially primary care that have delivered the majority of the community vaccination programme. Now all adults are able to schedule a vaccine and uptake across most age groups is high. Whilst there are some groups of people choosing not to be vaccinated the impact is beginning to break the link between infection, serious illness and mortality. Unless there is a new dominant variant that behaves very differently to the original virus and the alpha and delta variants that have been dominant in this country since there is great cause for optimism that the relatively low levels of infection and illness now, compared to the early Spring and Winter peaks will continue.

Throughout the pandemic the public have stepped up to the challenge of containing the virus by following the difficult advice to reduce avoidable social contacts and adhere to strict infection and prevention and control precautions. Whilst this was necessary in order to control the virus is brought about great hardships for people, particularly those most vulnerable in society and will have a long-lasting impact.

The health and care sector has been deeply encouraged by the support and solidarity shown by the public throughout the pandemic. The support shown to health and care staff has been greatly appreciated. Overall people have been patient and considerate when choosing when and how to access care and support through the pandemic. However, there is a downside to some of the trends we have seen despite the good intent and that is some people who have chosen not to access services when they have a health concern that would benefit from early diagnosis and treatment.

Many people have waited longer for treatment because of the pandemic and whilst the majority of services were sustained or have been recovered, social distancing measures and the limitations of the health and care estate mean that not all services are operating at the same level as before the pandemic. We remain committed to restoring services safely and as quickly as possible as well as building back fairer by prioritising those people most at risk of poor health outcomes. In South Yorkshire and Bassetlaw we are proud to be part of the accelerator programme that will mean levels of planned hospital care will increase to above previous years in order to try to work through the backlog of delays.

Recently we have seen that some people are unhappy with some of the difficulties accessing care and delays to treatment and are becoming angry and upset. There also appears to be a trend of people seeking a consultation with a health and care professional for problems that do not require professional input. Many services are now experiencing unprecedented levels of demand. Across general practice, A&E and parts of community services activity is now higher than before the pandemic and is becoming unsustainable. Helping people to self-care , to help each other and build community resilience has never been more important.

Our priorities for 2021/22 build on the progress made over the last year to sustain and transform services during the pandemic, recognise the associated ongoing demands and aim to ensure that Barnsley residents and service users get the maximum benefits from the changes proposed through the Government's legislative programme. Our priorities are to -

- Look after our people including their mental health and wellbeing
- Deliver the COVID vaccination programme
- Accelerate recovery of planned care services for physical and mental health and transform delivery
- Increase uptake of early help for children and young families.
- Joining up care and support in thriving communities
- Responsive and accessible care in a crisis
- Strengthen our partnership
- Make mental health everybody's business

We are proud to serve people of Barnsley and look forward to listening to and working with residents and our communities to deliver our ambitions plans for better health and care in Barnsley.

About us

Health and care commissioners and provider organisations have been working collaboratively across Barnsley to integrate services and provide more care closer to home for local people for some time.

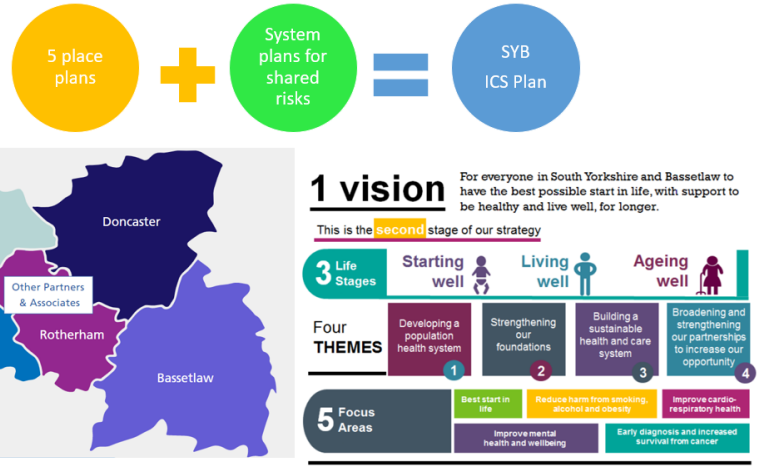
We are one of five place partnerships in our South Yorkshire and Bassetlaw Integrated Care System, pioneering the way of collaboration across health and care and with other sectors. We believe that *place* is the engine room of change and maximum delegated responsibility to Barnsley in our future system we lead to the best possible outcomes for our residents.

Our goal is to dismantle boundaries at the point of delivery of care. These boundaries exist because of the complexity of separate funding, multiple contracts, different organisations with different accountabilities, responsibilities and regulators.

We want people who use our services to be supported and empowered by what feels like 'one team', each delivering their part without duplication along common pathways of care. One team that is responsible to the people of Barnsley.

Above all we want to improve the quality of life of people in Barnsley and reduce the inequalities that exist in health and wellbeing outcomes. We want to better meet the needs of our population in Barnsley, preventing chronic illness, deaths from preventable causes and see a rise in the number of individuals making informed decisions about their care and support alongside health and care colleagues.

Our local partnership is part of a wider system and plan



One vision for Barnsley

An integrated joined up health and care system where the people of Barnsley experience continuity of care.

Patients and their families are supported and empowered by what feels like "one team", each delivering their part without duplication.

A shift in focus on treating patients with health problems to supporting the community to remain healthy in the first instance.

Integrated care that delivers the best value for the Barnsley pound.

Adopting a life-course approach to improving health and wellbeing and creating a system that is accountable for health outcomes and all determinants of health and wellbeing

Start well	Live well	Age well
Services able to intervene early and promote a strengths-based approach to encouraging increased family and community resilience. Implement a localised, equitable and integrated health, care and education offer to substantially increase opportunities and reduce social, health and economic inequalities	Individuals and families are healthy, resilient and have the confidence and skills to thrive and achieve their full potential so that collectively our communities achieve the best possible outcomes for themselves, their families and each other. Support to individuals and families will be offered within their community and as close to home as possible.	In Barnsley we will support our ageing population by offering person-centred, flexible, integrated care and support in their community or at home. Through early interventions we will aim to maximise people's health, well-being and independence and reduce the need for long term support wherever possible

Common principles

Mutuality	Population focussed	Shared values & governance

• Systems leadership encompassing health, social care and wider system partners
• Strong clinical operational leadership including general practitioners as expert generalists with the patient
• Enabling the leadership role of citizens, communities and voluntary sector
	• A population health management approach to develop strategies to improve the health and wellbeing of the population and reduce health inequalities
	• Integrated and holistic approach to care including physical and mental health
		• Adopt an asset based approach
		  • citizen-led
		  • relationship orientated
		  • asset-based
		  • place-based
		  • inclusion focussed
		• Provide a proactive and person-centred approach that empowers patients and addresses peoples' needs
		• Improve quality and efficiency of services through sharing records, data and information including integrated information management and technology
		• A single set of measures to underpin shared objectives

Care closer to home	**Staying well**	**Use of resources**
• Support the delivery of more enhanced and specialised services in the community where appropriate • Neighbourhood focus for delivery of services whilst ensuring services are wrapped around patients and aligned to GP practices	• Focus on self-care to promote independence and reduce pressures on the health and care system • Focus on prevention including the wider determinants of health	• Single whole population budget • Maximise the agreed outcomes within the resources available to deliver best possible value for the Barnsley pound

Our progress in 2020/21

Despite continued pressures because of the COVID pandemic, partners in Barnsley have achieved a great deal of what they intended to back in the Summer of 2020. Progress is shown in the table to the right.

Area that are behind where we expected to be include –

- Work with the ECIST team on the "front door" to A&E
- Further development of the vulnerability index as a tool for prioritising inequalities
- Shared care record
- Identify, work up, co-design and embed reformed priority clinical pathways to support place based case load across primary and secondary care
- Complete review of reablement services

Our partnership priorities for 2020/21	Coronavirus management and recovery	Supporting complex, vulnerable and shielded people (including the health and care workforce)	Understanding the impacts of the epidemic	Lock in change	Financial balance
What we have achieved	• Everyone pulled together, to find solutions and prevent problems and issues occurring or escalating • Delivered local testing strategy • Delivering the local COVID vaccination programme • Tight grip on situations and outbreaks to prevent escalating case numbers	• Successfully targeted support for people who are vulnerable • Created a vulnerability index • Sustained COVID 19 support service • Adapted offer of support for those who are self-isolating • Health and wellbeing hubs for staff	• Established a Health intelligence cell • Recruited a population health analyst • Produced projections of future needs • Behavioural insights • Informed a local recovery roadmap • Huge appetite to tackle inequalities head on • Improved information sharing	• Continued to offer video/telephone appointments • Coordination across planned care • Rapid collaborative response to system pressures • Delivered the optimum model of discharge to assess • Rapid wrap around to support for Care Homes	• We achieved system financial balance year end 2020/21 but in part due to COVID monies. • Exceptional contracting arrangements will continue for the first half of 2021/22 which presents a challenge to achieving efficiencies.
What we have learned	• Need for clear shared leadership across Barnsley place with accountability • Benefit of peer support when things get difficult • Need to be able to escalate issues quickly and get them resolved	• Benefits of closer working between NHS, local government and wider partners in the community • People appreciated an outreach approach • Needs to support communities and asset based community development	• Susceptible population / occupational and health-related risk • Generally people have tried to comply with the restrictions • Community resilience – people helping people • People have chosen to stay away from services because not wanting to be a burden	• For some people face to face appointments are preferred and a blended approach is required	• With new legislation this year the financial architecture of the NHS will change. • 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.

Developing our plan for 2021/22

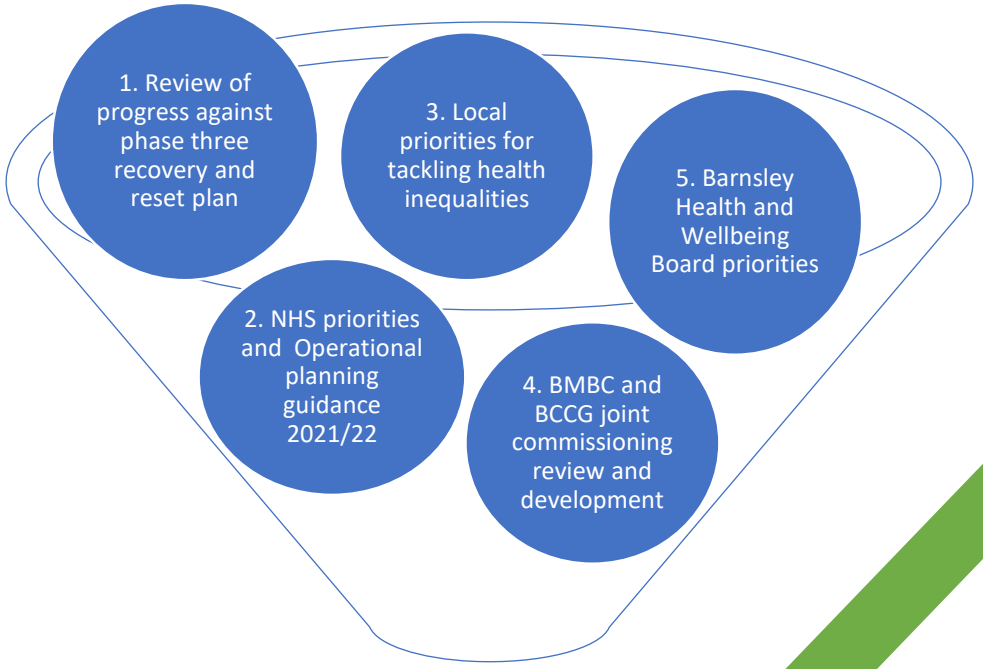
Our priorities for 2021/22 have been shaped by several policy initiatives and developments across health and care locally and nationally.

The NHS Long Term plan sets out a series of ambitions and the operational planning guidance published earlier this year sets out those that are must dos over the coming months. Our priorities reflect some of these requirements where they require or would benefit from collective effort from across our partnership.

The Government White Paper *Integration and innovation: working together to improve health and social care for all* and subsequent guidance will involve massive change in the NHS, and it is important that partners in Barnsley make the best of the opportunities this presents by joining up commissioning and delivery wherever this makes sense.

The planning guidance and white paper both emphasis the role that health and care must play in tackling inequalities. Residents in Barnsley experience poorer health outcomes when compared to most other parts of the country and increasingly through the COVID pandemic we have seen health inequalities play out in the rates of infection, illness and wider impacts on families, social networks, communities and the economy. We therefore welcome the opportunity to focus effort and resource on levelling up.

As partners to Barnsley 2030 we hope that our priorities and plans will help to promote Barnsley as a place of opportunity and realise the vision and local ambition for a healthy, learning, growing and sustainable borough.



Barnsley 2030

Healthy Barnsley | Learning Barnsley

Growing Barnsley | Sustainable Barnsley

Long list of priorities

Test alignment to our outcomes framework and Barnsley 2030 vision

Proposals for priorities short list

Delivery/Enabler Group Chairs validate short list and agree 21/22 deliverables and impacts

Draft plan submitted to ICPG to endorse

Development of programme plan with Delivery/Enabler Groups – agreed with ICDG

Programme management – risks/issues/highlight reports – ongoing oversight from ICDG

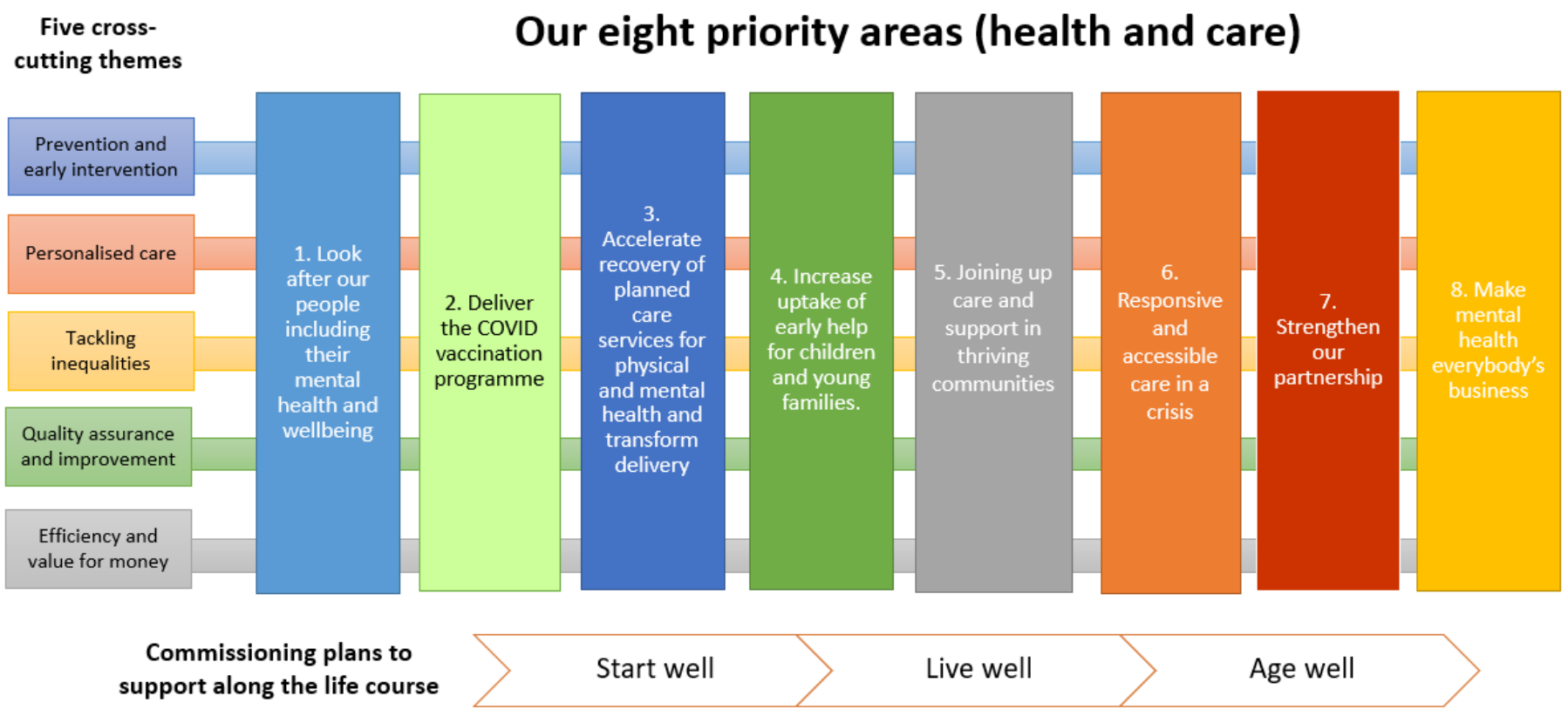
High-level priorities for 2021/22

The process of creating a long list of priorities, assessing these against our key strategic objectives and refining the list down to some important deliverables has identify eight areas where we would like to see significant impact in 2021/22. These broadly align with the NHS Priorities for this year but importantly our local priorities reflect our local partnership of health and social care and focus on wider determinants.

The prioritisation process also identified a series of cross-cutting themes. These are also priority areas but the delivery of these priorities span all parts of our system.

Successful delivery against our priorities for 2021/22 is contingent on collective effort in all these areas, ensuring the delivery groups that exist have a broad focus across physical and mental health and social care and that the work on one priority does not detract from others. For example, it will be imperative that our work to improve efficiency and value for money does not create a plan of action on different areas but that we ensure we identify and realise the finance and efficiency benefits associated with transformational change and improving outcomes across the eight priority areas.

Linked to our cross cutting themes we recognise that commissioning plans will need to be strengthened and focussed on these priorities areas.



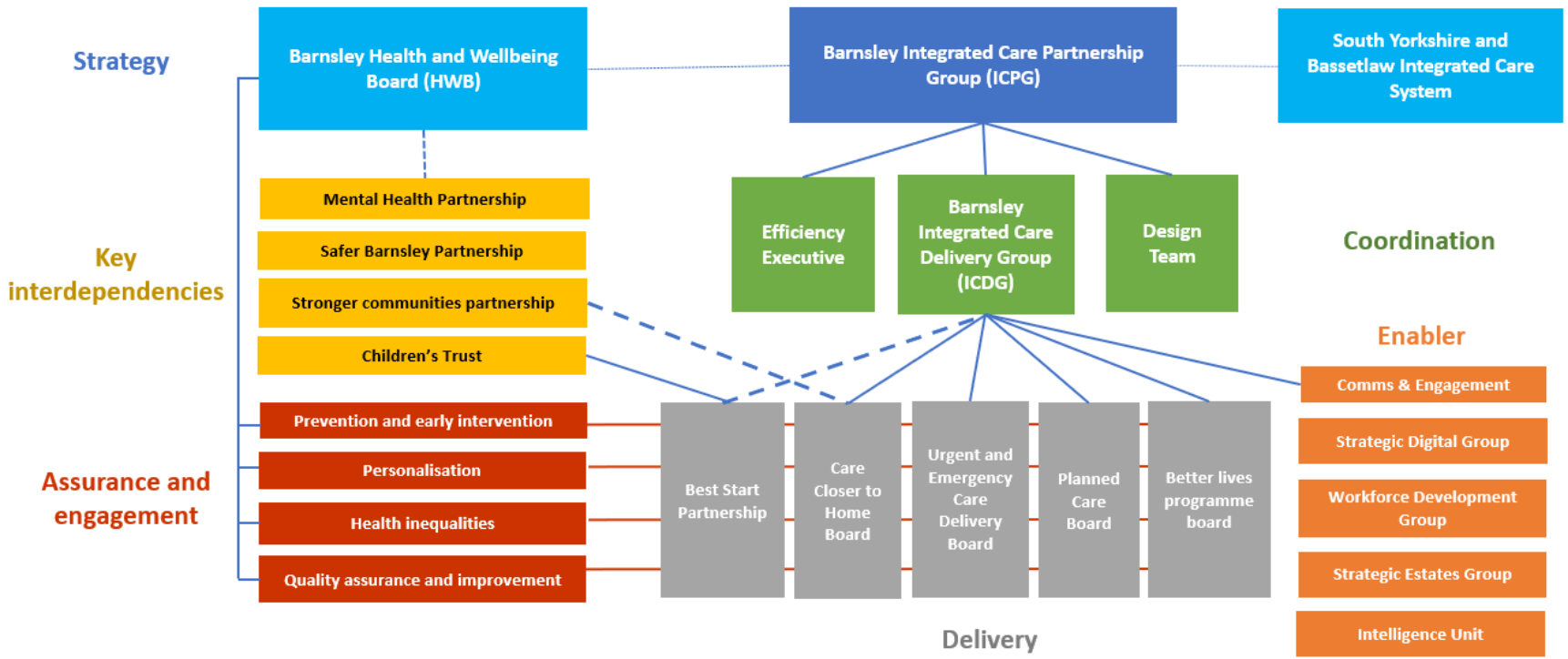
How we will organise to deliver

Prior to the pandemic the scope of work reporting through to integrated care delivery group (ICDG) was limited to population health management, strategic estates, digital, workforce and frailty.

In response to the COVID pandemic phase three letter from NHS England in summer 2020 a partnership plan was developed that included immediate priorities for reset and recovery along with a partnership response to NHS Long Term plan priorities for the NHS.

It is likely that from April 2022 the integrated care partnership will be recognised as a place board and assume responsibility of a broad range of delivery and transformation priorities for the integrated care system and therefore governance arrangements will need to develop.

Work to develop the local plan for 2021/22 has also highlighted interdependencies with other partnership groups and forums, particularly with regards to mental health and children and young people's priorities.
The slides that follow indicate where responsibility for delivery sits for each of our priorities.

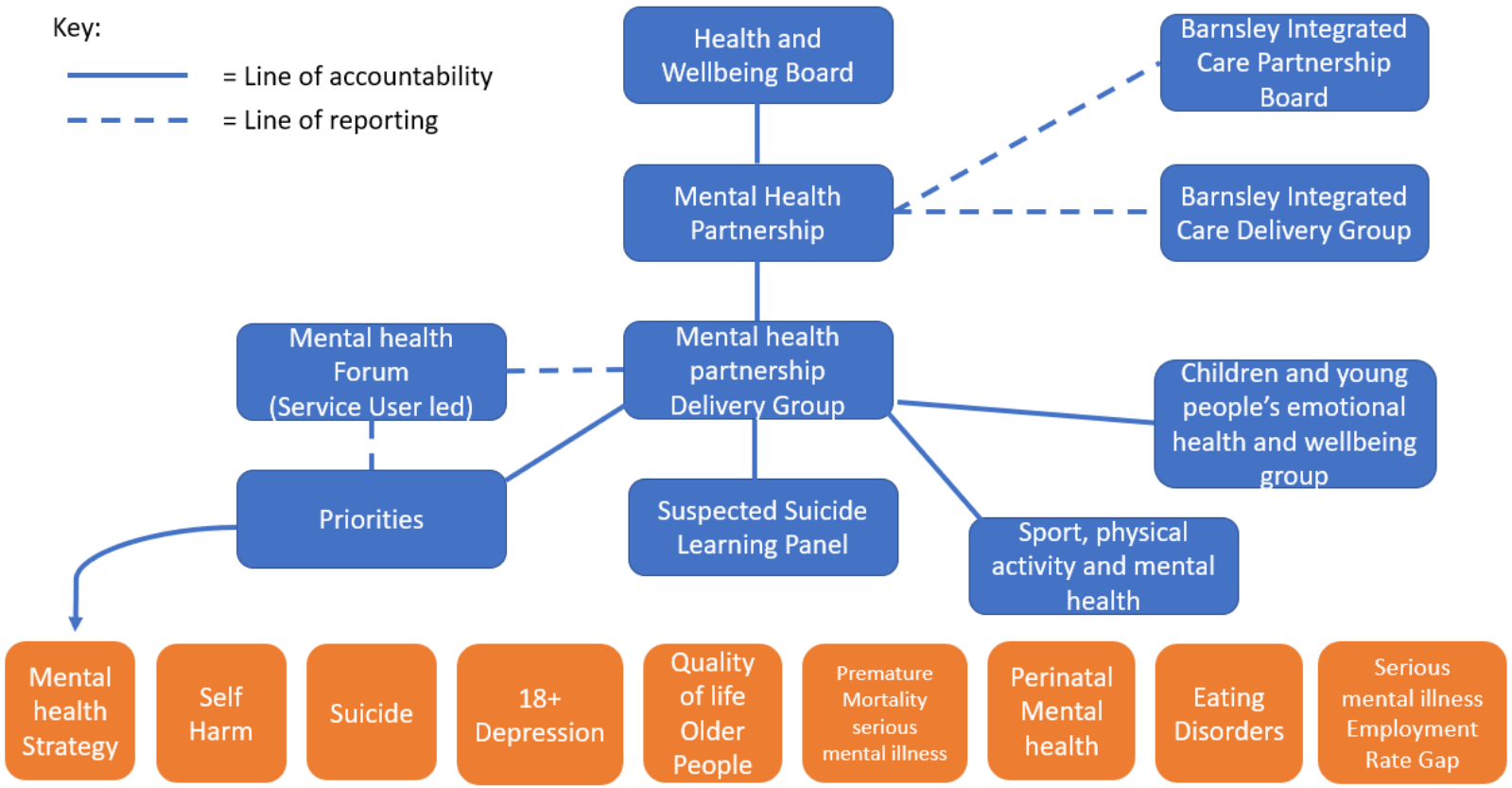


Prioritising mental health and wellbeing

Barnsley's Mental Health Partnership is an alliance of people and organisations across the borough focused on improving people's mental health; this includes support for people contemplating suicide.

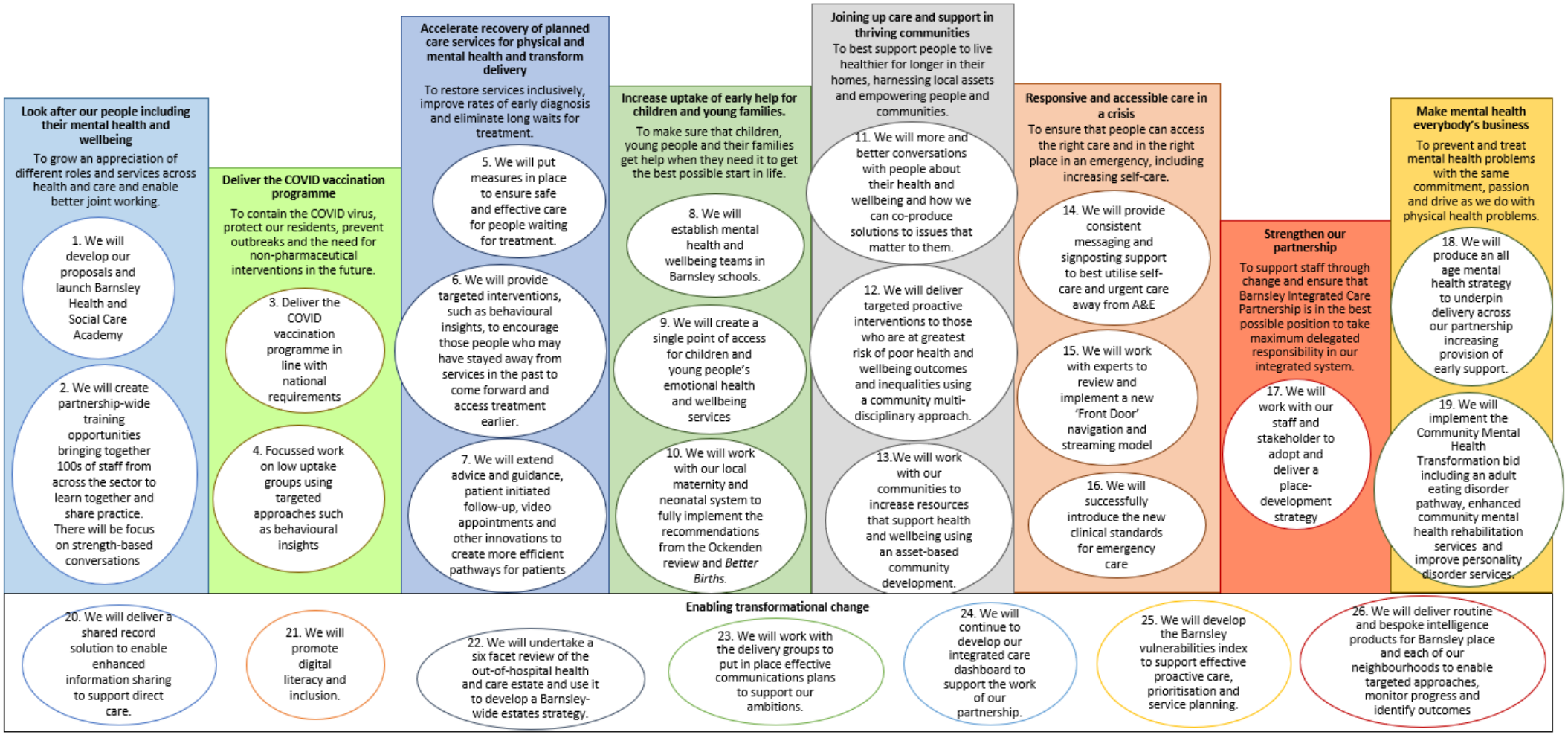
Partners are working together to instil hope into individuals and communities that suicide is preventable and tackle the stigma associated with poor mental health. We also want to ensure people know where to go for help when they need it.

Barnsley has a zero suicide ambition which is a key part of this, by ensuring people and organisations in Barnsley are committed to preventing deaths by suicide in the borough, so people can achieve their potential and lead better, healthier lives.



What we will deliver – summary on a page

The illustration shows 26 deliverables drawn from the long list of priorities that have been identified as top priorities of the integrated care partnership. It does not represent an exhaustive list of all the planned work by partners in 2021/22. What it shows is those deliverables that will benefit most from a collaborative approach and those that are critical to development of the partnership and delivery of its ambitions. As such, Barnsley Integrated Care Delivery Group (ICDG) will provide oversight of all of these deliverables to ensure that risks to delivery are managed and give assurance to the Integrated Care Partnership Group (ICPG).



Programmes – Work Breakdown Structure

Delivery

Community vaccination

3. Deliver the COVID vaccination programme in line with national requirements

4. Focussed work on low uptake groups using targeted approaches such as behavioural insights

Planned Care

5. We will put measures in place to ensure safe and effective care for people waiting for treatment.

6. We will provide targeted interventions, such as behavioural insights, to encourage those people who may have stayed away from services in the past to come forward and access treatment earlier.

7. We will extend advice and guidance, patient initiated follow-up, video appointments and other innovations to create more efficient pathways for patients

Children & Young People/ Best Start partnership

8. We will establish mental health and wellbeing teams in Barnsley schools.

9. We will create a single point of access for children and young people's emotional health and wellbeing services

10. We will work with our local maternity and neonatal system to fully implement the recommendations from the Ockenden review and Better Births.

Care Closer to Home

11. We will have more and better conversations with people about their health and wellbeing and how we can co-produce solutions to issues that matter to them.

12. We will deliver targeted proactive interventions to those who are at greatest risk of poor health and wellbeing outcomes and inequalities using a community multi-disciplinary approach.

13.We will work with our communities to increase resources that support health and wellbeing using an asset-based community development.

Urgent & Emergency Care

14. We will provide consistent messaging and signposting support to best utilise self-care and urgent care away from A&E

15. We will work with experts to review and implement a new 'Front Door' navigation and streaming model

16. We will successfully introduce the new clinical standards for emergency care

Mental Health

18. We will produce an all age mental health strategy to underpin delivery across our partnership increasing provision of early support.

19. We will implement the Community Mental Health Transformation bid including an adult eating disorder pathways, enhanced community mental health rehabilitation services and improve personality disorder services

Design/ICP Development

17. We will work with our staff and stakeholders to adopt and deliver a place-development strategy

Integrated Workforce

1.We will develop our proposals and launch Barnsley Health and Social Care Academy

2. We will create partnership-wide training opportunities bringing together 100s of staff from across the sector to learn together and share practice. There will be focus on strength-based conversations.

Strategic Digital

19. We will deliver a shared care record solution to enable enhanced information sharing to support direct care.

20. We will promote digital literacy and inclusion.

Strategic Estates

21. We will undertake a six facet review of the out-of-hospital health and care estate and use it to develop a Barnsley-wide estates strategy.

Communications

22. We will work with the delivery groups to put in place effective communications plans to support our ambitions.

Health Intelligence Cell

23 We will continue to develop our integrated care dashboard to support the work of our partnership.

24. We will develop the Barnsley vulnerabilities index to support effective proactive care, prioritisation and service planning.

25. We will deliver routine and bespoke intelligence products for Barnsley place and each of our neighbourhoods to enable targeted approaches, monitor progress and identify outcomes

Enablers

Programme	SRO (Org)	Programme Manager (Org)
Early Start Partnership	Melanie John-Ross (BMBC)	Patrick Otway (BCCG), Alicia Marcroft (BMBC)
Mental Health Partnership	Adrian England (HW)	Patrick Otway (BCCG)
Care Closer to Home	Jeremey Budd (BCCG), Wendy Lowder (BMBC)	Joe Minton (BCCG)
Urgent & Emergency Care	Bob Kirton (BHNFT)	Emma Bates (BCCG)
Planned Care	Bob Kirton (BHNFT), Nick Balac (BCCG)	Leanne Sparks
Better Lives	Wendy Lowder (BMBC), Julie Chapman (BMBC)	Jacqui Atkinson (BMBC)
Barnsley community vaccination	Jamie Wike (BCCG)	Janine Quate (BCCG)
ICP Development	Jeremy Budd (BCCG)	Andrew Messina (BCCG)
Strategic Digital	Jeremy Budd (BCCG)	TBC (funding released, job description being agreed)
Strategic Estates	Jeremy Budd (BCCG)	TBC (SEG will prioritise estates out of hospital use)
Integrated Workforce	Joe Minton (BCCG)	Claire Knight (BCCG)
Communications & Engagement	Wendy Lowder (BMBC)	Kirsty Waknell (CCG)
Health Intelligence Cell	Andy Snell (BHNFT)	Joe Minton (BCCG)

	Look after our people (Integrated Workforce Group)		**Deliver the local COVID 19 vaccination programme** (Multi-agency vaccination cell)		**Accelerate recovery of specialist and secondary care services and transform delivery** (Planned Care Board)
What we will do	1. We will develop our proposals and launch Barnsley Health and Social Care Academy	2. We will create partnership-wide training opportunities bringing together 100s of staff from across the sector to learn together and share practice. There will be focus on strength-based conversations.	3. Deliver the COVID vaccination programme in line with national requirements	4. Focussed work on low uptake groups using targeted approaches such as behavioural insights	5. We will put measures in place to ensure safe and effective care for people waiting for treatment.
Why is this important	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 staff choosing to leave the sector are also greater than before the pandemic.		The COVID vaccination programme has been successful in reducing infections and cases of serious illness in the older age groups and those who are clinically vulnerable. Immunisation of the adult population is essential in bringing the virus under control and bringing to an end the restrictions such as social distancing.		The pandemic has had a significant impact on the delivery of elective care and, as a result, on the lives of many patients who are waiting for treatment. Historically in Barnsley we have had very low numbers of people waiting more than a year for a planned procedure but this number has grown to around 500.
What will be better	Partners will work to develop the future health and care workforce, recruiting from local communities including those that are currently under-represented or experience some of the poorest outcomes.	There will be greater appreciation of different roles and services across health and care and enable better joint working. The health and care workforce will feel valued and empowered. There will be improvement to staff satisfaction and retention resulting in better quality of care for local residents.	There will be increased levels of immunity to the variants of COVID-19 that are currently dominating which means fewer infections, outbreaks, cases of severe illness and COVID-related deaths. If this trend continues then it will be possible for the Government to continue to reduce current restrictions and prevent the need for introducing restrictions in the future. If the virus is controlled it is less likely that new strains will appear with potential to disrupt recovery efforts.		People in Barnsley will know when they can expect to be seen for routine care and what to do to keep them as well as possible whilst they are waiting
How we will measure success	• Improved staff engagement • Reduced vacancy rates across our services and reduced staff turnover	• Uptake of training offer and evaluation of training provision	• Uptake of vaccine amongst JCVI priority groups	• Uptake of vaccine amongst locally determined target groups and protected characteristic groups	• Reduced patients waiting more than 18 and 52 weeks
Interdependencies	NHS People Plan and SYB Workforce Strategy Group, SYB ICS Workforce Programme and South Yorkshire Regional Excellence Centre		Vaccine supply and guidance from the Joint Committee on Vaccination and Immunisations		Communications, engagement and participation, sharing of data and intelligence across the system to identify issues and pressures, consistent messaging, elective recovery framework and accelerator programme
Key milestones	• Establish a working group in June 2021 • Identify existing training, skills and employment support provision that can form part of the academy in July 2021 • Develop a proposal and business case to address any gaps in provision by March 2022	• Training needs assessment by September 2021 • Construct a programme of training for health and care staff across different disciplines and settings by November 2021 • Begin delivery of the programme by January 2022	• All adults to be offered the COVID vaccine by 31 July		

	Accelerate recovery of specialist and secondary care services and transform delivery (Planned Care Board)		Increase uptake of early help for children and young families (Best Start Partnership and Mental health partnership)		
What we will do	6. We will provide targeted interventions, such as behavioural insights, to encourage those people who may have stayed away from services in the past to come forward and access treatment earlier.	7. We will extend advice and guidance, patient initiated follow-up, video appointments and other innovations to create more efficient pathways for patients	8. We will establish mental health and wellbeing teams in Barnsley schools.	9. We will create a single point of access for children and young people's emotional health and wellbeing services	10. We will work with our local maternity and neonatal system to fully implement the recommendations from the Ockenden review and *Better Births.*
Why is this important	The number of patients being referred to Barnsley hospital dropped significantly during the pandemic and there is evidence to suggest people are delaying seeking treatment. We also know that the impact of the pandemic and accessing healthcare through the pandemic has not been the same for different groups within our population, for example some minority ethnic groups and people from more economically deprived communities.	New models of securing specialist input to support patients outside of hospital will be critical in releasing resource to invest in primary and community care.	Over half of mental health conditions start by the age of 14 and 75% start by age 18 and it is often the case that children and young people do not get the help they need, as quickly as they should. As a result, mental health difficulties such as anxiety, low mood, depression, conduct disorders and eating disorders may prevent some young people achieving their full potential and making a full contribution to society (Future in Mind, 2015).		Implementing the vision set out Better Births will support the Secretary of State's ambition to halve the number of stillbirths, neonatal and maternal deaths and brain injuries by 2030. The Ockenden report was written following an independent review of maternity and neonatal services at Shrewsbury and Telford Hospital NHS Trust. Although the investigation is not complete, it has identified immediate and essential actions for maternity services in England.
What will be better	There will be earlier diagnosis of illness resulting in quicker treatments and better outcomes, particularly for those people who currently experience inequalities.	Technology and innovation will provide greater choice to patients and for many it will mean that they are less likely to have to travel significant distances for appointments.	There will be increased support for children and young people that is accessible and integrated within the existing service offer. This will lead to higher uptake of early interventions preventing problems from getting worse.		Maternity transformation will improve continuity of care, personalisation and choice as well as ensure better management of maternal risks.
How we will measure success	• Meeting the elective recovery framework gateway • Earlier diagnosis of cancer • Increased referrals from community and primary care people who are vulnerable or from deprived communities	• The number of specialities offering advice and guidance and patient initiated follow-up • Number of referrals resulting from advice and guidance • Number and proportion of outpatient appointments that are by telephone or video	• Total referrals received • Outcome and experience measures for service users • Uptake of services from vulnerable groups • A reduction in referrals to specialist services by providing early intervention support • Lower levels of exclusions	• Increase early help interventions • Rate of referrals to specialist services • Reduced waits from referrals to treatment	• Continuity of carer • Improving outcomes for black and minority ethnic groups • Increased breast feeding initiation • Percentage of pregnancies where first contact with the antenatal diabetes team was before 10 weeks gestation
Interdependencies	Behavioural insights and harm reduction plans, Barnsley cancer steering group and SYB cancer alliance, rapid diagnostics pathways, vulnerabilities index.	SYB outpatients transformation programme, local and system-level digital and primary and community estates strategy	Barnsley schools, special educational needs and disability (SEND) improvement plan.		Local maternity and neonatal system and quality surveillance group, better information sharing between primary care and maternity services, extra capacity for longer appointments in antenatal clinics.
Key milestones	• Ensure there is capacity in community to support secondary care accelerator sites pre and post op		• Mindspace Establish joint working with key partners and place within the system by September 2021 • Commence NHSE Trailblazer by February 2022 • Commence primary schools team by April 2022		

	Joining up care and support in thriving communities (Care Closer to Home Board)			Responsive and accessible care in a crisis (Urgent and emergency care delivery board)		
What we will do	11. We will more and better conversations with people about their health and wellbeing and how we can co-produce solutions to issues that matter to them.	12. We will deliver targeted proactive interventions to those who are at greatest risk of poor health and wellbeing outcomes and inequalities using a community multi-disciplinary approach.	13.We will work with our communities to increase resources that support health and wellbeing using an asset-based community development.	14. We will provide consistent messaging and signposting support to best utilise self-care and urgent care away from A&E	15. We will work with experts to review and implement a new 'Front Door' navigation and streaming model	16. We will successfully introduce the new clinical standards for emergency care
Why is this important	Engagement brings more information to the decision, including clinical or technical expertise, personal experiences from patients, service users, carers and the general public, and knowledge about the wider context and history. These conversations will ensure that support is based on how people want to be supported and they are seen as experts in their own support.	People with multiple and complex needs are perhaps most at risk of experiencing disjointed care as health and care services traditionally focus on individual needs or deficits rather than taking a person-centred approach. As well as duplication, this can also lead to gaps in care putting people at risk of crisis or deterioration.	Many of the solutions to health and wellbeing challenges lie with individuals experiencing the issues themselves and the communities where they live. Supporting communities using an asset based approach can help to build resilience to issues and challenges.	A&E at Barnsley Hospital has seen a steady year on year rise in attendances. The growing demand was approaching an unsustainable level for the system including the workforce, building and facilities. This level of demand has returned and is continuing to rise. A high numbers of people getting through to care teams could be managed at first point of contact.	During the pandemic the GP streaming service in A&E was suspended because of social distancing requirements.	The updated standards aim to capture what matters clinically and to patients, end hidden waits and reduce the risk of spreading COVID-19. All hospitals with a major A&E department will be required to provide same-day emergency care services at least 12 hours a day, 7 days a week.
What will be better	Local residents are engaged and involved in health and care service development and design as they want to be and engagement is proportionate for protected characteristic and seldom heard groups	Multi-disciplinary teams will work proactively to support those people at greatest risk of crisis with joint assessments and strengths-based personalised care and support planning.	There will be a clear community model of wrap around support linking people to third sector support with clear referral pathways and a range of providers who can meet the needs of our vulnerable groups so people can live independently as long as possible.	People who do not need emergency care will have timely access to urgent treatment services as an alternative to A&E. People who do need emergency care will experience fewer delays because the accident and emergency department will not be as busy. This will lead to a better experience for staff as well as service users.		Patients will have improved access to specialist care and diagnostics that prevent a hospital stay, Same day emergency care will also avoid the need for patients to attend A&E in some cases and consequently reduces delays and pressure in the department.
How we will measure success	• Number of people views captured from people and communities • Participation and engagement with protected characteristic groups	• Number of people who receive proactive interventions • Improved Health related quality of life for people living with long term health conditions and carers • Fewer unplanned admissions for ambulatory care sensitive conditions	• Increase referrals to social prescribing services • Increase in the number of new community groups supporting health and wellbeing • Increase number of people signposted to community groups and organisations • Increased investment in community and voluntary sector organisations	• Number of A&E attendances • Increase use of NHS 111 and signposting to alternatives to A&E • Urgent community response – two hours and two days	• Activity through streaming • A&E performance • Staff and patient experience	• Availability and access to same day emergency care • Improving staff and service user satisfaction (friends and family test)
Interdependencies	Participation Groups, engagement forums, Community Voluntary Services and Healthwatch Barnsley. Workforce development / strengths based practice	Population health management tools, anticipatory care and personalised care national specifications and programmes.	Barnsley Area Councils and Ward Alliances, social prescribing services	NHS 111, Yorkshire Ambulance Service, communications and engagement plans.	NHS 111, Yorkshire Ambulance Service, communications and engagement plans.	NHS 111, Yorkshire Ambulance Service, communications and engagement plans.
Key milestones	• Principles and approach to health inequalities is adopted by the partnership in June 2021 • Priority cohorts of people are identified through analysis of health inequalities in July 2021 • Engagement plan developed with all stakeholders by September 2021	• Reablement pilot from Sep 21 to Mar 22 • NHS Pathways system configure for proactive case finding in June 21 • Testing of strengths based conversation tool in July 21 • Tools and pathway agreed and ongoing monitoring from Sep 21	• Baselining of current position in each of our neighbourhood for priority cohorts identified through analysis of health inequalities by September 2021 • Relaunch of Live Well Barnsley to support community prevention and early intervention model • Trial changes to front door of adult social care to redirect people to community / preventative resources	• Increase NHS 111 capacity • Ensure availability of alternative secondary care dispositions to users of NHS 111 services • Implement an ED referral and booking system for users of NHS 111 services • Develop and deliver a local communication strategy	• Agree the front door model • Develop method to send patients away with appointment • Development of 'crisis café' - virtual support mechanism for people out of hours • Development of ambulance pathways through RightCare Barnsley	• Development of frailty virtual ward (similar to virtual COVID ward). • Capital works to support reconfiguration of site. • Monitoring in place to achieve % reduction in LOS <24 hours.

	Strengthening our partnerships (Design Team)	**Make mental health everybody's business** (Mental health partnership)		**Enabling of transformational change** (Strategic digital group)	
What we will do	17. We will work with our staff and stakeholders to adopt and deliver a place-development strategy	18. We will produce an all age mental health strategy to underpin delivery across our partnership increasing provision of early support.	19. We will implement the Community Mental Health Transformation bid including an adult eating disorder pathway, enhanced community mental health rehabilitation services and improve personality disorder services	20. We will deliver a shared record solution to enable enhanced information sharing to support direct care.	21. We will promote digital literacy and inclusion.
Why is this important	In February 2021 the Government set out proposals to bring forward legislation that aims to further integrate and improve care at neighbourhood, place, and system level. This presents Barnsley place with an opportunity to further build on partnership working but also is a promise of further change which can be unsettling for the workforce. Being in the position to secure benefits from this change will be paramount.	Mental health and wellbeing is consistently raised as a priority by people and health and care providers in Barnsley. Barnsley has relatively high rates of depression, hospital admissions for self-harm and suicides. The COVID pandemic will have significant longer term impacts on people's mental health and wellbeing and consequently further rises in demand for services are likely.	The NHS Long Term Plan and NHS Mental Health Implementation Plan 2019/20 – 2023/24 set out that the NHS will develop new and integrated models of primary and community mental health care. A new community-based offer will include access to psychological therapies, improved physical health care, employment support, personalised and trauma informed care, medicines management and support for self-harm and coexisting substance use.	Investing in the digital capabilities of health and social care is a clear priority in the NHS Long Term Plan and over future years we will see the transformation of care through digital services and data interoperability. A Shared Care Record (SCR) is at the core of the roadmap. SCRs can deliver a range of benefits encompassing clinical safety, operational efficiency, improved patient care and experience, and financial savings.	Access and use of information and communication technologies impacts individuals and the community as a whole. Through the pandemic there has been a significant shift to online and remote technology in healthcare and it is critical that this does not widen the inequality gap.
What will be better	The health and care workforce will feel empowered. Professionals from across health and care will be engaged and involved in the process of system change, see the benefits and opportunities presented and also the risks, and understand how they can help to ensure the best possible outcome for Barnsley people through recovery, restoration and renewal.	There will be joined up vision and approach to supporting people who have or are at risk of developing mental health conditions. Communities and services will work together to prevent people from suffering from mental health problems.	People with mental health problems will be enabled to access mental health care where and when they need it, manage their condition or move towards individualised recovery on their own terms and contribute to and be participants in the communities that sustain them, to whatever extent is comfortable to them	Patients only have to tell their story once. Initial assessments take less time. There will be fewer unnecessary appointments and related travel. Clinicians involved in care are able to treat the individual with the benefit of up to date knowledge about them. There will be less duplication and better joined up care across services.	Nobody will be excluded from health and care because of limited access to technology or internet connectivity. More people will be able to use new technologies to manage their own health and wellbeing.
How we will measure success	• Improvement from baseline position against the SYB ICS Development Matrix • Continued positive staff engagement	• Mental health strategy adopted by the Health and Wellbeing Board • Increasing early help for people's mental health		• Number of people accessing shared care records • Staff and patient feedback • Return on investment	
Interdependencies	Guidance from the Department of Health and Social Care, NHS England and the SYB integrated care system. Development of strategic commissioning and support functions across SYB Integrated Care System.		Development of the all age mental health strategy, care closer to home agenda, national transformation community mental health services programme and primary care network guidance and development.	SYB digital strategy, programme management and business change resource and investment.	SYB digital strategy and digital literacy programme.
Key milestones	• Undertake self-assessment against the different domains of the development matrix in June 2021 • Agree priority areas and actions to deliver improvements against the framework in July 2021	• Public consultation in August 2021 • Presentation at the mental health partnership in September 2021 • Presentation at health and wellbeing board in October 2021	• Report exploring issues with recommendations to mental health partnership in July 21	• Minimum viable shared care record by October 2021 • Plan for full shared care record by TBD • Barnsley digital strategy by March 2022 • SWYPFT and Barnsley Hospital onboarding to YHCRE by TBD	

	Enabling of transformational change (Strategic Estates Group)	**Enabling of transformational change** (Communications and engagement Group)	**Enabling of transformational change** (Health intelligence group)		
What we will do	22. We will undertake a six facet review of the out-of-hospital health and care estate and use it to develop a Barnsley-wide estates strategy.	23. We will work with the delivery groups to put in place effective communications plans to support our ambitions.	24. We will continue to develop our integrated care dashboard to support the work of our partnership.	25. We will develop the Barnsley vulnerabilities index to support effective proactive care, prioritisation and service planning.	26. We will deliver routine and bespoke intelligence products for Barnsley place and each of our neighbourhoods to enable targeted approaches, monitor progress and identify outcomes
Why is this important	More care in the community is a cornerstone of the NHS long-term plan and essential to the future sustainability of the NHS. It is important that the productivity of the estate is maximised and funding released to develop transformation projects. The need for modern, efficient buildings within primary care has been well documented. Providers need to work together to avoid planning in isolation.	Strong engagement and communication with a wide range of people and organisations throughout the health and social care system is vital for the successful delivery of better care. It is important to create a compelling story which everyone at all levels across the system can associate with and take themselves back to when they are facing a challenging situation to remind themselves that this is why we are on this journey.	Monitoring outcomes that are important to people and communities, that cover the continuum of health and wellbeing from informed care to the determinants of health and inequalities will ensure the priorities and action will have the greatest possible impact.	Rightly, the local NHS is increasing being asked to prioritise health inequalities whilst planning and delivering health and care. The are several factors that influence the risk of somebody experiencing poorer health and outcomes from treatment. Often many of these factors are not known to services and clinicians to inform decision making. The vulnerabilities index offers an objective assessment of a person and household's risk of experiencing health inequalities.	A learning system that draws on knowledge and best practice from other parts of the UK and internationally to improve health and wellbeing outcomes for local people and address inequalities
What will be better	Improved facilities for patients and efficient use of building. Support the delivery of more care closer to home.	Clear identity for the health and care partnership in Barnsley. Key messages are consistently shared with staff, patients and other stakeholders to support shared objectives.	Decision making at every level of the system is demonstrably evidence based and community orientated.	Services can be tailored to target those people most at risk.	
Interdependencies	National primary care estates programme, investment to support estates strategy development	Media, social media channels, patient and service user forums and representatives.	Access to local datasets, development of adult social care performance framework and national data collection and reporting.	Continued information sharing between partners.	Continued data sharing between partners, and sharing of intelligence and best practice with other areas through networks including the SY Data Cell
Key milestones	• Six facet review TBD • Development of Barnsley health and care estates strategy	• Review of finalised health and care plan to develop communications strategy in July 2021 • Development of an identify for joint working across health and care in Barnsley	• Incorporation of key measures for health inequalities and health and care priorities by September 2021	• Development of a minimum viable product for healthcare prioritisation in June 2021 • Testing of dataset in secondary care TBD • Communications and engagement plan by July 2021 • Development of further use cases and information sharing arrangements for secondary use by October 2021	• Ongoing

Tackling health inequalities

Tackling health inequalities is a priority that cuts across all of our work as a partnership. We have developed 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.

For tier one our approach will be to use data and insights to identify groups within our population who are experiencing health inequalities, engage representatives in rich dialogue that starts with the assumption that the majority of solutions lie with individuals and within their communities, and then devise a series of initiatives that will improve how health and care organisations serve their needs. This work with sit with the Care Closer to Home Board predominantly.

For tier two we will use the best evidence available to determine how we prioritise access to health and care across all of our core services. This work will sit with the planned care and urgent and emergency care delivery groups predominantly.

For tier three we will work with partners to advocate for, promote and prioritise the needs of groups in our population that are currently disadvantaged. This will be achieved through our work on anchor institutions, inclusive economy, Barnsley 2030, workforce development and other areas.

Our emerging framework for tackling inequalities in Barnsley

How we develop our service offer

- Engaging with people and communities who are experiencing poorer health outcomes to co-create future models of care
- New interventions and services that aim to prevent new illness and deterioration of illness for those individuals and communities that experience poorer outcomes
- Increasing relative investment in areas that have been historically underfunded – prevention/primary care/mental health services

How we deliver our existing core services

- Engaging with people from communities that experience poorer health outcomes to understand their collective experience of health and care
- Taking account of health inequalities in prioritising people for treatment
- Systematically tackling barriers that people experience when accessing/engaging with health and care services

Helping to drive a more inclusive society and economy in Barnsley

- Contribution to Barnsley 2030 aspirations as anchor institutions
- Improving sustainability of services – social, economic and environmental
- Creating diverse and inclusive workforce and leadership that represents our changing communities in Barnsley
- Providing excellent employment and career opportunities for local communities experiencing inequalities
- Influencing wider socio-economic policy to improve living environments and opportunities for local communities

Gradual shift in our focus and investment as a system to support the needs of all, starting with the most vulnerable; improving health and wellbeing across the whole life-course; and developing a parity across physical, mental, social, environmental and economic health.

Healthy Barnsley

Learning Barnsley

Growing Barnsley

Sustainable Barnsley

Involving people | The Barnsley Approach

During the COVID pandemic our engagement and experience teams have worked together to help ensure that the experiences and perspectives of our residents and service users have informed our priorities and delivery. A component of this work has been to share insight gathered from across our services to regularly report *What people are telling us* as part of regular surveillance.

We will build on this to deliver a shared approach to engagement and participation that truly values to perspectives and contributions of people in our place.

Engagement and experience leads have already agreed a series of principles that will be core to this approach in 2021/22.

- Have a strong local focus and work on both strengths and solutions with local communities
- Value equality and the diversity of local communities
- Make sure information is accessible and jargon free
- Ensure that everyone has a voice and we listen and learn from our staff and communities
- Involve the right people, at the right time and come to you
- Keep it simple and be honest about what you can influence
- Avoid repeating the same conversations
- Be open and transparent with what we know and what we have done and why

Issues and constraints

Area	Description of constraint, risk or issue
Demand	Several service areas are experiencing extremely high levels of demand including A&E, primary care, inpatient mental health services and parts of community services.
Provider failure	The care home market in Barnsley is quite fragile. Historically there has been an over-reliance on long term placements in residential care settings and the shift towards home first means over-supply of placements in Barnsley. Throughout the C19 pandemic the Council and NHS has been supporting care providers to respond and be resilient as a sector.
Mental health demand	Various studies and reports suggest that mental health needs will increase as a result of the pandemic. Evidence suggests that areas like Barnsley which already has a relatively high rates of depression and harmful drinking and are more at risk of job losses could see a more significant impact on mental health wellbeing and resilience.
Workforce	The health and care workforce have gone above and beyond to deliver personalised care to patients and service users throughout the pandemic in difficult and challenging circumstances. Staff members and teams will have been affected directly by the pandemic and there will continue to be tests and challenges which could effect capacity and resilience including school closures.
Community resources	Community and voluntary sector organisations in Barnsley have played an vital role in supporting vulnerable people through the pandemic despite capacity being limited due to social distancing restrictions and shielding. As a result of lockdown many will have experienced disruption to normal fundraising routes and face an uncertain future.
Inequalities	The pandemic has had a greater impact on particular groups of the population, including some already experiencing health inequalities. The changes to how people have accessed health and care services during the pandemic will mean some are at increased risk of poorer outcomes.
Finances	The system was in a challenged financial position prior to COVID.
Social distancing	Services are not able to recover to pre-pandemic levels of activity because social distancing requirements is limiting capacity, for example limited space in waiting areas and insufficient bathroom facilities to be COVID safe.

NHS
Barnsley
Clinical Commissioning Group

GOVERNING BODY

9 September 2021

CANCER PROGRAMME ASSURANCE

PART 1A – SUMMARY REPORT

1.	**THIS PAPER IS FOR**							
	Decision		*Approval*	X	*Assurance*	x	*Information*	x
2.	**PURPOSE**							

The purpose of this report is:

1. To provide Governing body with assurance about the cancer programme position and update on the Cancer priorities within the Governing Body Assurance Framework (GBAF). These are outlined in the table below.
2. To provide assurance to the Governing body and Barnsley population that the CCG has a plan in place for managing the impact of COVID on the pathways.

Priority	Progress /assurance
Preventing cancer incidence	Refer to the section Minimising harm due to Covid on the cancer pathways
Reduced Inequalities especially those diagnosed at emergency admission	Refer to the section Minimising harm due to Covid on the cancer pathways
Better cancer survival to be diagnosed at stage 1 or 2	Refer to the section on restoring the 28 days cancer referrals to diagnosis pathway service improvements and cancer waiting times
Implement rapid assessment and diagnosis pathways for all tumour sites	Refer to the section on restoring the 28 days cancer referrals to diagnosis pathway service improvements and cancer waiting times
Improve care and treatment - embed new cancer waiting times system	Refer to the section on restoring the 28 days cancer referrals to diagnosis pathway service improvements and cancer waiting times

Access to the most modern cancer treatment	This is embedded within the cancer programme
Increasing Positive Experience at EOL by increasing early identification and reducing 3 or more admissions in last 3 months of life	This is monitored by CCG QIPP assurance governance and Barnsley EOL Steering group
Improve Patient Experience along pathways and Living With and Beyond Cancer (LWBAC)	Refer to LWABC section
Deliver Survivorship Program (LWABC) including recovery package Stratified follow up pathways breast, prostate and urology rolled out	Refer to LWABC section
Commissioning for Value adopted if appropriate	This is adopted when appropriate. Refer to conclusion section of the report
Achieve 10 waiting time standards including the 62 day referral-to-treatment cancer standard and 28 day faster diagnosis standard and pre-covid position	Refer to the section: Restoring the 28 days referrals to diagnosis at 62% (target is 75%) Diagnosis referrals are that 85% of people within 62 days from referral from a GP practice will have a treatment date. The latest validated performance is 84% at June 2021.

3. REPORT OF

	Name	Designation
Executive	Jamie Wike	Chief Operating Officer
Clinical Leads	Dr Kadarsha Mr M Simms	Cancer Governing Body Clinical Lead Secondary Care-Governing Body Member
Author	Siobhan Lendzionowski	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
Barnsley Cancer Steering group	29/7/2021	Noted issues and ongoing actions being delivered
Local Authority Overview and Scrutiny Committee	20/7/2021	Noted issues and ongoing actions being delivered
Quality and Patient Safety Committee	15/3/2021	Noted issues and ongoing actions being delivered

5.	EXECUTIVE SUMMARY

The aim of this paper is to provide a 6 monthly assurance update to the Governing Body for the CCG cancer programme, which is part of the CCG GBAF.

It is also to instil confidence to the Barnsley public and the Governing body that actions are in place to respond to the 2021/22 NHS Planning guidance document that was published in March 2021.

It outlines that the CCG and Providers via the Cancer Alliance are to draw up a single delivery plan on behalf of the integrated care systems (ICSs) for April 2021 to September 2021 to deliver the following actions:

- Ensuring patients come forward - work with GPs and the local population to increase the number of people coming forward and being referred with suspected cancer, with a particular focus on groups under-represented among those who have come forward.
- Systems should in 2021/22 prioritise actively support their practices as they complete the QOF Quality Improvement module on early cancer diagnosis, which has been continued into 2021/22 as part of GP contract arrangements.
- Work with public health commissioning teams to increase take up of innovations like colon capsule endoscopy and Cytosponge to support effective clinical prioritisation for diagnostics.
- Accelerate the development of Rapid Diagnostic Centre pathways for those cancer pathways which have been most challenged during the pandemic.
- Restore first phase Targeted Lung Health Check projects at the earliest opportunity and begin planning the launch of the Phase 2 projects. It is expected that Barnsley will be one of the new areas to be launched by April 2022.
- Systems will be expected to meet the new Faster Diagnosis Standard from Q3, to be introduced initially at a level of 75%.

All these areas are being actioned by the Barnsley Cancer Steering Group Programme Plan including any ongoing mitigating actions. This is in conjunction within the SY&B Cancer Alliance governance routes.

This paper focuses on providing assurance about three areas that are either the priorities for the cancer programme or have not had a focus within previous governing body reports. The areas are:

1. Restoring the 28 Days Cancer Referrals to Diagnosis Pathway service improvements and cancer waiting times
2. Living With and Beyond Cancer Programme
3. Minimising harm due to Covid on the cancer pathways

The main risks to the CCG of the cancer programme delivery are:

- The impact of COVID demand on the delivery of the pathways and restoration to a Pre-Covid position both at Barnsley and Sheffield Hospitals
- The impact of COVID transmission fears or restrictions on patients abilities to present at services

	• Impact of COVID demand on Primary care ability to engage and take part in new ways of working and initiatives.
6.	**GOVERNING BODY IS ASKED TO:**
	• Note the information that is providing assurance for the cancer programme delivery and approve this assurance paper.
7.	**APPENDICES / LINKS TO FURTHER INFORMATION**
	Appendix A : Validated performance data - June 2021  Appendix A.doc

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:	*Cancer delivery* *15/12*

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?	***Yes***
Approved the paper content	

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?	***Yes***
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***

1.	**DISCUSSION / ISSUES**
	The cancer programme remains on track to meet the majority CCG GBAF priorities, as outlined within the table on page one. This paper focuses on providing assurance about three areas that are the priorities for the cancer programme or have not had a focus within previous governing body reports. These three areas are outlined in more detail within the sections below:

1. Restoring the 28 Days Cancer Referrals to Diagnosis Pathway Service Improvements and Cancer Waiting Times

The COVID Pandemic has had an impact on early diagnosis and people with cancer in a number of ways.

During the pandemic referrals for people whom have had a referral by a GP because they suspect cancer dipped dramatically in June 2020 to less than 60 compared to over 400 per month. Referrals have been steadily rising since January 2021 to 683 and are now above pre-Covid rates by 27% and to an average of 800 referrals a month coming into the hospital.

The most up to date validated performance data is for June 2021, as outlined in the table below: (Refer to appendix A for a larger table)

Focus Month Breakdown:

		14 Day Standard				28 Day Standard						31 Day Standard						38 Day Standard		62 Day Standard					
June 2021		Two Week Wait Referrals		Breast Symptomatic 2WW Referrals		Faster Diagnosis Standard (FDS) Two Week Wait		Breast Symptomatic		Screening		First Treatment		Subsequent Treatment Surgery		Chemotherapy		Inter Provider Transfer		GP Referral to Treatment		Screening Referral to Treatment		Consultant Upgrade to Treatment	
TARGET		93.0%		93.0%		75.0%		75.0%		75.0%		96.0%		94.0%		98.0%		85.0%		85.0%		90.0%		85.0%	
CBU 1	Haematology	9/10	90.0%	-		7/9	77.8%	-		-		8/8	100.0%	-		7/7	100.0%	0/1	0.0%	1.0/1.0	100.0%	-		5.0/6.0	83.3%
	Lung	18/21	85.7%	-		13/17	76.5%	-		-		2/2	100.0%	-		-		5/8	62.5%	1.0/1.0	100.0%	-		3.0/5.0	60.0%
	Skin	175/185	94.6%	-		127/160	79.4%	-		-		20/20	100.0%	-		-		1/1	100.0%	15.0/15.0	100.0%	-		3.0/3.0	100.0%
CBU 2	Breast	130/183	71.0%	77/91	84.6%	166/169	98.2%	88/90	97.8%	40/40	100.0%	20/20	100.0%	11/11	100.0%	-		-		12.0/12.0	100.0%	6.0/6.0	100.0%	1.0/1.0	100.0%
	Head & Neck	82/84	97.6%	-		62/83	74.7%	-		-		1/1	100.0%	-		-		2/4	50.0%	0.5/1.0	50.0%	-		1.0/1.0	100.0%
	Lower GI	204/209	97.6%	-		36/184	19.6%	-		3/18	16.7%	14/14	100.0%	1/2	50.0%	-		0/4	0.0%	1.0/6.0	16.7%	0.0/2.0	0.0%	6.0/7.0	85.7%
	Upper GI	79/83	95.2%	-		51/74	68.9%	-		-		11/11	100.0%	1/1	100.0%	-		5/8	62.5%	0.5/2.0	25.0%	-		11.5/12.5	92.0%
	Urology	82/93	88.2%	-		38/85	44.7%	-		-		13/13	100.0%	1/1	100.0%	2/2	100.0%	1/2	50.0%	9.0/9.5	94.7%	-		3.5/3.5	100.0%
CBU 3	Gynaecology	78/81	96.3%	-		20/54	37.0%	-		6/30	20.0%	6/6	100.0%	-		-		1/2	50.0%	2.5/3.0	83.3%	1.0/1.0	100.0%	3.0/3.0	100.0%
TRUST TOTAL		858/950	90.3%	77/91	84.6%	522/838	62.3%	88/90	97.8%	49/88	55.7%	96/96	100.0%	14/15	93.3%	9/9	100.0%	15/30	50.0%	42.5/50.5	84.2%	7.0/9.0	77.8%	37.0/42.0	88.1%

That shows that 28 faster diagnosis day standard is 62% (target 75%) and 62 days referral to treatment is 84.2% (target 85%) and back at pre-Covid level. This improvement is because over a 100 patients were treated in a single month in June at BHNFT, which is an 80% increase from June 2019 figures.

There have also been a number of patients whom were waiting the longest that now have had a treatment dates agreed, as capacity has increased to accommodate this backlog. This includes some patients whom previously have chosen to defer their treatment date due to COVID fears. The tumour pathways for lower GI and Urology performance remains a challenge. It is expected that the introduction of the FIT test to exclude cancer within primary care and improving the speed that patients treatment planning occurs will improve this position.

The hospital has seen a stage shift during the COVID pandemic from the first wave reduction, to the pause in Endoscopy Services, to the increase in referral rates and delays to treatment due to Bed pressures. However, throughout the past 6 month Cancer services have continued to be maintained and patient journeys have progressed.

Cancer services have been fully staffed throughout this period and continue to be fully staffed. This has ensured that Cancer services have been running throughout the whole last 6 months.

The table below show the main areas that BHNFT are currently working on to deliver and improve patient experience and restore the cancer compliancy standards.

Area of Challenge	Mitigating Actions to Meet Challenge
Referral Volume and Quality	C the Signs referral system in GP Practices will improve the consistency High quality patient information in place so patients aware that on a suspected cancer referral and that need to attend asap Understanding patient numbers accessing GPs compared to patient whom go straight to have a test instead of an avoidable appointment first
Pre-Work in GP Practices	FIT test for lower GI – ensuring all tests undertaken before the referral Performance status of patients collected to improve speed of referral process
Access to Straight to test for Referrals	Using rapid diagnostic project to improve all pathways performance Working on having 'one stop' Upper GI journey for the patient – that has the least possible steps in place and appointments on one day
Improving Turn Around Times in Histopathology and Radiology	Joint workforce increased by working with Universities and Colleges Progressing 10 days from request to report
Urology pressures	Expand on Mid Yorkshire Hospital working mode to increase capacity and less invasive diagnostic testing
Meeting 28 days faster diagnosis by October 2021 , April validated performance is 62.1% compared to 75%	Design of template letters to support Consultant dictation to be much quicker so patients are told if have cancer or not Increasing endoscopy capacity to meet the targets
Management of the Volume of Patients	Additional post in the referral team to support administration and triage of referrals and less burden on Clinician so can focus on complex patients Creating local demand and capacity planning so that can anticipate the surge and change capacity to meet demand much quicker Increasing navigator roles in 5 tumour referral pathways so patient whom are referred have one point of contact in the hospital

2. Living With and Beyond Cancer (LWABC) Programme

The LWABC Macmillan Funded 5 year programme finished in March 2021. Based on the evaluation of the programme in South Yorkshire, the four main personalised care and support interventions will continue, to all people affected by cancer.

During the last four years the following changes have occurred:

LWABC Interventions	Before Programme	Programme Outcomes for Breast, Colorectal and Prostate
Holistic Needs Assessments (HNA) & Personalised Care Planning (PFU)	Capacity challenges meant that CNSs often lacked the time to have meaningful conversations with every patient.	• Programme facilitated improvements in the quality, availability and value of meaningful conversations, using the HNA as a structured framework. Conversation is a powerful support tool, which improves the quality of the patient experience, and equips patients with the skills, knowledge and confidence for self-management in the future, which is a critical enabler for the success of PSFU. • Insights gained from aggregate data and enhanced services and models of care. • Personalised Care & Support Plan now shared electronically with GP.
Cancer Support Worker (CSW)	Holistic support needs not consistently discussed or addressed.	• Introduction of 3 CSW roles pivotal to embedding meaningful conversations, underpinned by the HNA framework. • Clinical team have access to a record of each conversation to refer back to and build on. • Patients have access to a care plan which is shared with the GP and other agencies where helpful. • Knowledge of community services has increased
Health Well Being Information and Support (HWBIS)	Developing programme of work but no committed resource.	• Dedicated HWB Facilitator now formally coordinating HWB opportunities on behalf of BHNFT. • The Well successfully relocated to Regent Street Emerging as the community cancer Hub, with an expanding menu of services and opportunities e.g. coffee morning, two Macmillan Benefits Advisors based there two half days a week. • Collaboration with national charity Look Good Feel Better; now offering to men
End of Treatment Summary (EOTS)	Traditional clinical letter produced; not always meaningful to patients or primary care.	• EOTS templates developed for 3 tumour sites. Patients and GPs empowered with key information about diagnosis, treatment and likely longer term needs. Able to self-manage more effectively. • EOTS where available, now shared electronically with GP.
Cancer Care Review (CCR)		• Prior to COVID, CCR templates refreshed, User Guide and Local Directory of Services developed 22 practice visits undertaken (others were planned) and education events supported.

		'QOF data for 2019/20 shows an increase in the proportion of eligible patients receiving a CCR from 71% in 2017/18 to 89% in 2019/20. Furthermore, only three practices in 2019/20 were providing CCRs to less than 75% of eligible patients, compared to 19 practices in 2017/18.' • Personalised Care & Support Plan and EOTS now shared to inform. • New monthly LWABC Newsletter produced for Primary Care. • CCR now part of the PCN Care Coordinators and HWB Coaches Work Plans.
Personalised Stratified Follow Up (FU) Pathways		• On track for 3 teams with FU pathways revised to improve patient experience and create efficiencies. • Prostate Cancer Study of interest; inform next steps for the Urology service but shared learning for all tumour sites. • Upper GI, Head & Neck, Gynaecology, Skin next for 2021/2022 with full implementation.
Remote Monitoring		• Technical process in place; Patient Information developed.

Evidence from Bright Purpose Independent Evaluation on the programme from the Patient Survey results showed that people who had one or more HNA conversation:

- described a significantly better experience of care and support than those who hadn't
- were much more likely to say their care and support had a positive impact on their quality of life
- felt more supported to adapt to changes that cancer had led into their lives
- knew where to go for support in future, for both clinical and non-clinical concerns
- felt more confident to self-manage and look after their health and well-being

Activity Trackers demonstrated over a 2 week period a saving of approx. 2 hours per day for other clinicians. In monetary terms this average saving equates to £14,000per annum. This evidence has supported a recent decision by BHNFT to adopt these roles on a permanent basis and to support the introduction of CSW roles for other tumour sites.

In addition, staff at The Well made over 500 well-being calls to patients new and old during the pandemic when services were paused.

In summary the evaluation highlighted that:

If the COVID-19 pandemic had not happened, the programme was on track for achieving full implementation of the LWABC model in all seven localities.

Those elements that were in place before the pandemic have been embedded into BAU and services, staff and volunteers adapted at speed. This should be celebrated. When the world felt like it was on fire, personalised care and support for people with cancer was still delivered.

Some of the next steps for the LWABC Programme are:

- Build on The the Well as a community hub especially to those groups whom are low attendees
- Cancer Care Reviews – continue to work with PCN Managers and to support new roles within Primary Care.
- Remote monitoring systems in place and fully utilised for colorectal, prostate and hematology.
- Continue the Hospice trialing a six week self-management course for people whom may be dying within the next 6-12 months. This is not only for cancer patients but for anyone who would like this support. The sessions focus around sleep, fatigue management, breathlessness management, uncertainty, hygiene etc.

3. Minimising Harm due to Covid on the Cancer Pathway

The focus of this work has been about minimising the harm to four Patient Cohorts. These are:

1. People referred via the 2 week wait urgent cancer pathways or on a cancer pathway including those on surveillance
2. People delaying care or treatment due to Covid
3. Patients who are currently on elective waiting lists and have been waiting for some time (and may continue to do so) as 6% may have a diagnosis of cancer via this route
4. The management of potential new referrals by General Practitioners and alternatives to referrals / patients whom are not presenting to services

To address these risk Barnsley services are :

1 Contacting frequently anyone whom is waiting more than 62 days or more to check their wellbeing and any anxieties they may have about the waiting time.

2 Been adjusting services to reduce patient concerns e.g. offering an appointment on Monday to reduce the days patients will lose salary and offering transport

3 Introduced C-theSigns, a clinical decision support tool to support GPs rapidly identify and manage patients at risk of cancer at the earliest and most curable stage. Also are developing the PCN additional Care-Coordinator to be a point of contact for patients whom are referred and to support the administration part of the referral process

4 Produced a guidance document for clinician and patients around what they can expect around social distance restrictions ie, that they can be accompanied for cancer appointments at the hospital

5 Weston Park introduced the option for patient carer/relatives to be included virtually during appointments

6 Introduced a lower stomach test (FIT) that GP's can use at the first appointment to check if the person has cancer. This has reduced already the number of people whom do not need to go the hospital. It also has freed up slots at the hospital for people whom need to go or are waiting for an appointment.

7 BHNFT has set up a more robust recording system to ensure patients are prioritised based on clinical need and will continue to keep prioritising patients treatments based on clinical need. This is the same for STHT and Weston Park patients (that provide chemotherapy and radiotherapy services).

8 Applying for extra funding from NHS to increase diagnostic equipment and to have more space to run the cancer identification tests and breast screening services.

9 The hospital continues to run additional appointment slots in the evening and the weekend to reduce the people whom are waiting.

10 Receptionists in GP Practices are being provided with additional training about cancer symptoms. This is so that they can be more effective about how they manage patient calls for the GP.

To change this position Barnsley Cancer Steering Group are also undertaking a Behavioural Insights Project. This work will build on the Be Cancer Safe cancer champions whom have continued.

NUDGE THE ODDS
Let's find cancer early

The overarching ambition of the project is to get people and services to work together to reduce harm, tackle inequalities and save lives. This will be by nudging people whom do not usually come forward early to go to GP Practice if they are worried Three target cancers have been identified based on data showing inequalities around accessing services and an impact from Covid: Lung, Head and Neck and Upper GI.

Barnsley is one of three pilot areas and is deploying three trials to test the application of behavioural science in specific settings. This is overseen by a local Operational Group to guide it, that includes the local authority staff; Barnsley voluntary sector. The three trials are at Barnsley Food Bank and Dove Valley (central area) and Hollygreen Medical Practices (Dearne area).

The Trials are adjusting current text, letters and trialling the way they talk to people, to 'nudge 'them to come forward if they are worried about cancer. All the staff has been trained in how to change their language to encourage people to make the decision to not sit at home if they have symptoms and to go to their GP Practice early. The hospital is also using this way of working to encourage more people to complete their treatment regime and not stay away because they fear getting COVID.

4. Conclusion

In conclusion the cancer programme deliverables outlined above will lead the CCG to meeting the Governing Body Assurance Framework cancer priorities. It also provides a framework upon which the Primary Care Networks and

	Barnsley Integrated Delivery group can base their mobilisation and priority planning decisions upon. The Governing Body it therefore asked to approve this assurance report.
Refer	**DELIVERY OF STATUTORY AND GOOD GOVERNANCE REQUIREMENTS** No material issues identified
3.1	**Management of Conflicts of Interest (s14O)** Not Appropriate
3.2	**Discharging functions effectively, efficiently, & economically (s14Q)** Not appropriate
3.3	**Improving quality (s14R, s14S)** This programme will support the delivery of other CCG improving quality duties by focusing on reducing clinical and safety harm to people on the cancer pathway and improving patient safety and experience via a number of deliverables outlined in this paper that will contribute to this duty.
3.4	**Reducing inequalities (s14T)** This programme will focus on reducing HIE to areas/people affected by impact of covid conditions on the cancer programme deliverables.
3.5	**Public Involvement & Consultation (s14Z2)** As outlined in the report
3.6	**Data Protection and Data Security (GDPR, DPA 2018)** Not Appropriate
3.8	**Human Resources -** Not Appropriate
3.9	**Environmental Sustainability** Not appropriate
5.	**RISKS TO THE CLINICAL COMMISSIONING GROUP**
	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. To note that the current operational pressures within the Trust and Primary Care are a risk to the groups work progressing as expected. This is due to the limited staff resource available to work with the CCG to provide the necessary information to mitigate these risks. The risks to the CCG of this paper not being approved are :

	1. The Cancer Programme will not be implemented 2. The CCG will be unable to meet the statutory and constitutional targets requirements **3.** Barnsley population cancer outcomes will not continue to be improved.
6.	**CONCLUSIONS & RECOMMENDATIONS**
	Governing body are asked to: 1. Accept this assurance report.

Appendix A: Validated performance data - June 2021

Focus Month Breakdown:

June 2021		14 Day Standard				28 Day Standard						31 Day Standard						38 Day Standard		62 Day Standard					
		Two Week Wait Referrals		Breast Symptomatic 2WW Referrals		Faster Diagnosis Standard (FDS)						First Treatment		Subsequent Treatment				Inter Provider Transfer		GP Referral to Treatment		Screening Referral to Treatment		Consultant Upgrade to Treatment	
						Two Week Wait		Breast Symptomatic		Screening				Surgery		Chemotherapy									
TARGET		93.0%		93.0%		75.0%		75.0%		75.0%		96.0%		94.0%		98.0%		85.0%		85.0%		90.0%		85.0%	
CBU 1	Haematology	9/10	90.0%	-		7/9	77.8%	-		-		8/8	100.0%	-		7/7	100.0%	0/1	0.0%	1.0/1.0	100.0%	-		5.0/6.0	83.3%
	Lung	18/21	85.7%	-		13/17	76.5%	-		-		2/2	100.0%	-		-		5/8	62.5%	1.0/1.0	100.0%	-		3.0/5.0	60.0%
	Skin	175/185	94.6%	-		127/160	79.4%	-		-		20/20	100.0%	-		-		1/1	100.0%	15.0/15.0	100.0%	-		3.0/3.0	100.0%
CBU 2	Breast	130/183	71.0%	77/91	84.6%	166/169	98.2%	88/90	97.8%	40/40	100.0%	20/20	100.0%	11/11	100.0%	-		-		12.0/12.0	100.0%	6.0/6.0	100.0%	1.0/1.0	100.0%
	Head & Neck	82/84	97.6%	-		62/83	74.7%	-		-		1/1	100.0%	-		-		2/4	50.0%	0.5/1.0	50.0%	-		1.0/1.0	100.0%
	Lower GI	204/209	97.6%	-		36/184	19.6%	-		3/18	16.7%	14/14	100.0%	1/2	50.0%	-		0/4	0.0%	1.0/6.0	16.7%	0.0/2.0	0.0%	6.0/7.0	85.7%
	Upper GI	79/83	95.2%	-		51/74	68.9%	-		-		11/11	100.0%	1/1	100.0%	-		5/8	62.5%	0.5/2.0	25.0%	-		11.5/12.5	92.0%
	Urology	82/93	88.2%	-		38/85	44.7%	-		-		13/13	100.0%	1/1	100.0%	2/2	100.0%	1/2	50.0%	9.0/9.5	94.7%	-		3.5/3.5	100.0%
CBU 3	Gynaecology	78/81	96.3%	-		20/54	37.0%	-		6/30	20.0%	6/6	100.0%	-		-		1/2	50.0%	2.5/3.0	83.3%	1.0/1.0	100.0%	3.0/3.0	100.0%
TRUST TOTAL		858/950	90.3%	77/91	84.6%	522/838	62.3%	88/90	97.8%	49/88	55.7%	96/96	100.0%	14/15	93.3%	9/9	100.0%	15/30	50.0%	42.5/50.5	84.2%	7.0/9.0	77.8%	37.0/42.0	88.1%

NHS
Barnsley
Clinical Commissioning Group

GOVERNING BODY

9th September 2021

TRANSFORMING CARE PROGRAMME UPDATE

PART 1A – SUMMARY REPORT

1.	**THIS PAPER IS FOR**
	Decision [ ] *Approval* [ ] *Assurance* [x] *Information* [ ]
2.	**PURPOSE**
	The purpose of this report is to assure Governing Body members of the ongoing work that is being undertaken to ensure that, where appropriate, patients falling within the TCP Programme are being discharged into placements within the local community.
3.	**REPORT OF**

	Name	Designation
Executive / Clinical Lead	Patrick Otway	Head of Commissioning (Mental Health, Children's and Maternity
Author	Gina Johnson	Complex Case Manager – TCP Programme

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
Governing Body	Sep 2020	Noted
Governing Body	March 2021	Noted

5.	**EXECUTIVE SUMMARY**
	On the 1st June 2011 BBC Panorama revealed a pattern of serious abuse at Winterbourne View private hospital in Bristol against a number of patients with a learning disability. 11 staff in total were sentenced for ill treatment. The care quality commission concluded there was **a systemic failure to protect people, over use of medications and restraint.** The Transforming Care programme (TCP) began in October 2014 and the aims

of this Programme have been outlined in previous Governing Body updates. Progress has been made within Barnsley to continue to adhere to the aims and objective embedded within the Transforming Care Programme even when faced with the current challenges of the Covid-19 pandemic.

Continuation of C(E)TRs (Care, Education and Treatment Reviews) has remained a priority during the Covid-19 pandemic period:
C(E)TRs are an embedded and essential part of the pathway of care for children, young people and adults with a learning disability and or autism in inpatient CCG-commissioned or NHS England commissioned mental health or learning disability and autism provision.

C(E)TRs have an important contribution to make in: ensuring people are not in settings or conditions that expose them to increased risk of harm

i. facilitating discharge
ii. preventing unnecessary admissions
iii. bringing together vital services across health, education and social care to help address barriers to providing the right support and find solutions.

COVID-19 rules and guidance has meant adapting the way C(E)TRs are undertaken, whilst still ensuring there is a robust process that fulfils this role.

NHS England and NHS Improvement commenced a study at the beginning of 2021 which concluded the new ways of working were not as comprehensive as face to face reviews but there were some benefits to using the virtual element of meetings such as facilitating the involvement of professionals and family members who cannot attend meetings in person.

During this difficult period, it has been vital to retain a continued focus on quality assurance - the six weekly commissioner oversite visits for adults and four weekly visits for children have continued when policy has allowed face to face visits. Where this has not been possible, the Complex Case Manager has attended virtual meetings and has liaised with advocates and family members.

Recordings on the Assuring Transformation Platform have increased to capture when these visits have taken place and any restrictions placed upon our patients such as segregation, Isolation, administration of chemical restraint and other restrictive practices. The Host Commissioner Role has also played a vital part in oversite, patient safety and Quality audits.

Currently Barnsley CCG is facilitating a mixture of face to face reviews and virtual reviews to fit into Government Guidance and hospital policies.

Numbers of C(E)TRs completed in the last six month period:

Community CETR (children)	Inpatient CETR (children)
15	1

Community CTR (adults)	Inpatient CTR (adults)
8	8

Numbers of Commissioner Oversite Visits completed in the last six month period:

Adult Inpatient visits	Child inpatient visits
44	6

From April 2021 Dynamic Support Registers have been developed to the new NHSE Gold Standards. The registers are maintained by a multidisciplinary team from health and social care, criminal justice system, housing, education and any other professional involved in the case. The register includes people with a learning disability, autism or both who display, or are at risk of developing, behaviour that challenges or mental health conditions who were most likely to be at risk of admission. The register allows MDT discussions to problem solve and plans for services, preventative support and where necessary, a C(E)TR when the level of risk becomes unmanageable. There are currently 14 children and 11 adults included in the registers.

Numbers of admissions

Barnsley CCG currently has eight adult inpatients, two of whom are detained to mainstream adult mental health wards with greenlight adaptations. There are two patients within assessment and treatment units and four patients detained to locked rehab wards.

There are five Barnsley patients in secure hospitals at this time.

There has been one child admission in the last six months for a twelve week assessment period and there is one pending admission for a child at present. The patients detained to secure hospitals remain under the Ministry of Justice restrictions and cannot be discharged until the risks to the public are deemed manageable. Since our last report, Barnsley CCG has successfully obtained high court approval to discharge one patient. This patient is closely monitored and has a number of restrictions placed upon them, but they are doing well.

Two of the patients within locked rehab units are waiting for sentencing from the criminal justice system to determine their future pathway. All other patients have a discharge plan in place.

Developments

- The closure of the Leeds ATU – this has reduced the amount of beds available across the West Yorkshire TC Cohort, in which Barnsley is included. The ATU beds available to Barnsley patients remain at the

	Horizon Ward within Fieldhead Hospital and Lynfield Mount Hospital in Bradford. If these beds are full when a bed is needed then it is the responsibility of the ATU lead provider (Bradford District Care NHS Trust) to find an appropriate placement. • Mayman lane, the £2.8m housing development scheme opened on the 8th March 2021 with a Barnsley patient being the first admission. Further admissions are planned throughout this year but have been delayed due to Covid restrictions impacting upon the transition plans and staff recruitment. The scheme remains under quality assurance and surveillance procedures due to some initial Management oversite concerns. The Barnsley patient is doing well. There remains one void within the scheme to which Barnsley CCG can bid to reserve the space if it is felt appropriate to meet demand. • The SYB ICS housing needs assessment was due to be circulated to the public in March 2021. This has been delayed until Autumn 2021. The assessment identifies the current housing gaps within the market and should encourage a new growth in provider services which ultimately should increase the opportunity for a prompt discharge from hospital or prevent an admission. • Safe space – There are a number of providers looking at options currently. The safe space could be utilised as a step up/step down facility to avoid an admission. This is an ongoing TCP project with an active working group. The Safe Space is hoped to be up and running within the next two year period. • The West Yorkshire TCP (CKWB) has developed a working hub to support commissioners. The hub provide admin support to take referrals and set up C(E)TRs. • Bespoke Care and Support have been registered with CQC last month. They are a step-down facility for TC patients in Barnsley. 6 male beds and 6 female beds. • There is a new 10 bed development in the early planning stages within the Barnsley Borough. This is hoped to be built and functional by September 2022. Currently, Barnsley remains under the West Yorkshire Transforming Care Programme Board in terms of every day functions and funding streams but the governance and assurance will shift to be reported via the South Yorkshire TCP Board. From next month Barnsley will be reporting into the South Yorkshire Partnership in readiness for moving into the South Yorkshire ICS from April 2022. This shift is causing challenges as the processes can be confusing at times but we are confident that processes / protocols will become clearer as we work towards next April. There continues to be good partnership discussions and it has been agreed that the Complex Case Manager is to attend both Board meetings to maintain up to date knowledge and ensure as smooth a transition as possible.
6.	**THE GOVERNING BODY / COMMITTEE IS ASKED TO:**
	• **Note the contents of the report**
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	
2.1 Primary Care		7.1 Transforming Care for people with LD	x
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)	x
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?	***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***

NHS
Barnsley
Clinical Commissioning Group

GOVERNING BODY

9 September 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 September 2021 Governing Body with the agreed highlights of the discussions at the Quality & Patient Safety Committee on 19 August 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	19 August 2021	To raise as highlights to the Governing Body

5.	**EXECUTIVE SUMMARY**
	At the Quality and Patient Safety Committee meeting on 19 August 2021, it was agreed that the following five quality issues are highlighted to the Governing Body and rated: • Green – Specialist Clinical Portfolio Quality and Finance Update • Green – LeDeR Interim Annual Report 2020/21 • Green – BCCG Patient Experience Report Qtr.1 2021/22 • Amber – Adults and Children Safeguarding Update • Amber– SWYPFT General 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
Specialist Clinical Portfolio Quality and Finance Highlight Report	QPSC received for assurance its inaugural report on the activities of the Specialist Clinical Portfolio which covers the following areas: • Children and Young People's Individual Funding Requests (IFR); • Children and Young People's Continuing Care; • Mental Health Act 1883 (2007), Section 117 Aftercare Arrangements (S117); • Transforming Care Partnership inpatient and community S117 patients – Adults and CYP; • Specialist Acute Mental Health Beds; and • Adults Individual Funding Requests (IFR/ Neuro Rehab). The report provided a thorough overview of the current position of these areas, but it was noted that the data is still being refined.	QPSC noted for assurance the content and progress described within the report.
LeDeR Annual Report 2020/21	QPSC received for assurance an interim annual report on the LeDeR programme, which included comprehensive updates on the national context, changes to the LeDeR programme and LeDeR activity in Barnsley.	QPSC noted for assurance the content and progress described within the report.
BCCG Patient Experience Report Qtr. 1 2021/22	QPSC received for assurance BCCG's Quarterly Patient Experience Report for Qtr. 1 of 2021/22. The report demonstrated that the CCG has met its statutory duties in relation to complaints handling and that it had improved its formal response timescales significantly from the previous quarter. The report also highlighted that the CCG is committed to using complaints as a means of learning how to improve its services. The report showed that learning from complaints received by the CCG in quarter 1 2021/22 has been shared with relevant staff.	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.

Issue	Consideration	Action
SWYPFT General Community Services Waiting Lists	QPSC was briefed on the progress made by SWYPFT to accurately identify length of waits for its general Community Services. A waiting list report is now included in the suite of monthly contract reports that SWYPFT provides the CCG. Currently this report only covers Adult Epilepsy, Continence & Urology, and Dietetics. The work completed so far has provided reassurance that waits in these specialties are not as long as previously thought following a review of data. Data cleansing for other services is expected to take another 3-4 months to complete, after which the CCG is expecting reporting to be extended to cover all services. In relation to Adult SALT waits, QPSC were informed that a private provider has been identified to help reduce the current waiting list, and arrangements are being made to Progress will continue to be monitored via SWYPFT's Clinical Board with updates provided to QPSC.	QPSC noted the current position in relation to SWYPFT Waiting Lists and in particular ADULT SALT.
Adults and Children Safeguarding Update	QPSC was provided with a comprehensive update on safeguarding adults and children for assurance including: • Significant changes in senior safeguarding posts in BMBC Social Care; • Increase in safeguarding cases relating to neglect; • BCCG Designated Nurse for Safeguarding Adults has accepted a full-time post with Sheffield CCG; • Safeguarding reviews; and • Safeguarding campaigns such as ICON and safe sleeping.	QPSC was assured that safeguarding requirements continue to be met but noted the potential risk in relation to the BCCG Designated Nurse for Safeguarding Adults post, and the mitigations in place for this risk.

NHS
Barnsley
Clinical Commissioning Group

GOVERNING BODY

9 September 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 • To provide Governing Body with the revised Quality and Patient safety Committee Terms of Reference for approval, and • To inform Governing Body of the annual assurance process for NHS England against the Emergency Preparedness, resilience & response (EPRR) Core Standards • To ask Governing Body to approve some minor updates to the CCG's Constitution.						
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
H&S and Business Continuity Group	2.9.2021	Reviewed the EPRR self-assessment

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. The GBAF continues to be monitored by the established mechanisms regular review by Exec Leads, and is attached at Appendix 1 for Governing Body's assurance.
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. • 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.
- Ref CCG 13/13 - If improvement in Yorkshire Ambulance Service (YAS) performance against the ARP response time targets is not secured and sustained, there is a risk that the quality and safety of care for some patients could be adversely affected.

Updates:

The Committees of the CCG continue to review and monitor risks in their areas of responsibility. The following updates to the corporate risk register arising from this process are presented to Governing Body for approval or noting in the table below:

Ref	Risk Description	Current	Proposed	Rationale
For approval:				
21/01	Risk in relation to Children's CHC	4x4=16	3x4=12	Following its meeting on 18.8.2021 Q&PSC recommends reducing the risk score as the Chief Nurse and DCO have now tightened up all the controls from a clinical and financial perspective.
13/13	Risk in relation to YAS performance	2x5=10	3x5=15	Following its meeting on 18.8.2021 Q&PSC recommends increasing the risk score due to due to concerns about current levels of demand and 2 serious incidents relating to Barnsley patients.

5.3 Committee Terms of Reference

In accordance with CCG policy, Committee Terms of Reference are reviewed on an annual basis. At its meeting on 18 August 2021 the *Quality & Patient Safety Committee* reviewed its Terms of Reference and agreed the following minor amendments subject to Governing Body's approval:

Ref	Proposed change
In Section 4 – Responsibilities, the following changes are proposed to the information the Committee will receive to perform its duties:	
4.2b	Safeguarding children and adults, including Domestic Violence, and Mental Health Reviews, Homicide investigations
4.2b	Cases managed by the Specialist Clinical Portfolio Team including Section 117 patients, Aftercare Arrangements (S117), Specialist Acute Mental Health Beds

	In Section 5 – Membership:	
	5.3	Chief Nurse (Deputy Chair)

Governing Body is also asked to note that the *Terms of Reference of the Audit Committee* have been subject to their annual review and, subject to approval and agreement by the Committee at its meeting on 16 September, no changes are proposed.

5.4 Emergency Preparedness, Resilience and Response (EPRR) Annual Assurance Process for 2021-22

Background

The letters attached (Appendix 3.1 and 3.2) outline the annual assurance process for EPRR required by NHS England. Stage 1 relates to the self-assessment which has been completed by NHS Barnsley CCG (Appendix 3.3) and requires sign off by Governing Body at its September meeting to allow us to hit the 29th October 2021 deadline for submission.

Summary of key issues

The EPRR assurance process usually uses the NHS England Core Standards for EPRR. However, in the light of the events of 2020, these standards did not receive their tri-annual review, therefore a small number of standards have been removed to accommodate this year's assurance process. This year the Deep Dive element to the assurance process focusses on internal piped oxygen systems which is not applicable to the CCG. The CBRN standards at the bottom of the spreadsheet are also not applicable to the CCG these have been included on the template in error. The full self-assessment document is attached at Appendix 3.2and the table below shows the summary:

Core Standards	Total Standards applicable in 2019	Total standards applicable 2021/22	Fully compliant	Partially compliant	Non-compliant
Governance	6	6	6	0	0
Duty to risk assess	2	2	2	0	0
Duty to maintain plans	9	9	9	0	0
Command and control	2	1	1	0	0
Training and exercising	3	0	0	0	0
Response	5	5	5	0	0
Warning and informing	3	3	3	0	0
Cooperation	4	4	4	0	0
Business continuity	9	7	7	0	0
CBRN	0	0	0	0	0
Total	43	37	37	0	0

	In the light of the above the Chief Operating Officer as Accountable Emergency Officer, with the support of the Health & Safety & Business Continuity Group, is seeking Governing Body's approval to submit a 'fully compliant' statement of compliance (Appendix 3.4) to the regional EPRR team on or before 29 October 2021.
5.5	**Updates and corrections to the CCG Constitution** Governing Body will recall that, in March 2020, the CCG adopted the 'new model' Constitution. Since then no further changes to the Constitution have been made; however, it is now timely to do some minor updates and corrections as follows: • The list of our member practices included within the Constitution is out of date – three practices (Caxton House, Cope Street Surgery, and Rotherham Road Practice) require removing from the list while two (Woodland Drive Medical Centre and Dr Mellors and Partners) need adding • Some of the URLs in both the Constitution and the Standing Orders need updating, and • The latest versions of the Terms of Reference for Audit Committee, Remuneration Committee, and Primary Care Commissioning Committee need adding as appendices. As these are non-material changes to the Constitution Governing Body is asked to approve them after which final approval will be sought from NHS England.
6.	**THE GOVERNING BODY IS ASKED TO:**
	• Review the GBAF for 2020/21, and consider whether the risks are appropriately described and scored, and whether there is sufficient assurance that they are being effectively managed • Identify any additional positive assurances relevant to the risks on the GBAF • Review the extract of the Corporate Risk Register to confirm all risks are appropriately scored and described, and identify any potential new risks. • Approve the reduction in the risk score for risk 21/01 and the increase in the risk score re 13/13 • Approve the revisions to the Quality & Patient Safety Committee Terms of Reference and note that (subject to Committee approval) no changes are proposed to the Terms of Reference of the Audit Committee • Note the self-assessment against the EPRR core standards and approve the submission of a 'fully compliant' statement of compliance • Approve the minor updates and corrections proposed to the CCG's Constitution.
8.	**APPENDICES / LINKS TO FURTHER INFORMATION**
	• Appendix 1 – GBAF 2021/22 • Appendix 2 – Corporate Risk Register • Appendix 3.1 - Emergency preparedness, resilience and response (EPRR) annual assurance process for 2021-22

	• Appendix 3.2 - North East & Yorkshire Annual EPRR Assurance Process for 2021-22 • Appendix 3.3 – NHS Barnsley CCG EPRR self-assessment 2021-22 • Appendix 3.4 – NHS Barnsley CCG EPRR Statement of Compliance 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***

02/09/2021

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 £ ✓ **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	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.

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	**Aug-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.

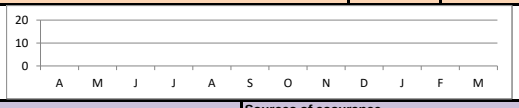
Key controls to mitigate threat:	**Sources of assurance**	**Rec'd?**
Operational planning process is underway for 2021/22 in line with the NHS Planning Guidance. All activity plans are being developed in line with national expectations for increased activity levels back toward those in 2019/20, reflecting local restrictions and transformation work to redesign services. Plans at provider and commissioner level will be aligned to reflect the total Barnsley population.	CCG worked with the NHSE and the SYB ICS to formulate a ICS level activity plan. Plan was submitted to NHSE in line with required deadlines. Activity levels are monitored on an ongoing basis to monitor delivery against submitted plans.	Ongoing
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. Revised UEC Board Plan has been developed in line with Planning Guidance and other NHSE Guidance on the transformation of urgent and emergency care, including implementation of new standards. Barnsley Flu Planis currently being developed by the operational Flu group and will be signed off by the UEC Delivery Board	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 working with partners 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' Barnsley Place plan has been agreed by the Barnsley Intergrated Care Partnership with clear priorities for out of hospital services which are being taken forward through the Care Closer to Home Board.	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 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 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.

02/09/2021 **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**			**Date reviewed**	**Aug-21**
Initial	3	4	12			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.	
Current	3	4	12				
Appetite	3	4	12				
Approach	**TOLERATE**						



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

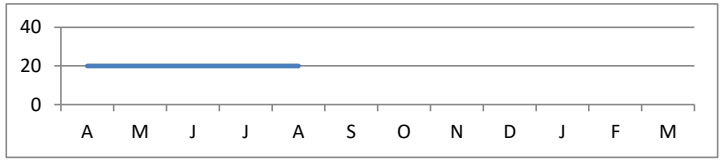
Gaps in assurance	Positive assurances received
APRIL 2021 - under recruitment in 2020-21 to ARRs roles has impacted on the additional support for the practices within the PCN - RISK HAS BEEN UPDATED TO REFLECT. JUNE 21 - BHF contract reporting and submitted SQP are under review due to data quality issues and outstanding reporting issues that remain unresolved. Update report submitted to PCCC reflecting the concern. JULY 2021 - BEST conrtract still requires work around KPI reporting and achievement.	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. JUNE 21- 2021/22 PDA working group re-established to complete the PC section of the PDA. Initial meeting very positive and work is underway to finalise this section of the PDA. JULY 2021 - Agreement from SMT to move to a Minimum Data Set to try to achieve accurate contractual reporting and to ensure the CCG has relevant quality data sets with which to monitor achievement.
Gaps in control	**Actions being taken to address gaps in control / assurance**
MAY 21 - PCN CD/Management meetings do not have regular input from CCG PC Commissioner therefore not able to support the development and maturing of the PCN nor have an effective comms route for sharing ICS/Regional and emergent information to support the Network Contract DES delivery.	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. Requested the the CCG Medical Director be involved with the planning of the BEST sessions as per contract. 2021-22 PDA includes reference to work required for PC from the Planning Guidance.

02/09/2021 **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 ✓ 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		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.

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	**Aug-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. 6 weekly reporting to BCSG about minimising harm and 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 and 28 FDS		
Current CCG performance for 62 RTT June 2021 is 84% from Q4 position that was 63% .(target 85%). Challenged pathways remain as Lower GI and Urology . Cancer patients remain first priority by BHNFT services . 28 FDS is for 62.3% June 2021 (75% target by October 2021) , main challenged tumour pathways are lower GI and Urology . To meet the target audit undertaken to identify how can improve referral form and tests completion so that BHNFT can triage and meet FDS target, employed patient tracking co-ordinators BHNFT to unblock any hold ups. PCN trialling using care-cordinators to support referral process .	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 6 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 . Restoration plan agreed with BHNFT by CCG. DON gaining assurance about maintaining quality from BHNFT and STHT during restoration period. t	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 .PHE provided additional recovery funding to BHNFT for Breast screening backlogs.	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 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 Re-launched with the start of Cthe Signs and referrals are increasing. .	Assurance is via 6 weekly 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.	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- Evaluation taking place about impact on patient experience and improving management gamnt primary care resircse baout . 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. New men's peer group for prostate cancer completed and being taken foward as outcomes were positive .	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. Plan in place that is focusing on increasing early care planning for patients and staff , proposal for a community based Consultant in palliative care been produced that being presented to ICDG in september. Palliative care GP for ICs and Barnsley engaging with practices to identidy how EOL working can be improved and working on supporting PCN.	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 6 weekly cancer programme assurance process that ensures programme is on track and lack of progress addressed; The CCG via CA established communication and engagement and Barnsley Communication and engagement group ensures actions and reporting are to CCG and via 6 weekly reporting for the cancer programme assurance reporting. Behavioural insight trials and wider work is targeting groups that have not returned to services compared to pre-covid. Communication and engagement linked into BMBC local areas council forums and structures to widen coverage .	
Gaps in assurance	**Positive assurances received**	

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

PRIORITY AREA 3.2: MAXIMISING ELECTIVE ACTIVITY

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.

- 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 95% target: From July 2021 deliver 95% 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)

Delivery supports

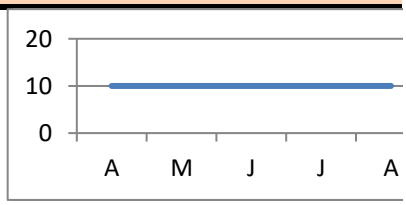
Highest quality gove
High quality health
Care closer to home
Safe & sustainable
Strong partnerships

Links to NHSE/I PI

C1 - Maximise elect

Committee Providing Assurance			**TBC**
Risk rating	Likelihood	Consequence	**Total**
Initial	3	4	3
Current	3	4	4
Appetite	3	4	12
Approach	**Tolerate**		

Executive Lead



Key controls to mitigate threat:

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.

The CCG and Trust are leading on the developing a clear, prioritised delivery plan

Operational planning process for the first half of 2021/22 has been completed in line with the NHS Planning Guidance. All activity plans are in line with national expectations for increased activity levels back toward those in 2019/20, reflecting local restrictions and transformation work to redesign services.

Gaps in control

Planned Care – backlog and demand surge

There is a risk of delay to treatment of patients either through restricted access to services (due to sc
IP&C, need to travel) or hidden harm through people failing to present with issues due to fears aroun
likely to result in an increased number of poorly managed chronic conditions or undiagnosed disease

Elective Pathways

There is a risk of delay to treatment of patients on elective pathways. This is caused by restrictions in
royal guidance re green sites e.g. orthopaedics. The impact will be to quality of life for individuals awa
operation and increased pressure on services to deliver.
A further issue is the reticence of local residents to travel outside of Barnsley for treatment.

vork 2021-22

these CCG objectives:		**PRINCIPAL THREATS TO DELIVERY**
ernance		There is a risk that the CCG will not be able to maximise elective activity if the following issues are not mitigated: 1. Clear and effective communication to the public about delays to treatment and prioritsation. 2. Where necessary improve uptake of residents to travel outside of barnsley for treatment. 3. If patients do not present for treatment. 4. If patients have a preference for face to face appointments. 5. workforce capacity to deliver over 85% of activity (taking into account IPC, social distancing, staff leave, burnout as well as access to diagnostics) 6. provider headspace to undertaken pathway transformation and adopt new ways of working e.g. PIFU
care	✓	
e	✓	
local services	✓	
, effective use of £	✓	
lanning Guidance		
tive activity		
	JW	*Clinical Lead* **NB,MS,JM**

Date reviewed	**Aug-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.	

Sources of assurance	Rec'd?
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.	Ongoing
Planned Care Board is established to provide oversight of the programme. The Board has representation from all partners. Clear priorities have been agreed as part of development of the Barnsley Place Plan	In Progress
Chief Operating Officer, CCG Chair and 2 x Governing Body members are represented on the Planned Care board. Work is ongoing to ensure align of the elective care system wide plan to the planning Guidance and other NHSE Guidance on the transformation of outpatients / specialty	Ongoing

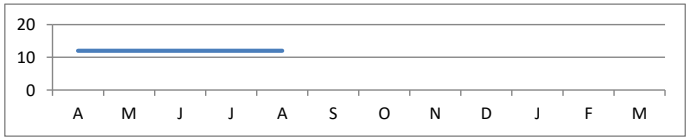
	Actions being taken to address gaps in control / assurance
ɔcial distancing, d covid. This is ˈs.	• All listed patients are clinically triaged, priority patients have been treated throughout the year, a green pathway and protected bed capacity have been agreed. • Patients with LTC have also been reviewed and prioritised in primary care. • Primary, community, mental health , outpatients and diagnostics services remain open. • Long waiters for Barnsley place are being reviewed and actions being taken to further support improved care delivery. • A system wide comms plan has been drafted to help maintain effective communication with patients including proactively reaching out to those who are
ı terms of ipc and ɨiting their	• All patients have been clinically triaged with emergency and urgent cases being seen. External assurance has been obtained through national clinical validation exercise. • System planned care group supports a system overview of the issues. • Green pathway is now in place and dedicated beds for elective orthopaedics • Use of Independent sector and mutual aid. • Plans have been updated in response to the 21/22 planning guidance and participation in the elective accelerator programme (enhancing plans to deliver capacity beyond 85%, to excess of 100% from July 2021). The work will focus on streamlining and developing pathways in key surgical specialties (orthopaedics, ophthalmology, paediatrics) and work with IS Sector. Local work is focused on

02/09/2021 **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	**Aug-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	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.	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.		

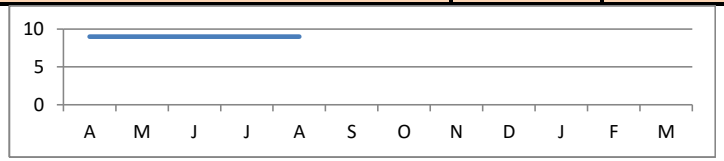
Gaps in assurance	Positive assurances received
Gaps in control	**Actions being taken to address gaps in control / assurance**

02/09/2021 **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	**Aug-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
Development of Barnsley Integrated Care Partnership (ICP) ensures strong Barnsley voice into the SYB ICS to influence the creation of the Statutory ICS.	Barnsley Place agreement finalised. Barnsley Health and Social care plan produced.	Complete
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

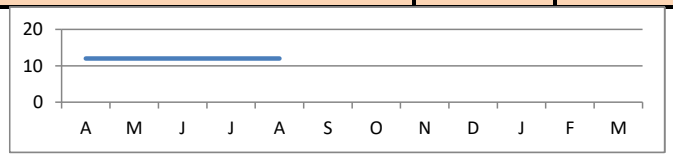
Gaps in assurance	**Positive assurances received**
• Ref 18/02 (rated score 16 'extreme') - If the CCG and BMBC do not develop a collaborative commissioning approach underpinned by shared values there is a risk that BMBC commissioned services will not meet the requirements and aspirations of the CCG 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. Barnsley Partnership agreement completed. Barnsley Health and Social Care plan agreed.
	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**

02/09/2021 **NHS Barnsley CCG Governing Body Assurance Framework 2021-22**

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	**Aug-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.

PRIORITY AREA 5.3: IMPLEMENTING POPULATION HEALTH MANAGEMENT AND PERSONALISED CARE

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

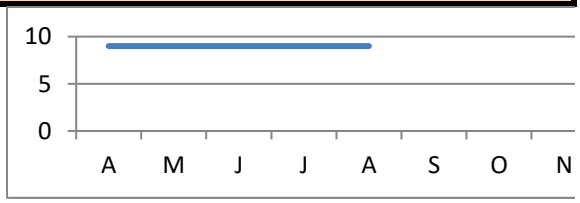
Delivery supports these CCG objectives

- Highest quality governance
- High quality health care
- Care closer to home
- Safe & sustainable local services
- Strong partnerships, effective use of £

Links to NHSE/I Planning Guidance

D2 - Implementing Population Health Mana
Personalised Care

Committee Providing Assurance			**TBC**	*Executive Lead*
Risk rating	Likelihood	Consequence	**Total**	
Initial	3	3	9	
Current	3	3	9	
Appetite	3	3	9	
Approach	**Tolerate / Treat**			



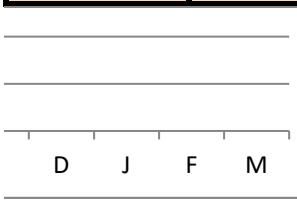
Key controls to mitigate threat:	**Sources of assur**
Executive leadership and sponsorship	Designated execut partner organisatic care delivery group ICPG. Health ineq Plan 2021/22 that
Improving health intelligence infrastructure across the partnership	Health intelligence the partnership. Pc health managemer COVID monies. In agreement endors Integrated Care Ou and Wellbeing Boa
Risk stratification tool to support proactive case finding	Eclipse platform er secondary care da

Prevention programmes in place and/or in development	Warm home healtl social prescribing s workers, care coor prevention prograr Barnsley Hospital s to support people t risk of complicatio
Personalised budgets	Embedding with N
Personalised care planning	Patient activation r conditions manage
Gaps in assurance	
Gaps in control	
Pending publication of PCN service specification for anticipatory care	
Pending publication of PCN service specification for personalised care	
Strength and balance offer for people at risk of falls	

2021-22

:	**PRINCIPAL THREATS TO DELIVERY**
	There is a risk that the CCG will not be able to successfully implement Population Health Management and Personalised Care if the following issues are not mitigated: - Lack of capacity in primary and community care to support delivery because of ongoing operational pressures - Failure to successfully recruit, train, develop and retain additional roles in primary care including social prescribing link workers, care coordinators and health and wellbeing coaches - Ability to access linked person-level data to identify priority cohorts, target interventions and demonstrate outcomes and impact - Lack of sufficient technical analytical capability and tools to support delivery - Failure to properly engage and involve people in decisions about their care and service development
✓	
✓	
✓	
✓	
agement and	

JB	*Clinical Lead*	**Dr M Guntamukkala**



Date reviewed	**Aug-21**
Rationale: - Major (3) impact due to 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	

ance	**Rec'd?**
tive leads for tackling health inequalities across all NHS ons. Workshop for health inequalities leads and integrated o representatives with outputs and framework endorsed by ualities cross-cutting theme in Barnsley Health and Care has been endorsed by partners	Ongoing
group established with positive engagement from across opulation segmentation analysis completed. Population nt analyst hosted by Barnsley Hospital funded through creased information sharing through COVID and high-level ed by all partners. Regular reporting of health surveillance. utcomes Framework adopted by ICPG and Barnsley Health ard	Ongoing
mbedded within medicines management team. Sharing of ta into Eclipse for pathway development	Ongoing

hy people team. Shaping Places Healthy Lives. My Best Life service. Primary care network social prescribing link rdinators and health and wellbeing coaches. Diabetes nme. Barnsley Hospital Health Lives Team established. selected to pilot an Alcohol Care Team. Get fit first in place to lose weight and stop smoking before surgery to reduce ns and achieve better outcomes	Ongoing
HS Continuing Healthcare practice and adult social care	Ongoing
neasures embedded with the SWYPFT long term ement services. Year of care in primary	Ongoing

Positive assurances received

Actions being taken to address gaps in control / assurance
Working group established to develop proactive care model focussed on mild to moderate frailty building on the learning from supporting vulnerable people through COVID and population segmentation analysis. Ongoing work with NHS Prescribing Solutions to configure local pathways for Barnsley beginning with frailty. Development of the Barnsley Vulnerability Index
Personalisation is identified as one of the cross-cutting themes of the Barnsley Health and Care Plan 2021/22. Providing joint training and development opportunities for health and care staff including strengths-based practice and shared decision making is one of the priorities of the Barnsley Health and Care Plan being taken forward through the workforce group
BMBC have identified funding and proposals are in development to strengthen the local prevention offer for healthy ageing

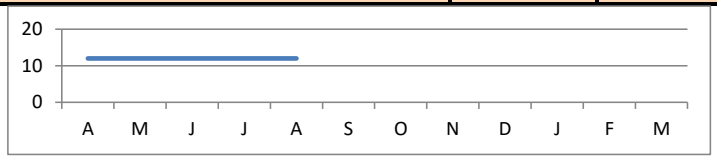
02/09/2021

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 for 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	**Aug-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.

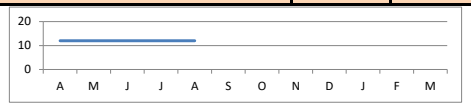
Gaps in control	Actions being taken to address gaps in control / assurance
13/31 - There is a risk that if the CCG does not develop a robust QIPP plan supported by effective delivery and monitoring arrangements, the CCG will not achieve its statutory financial duties and NHS England business rules.	The 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. 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 implementation and is likely to continue as we appproach 2022/23.

02/09/2021 **NHS Barnsley CCG Governing Body Assurance Framework 2021-22**

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	**Aug-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 is 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

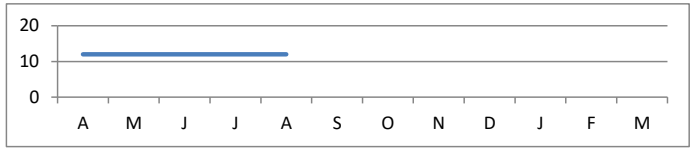
Gaps in control	**Actions being taken to address gaps in control / assurance**
Plans are to be established to improve the uptake of Annual physical Health chekcs for people with LD	

02/09/2021 **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 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	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

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	**Aug-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**

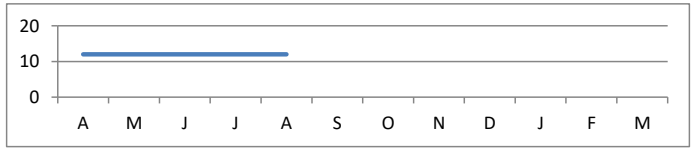
02/09/2021

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 Futures Model to: - Comply with mandatory core standards re: interoperability and cyber security - Ensure HSCN supports effective and fast connectivity - Support the identification of equipment that poses a threat to cyber security e.g. pre Windows 10 software - Support the implementation and roll out of the GPIT refresh of IT equipment - Support the wider use of digital technology as described within the Long Term Plan - Working closely with the SY&B digital and IT workstream to deliver the digital road map - Delivery of O365 across Barnsley - Support the transition of video and online consultation software as the Doctorlink contract ends - Support the delivery of the Digital Primary Care First projects - Support the development of the Digital Citizen project in collaboration across "place" - Support the GP practices with digitisation of the Lloyd George records when confirmed by NHSEI - Support the roll out of the corporate Wi-Fi solution - Support the resilience work at Hillder House with the servers and CCG corporate IT needs - Support the upgrade to utilise digital technology for telephony resilience across GP practices and Hillder House 3. Development of a Barnsley "place" Digital Strategy that reflects the "system" digital strategy and aligns with the emerging Eststes strategy	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	**Aug-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**

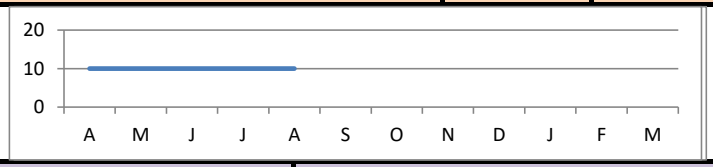
02/09/2021

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	**Aug-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). The CCG received a 'significant assurance' Head of Internal Audit Opinion at the conclusion of the 2020-21 Internal Audit programme (June 2021) The CCg received an unqualified opinion from KPMG on the CCG's Annual report & Accounts 2020-21 (June 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.	Training matrix / Plan in place and signed off. Both vacancies filled and nurses are 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.
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	4 o/s reviews – all booked in and aligned to EHCPs. Data cleansing exercise and negotiation with BMBC Social Care has resulted in a financial recoup of cases that were not CCC eligible and not funded through any formal route. Only 1 case remains to be discussed. Processes in place for CCC and transition to CHC.
RR 14/15 Discharge medication risks related to poor or incomplete D1 discharge letters	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. BHNFT is arranging a meeting for the D1 Group.

PRIORITY AREA 11: DELIVERY OF ENHANCED HEALTH IN CARE HOMES

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

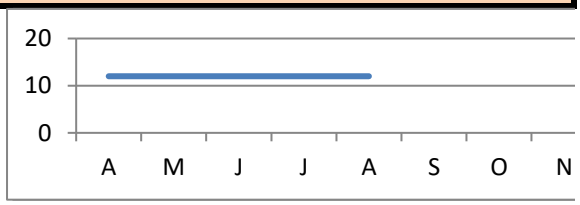
Delivery supports these CCG objectives

- Highest quality governance
- High quality health care
- Care closer to home
- Safe & sustainable local services
- Strong partnerships, effective use of £

Links to NHSE/I Planning Guidance

Committee Providing Assurance **Q&PSC** *Executive Lead*

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



Key controls to mitigate threat:	**Sources of assur**
Delivery work plan and risk log in place	Monitored and ma
Barnsley Care Homes Plan is being reviewed alongside the role of the Care Home Delivery Group to ensure the plan supports recovery and ongoing improvement in the support to care homes, recognising the significant impacts of COVID19	Work being led by Commisisoning. V and delivery arran

Gaps in assurance

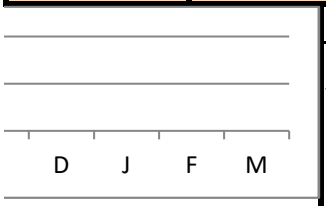
If the BCCG CHC team is unable to deliver its recovery plan to enable the backlog of reviews to be cleared and new cases to be processed in a timely way, with robust case management processes in place that demonstrate value for money whilst not compromising quality of care , there is a risk of adverse 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

2021-22

	PRINCIPAL THREATS TO DELIVERY
	There is a risk that the CCG will not be able to deliver the elements of the Care Homes Delivery Plan if the following issues are not mitigated:
✓	1.Acuity of the Covid 19 need across Barnsley meaning that the more transformational elements of the plan will need to be shelved or slowed down.
✓	2. Decrease in bed occupancy and risk to business viability and market sustainability
✓	3. Financial pressures and priorities
✓	4. CCG not having direct input and oversight of quality assurance monitoring and safeguarding in care homes
	5. Best use of technology in care homes - variance types of technology used and in consistency of use
	6. Potential IG issues in current methods of remote consultation using IT equipment
	7. Insufficient staff/resource (Matrons, Clinical Pharmacists and some GP practices) to undertake delivery of MDTs in care homes.
	8. Availability of essential equipment (e.g PPE)
	9. Interdependencies with other work streams and potential for gaps in communication and escalation of issues

JW	*Clinical Lead*	**Dr J MacInnes**



Date reviewed	**Aug-21**
Likelihood assessed as 3 'possible' taking into account learning from Phase 1 responses, service delivery, issues and risks; discussions about the risk and issues in recovery phase; and emerging picture in new phase of the pandemic in light of pending Winter pressures. Consequence assessed as 4 'major' given potential impact on Barnsley patients if the deliverables are not achieved.	

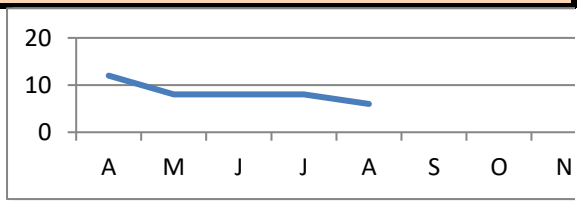
ance	**Rec'd?**
naged via a multi - agency Delivery Group and Bronze	Ongoing
the CCG Chief Operating Officer and BMBC Head of Joint Will feed into ICDG to agree priorities and future governance gements.	Ongoing
Positive assurances received	

Actions being taken to address gaps in control / assurance

02/09/2021 **NHS Barnsley CCG Governing Body Assurance Framework 2**

PRIORITY AREA 12: DELIVERING THE COVID VACCINATION PROGRAMME & MEETING THE NEEDS OF PATIENTS WITH COVID-19	***Delivery supports these CCG objectives***
• 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 patients with 'Long COVID'	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** B - Delivering the covid vaccination progra continuing to meet the needs of patients w

Committee Providing Assurance			**TBC**	*Executive Lead*
Risk rating	Likelihood	Consequence	**Total**	
Initial	3	4	12	
Current	2	4	8	
Appetite	3	4	12	
Approach	**Tolerate**			



Key controls to mitigate threat:	**Sources of assur**
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 Jointly Chaired by Hospital) and SRC Representation is
SYB Vaccine Delivery Group established to support coordination of delivery, ensure learning across SYB and maximise uptake across SYB.	Weekly - Chaired allocation of the va progress across al Workstreams inclu engagement, com
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 on partnership sup responding to char usage etc. Succes H&SC workforce a

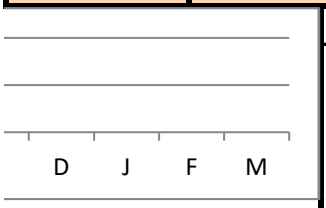
Barnsley Vaccination Engagement Group in place, bringing together local partners across Primary, Community and Acute Care and the Local Authority to support engagement activities and development of plans to target vaccination delivery models to meet the needs of local communities and reduce inequality in uptake	Weekly - Chaired b of engagement act Every Contact Cou have regular conta Inequalities in upta communities and c targetted to reacin
Contractual arrangements in place with General Practices to delivery phase 1, 2 and 3 of the vaccine programme working collectively as a single PCN Grouping	All GP practices in Programme via the BHF is leading del support of each pr workforce provisio 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 w Valley Group Prac Hubs are manage practices. All local sites. Roaving vaccinatic vulnerable groups patients Pop up clinics in G of patients who ma designated site. A range of booking invited and acess a messages, vaccine All targets/expecta 50's offered a vacc offered a first dose Delivery has comm

Gaps in control
• 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

2021-22

	PRINCIPAL THREATS TO DELIVERY
✓ ✓ ✓ ✓	There is a risk that the CCG will not be able to deliver the covid vaccination programme and meet the needs of patients with covid-19 if the following issues are not mitigated: 1. Staffing capacity being sufficient to continue to deliver the vaccination programme, 2. Vaccination supply being insufficient to meet targets 3. Negative public attitudes and hesitancy towards the vaccination impact upon uptake rates 4. Engagement and support of all partners to maximise available capacity and uptake of the vaccine 5. Understanding of the number of 'Long COVID' patients and establishment of pathways to provide ongoing support
mme and ith covid-19	

JW	*Clinical Lead*	**TBC**



Date reviewed	**Aug-21**
Likelihood currently judged to be 'possible' as there are many external factors such as supply and changes to vaccine that could impact particulalry on the delivery of the programme. Initial likelihood was likely but good progress has been made and early supply concerns have improved reducing the likelihood to possible. Consequence is judged as major due to the potential impact on both the health of the population and organisations reputation.	

ance	**Rec'd?**
Board made up of partners from key sectors across SYB. SRO for the Lead Provider (CE Sheffield Teaching) for the Primary Care Programme (AO Doncaster CCG) also included from PH and LA's to ensure wider supooi	Ongoing
by SRO for the Primary Care Programme, coordinates accine supply within SYB to ensure equitable supply and ll areas. ude, delivery models, health inequalities, staffing, munications and data.	Ongoing
by COO Barnsley CCG. All partners represented. Focus pport, working together, developing delivery models, nges to guidance or requirements in relation to vaccine ssfully coordinated delivery of vaccination programme for nd phase 1 of the overall vaccination programme.	Ongoing

by Service Director for Public Health, BMBC. Coordination tivities and development of approaches including 'Make unt' to maximise the reach of all teams across partners who uct with local people and communities. ake have been identified across different geographical certain groups of the population and activity has been g these and maximising uptake.	Ongoing
Barnsley have signed up to delivery of the Vaccine e Enhanced Service. ivery of the programme on behalf of BP practices with the actice in relation to delivery of local clinics in practice, n and inviting patients for vaccine/following up and recalling	Ongoing
were approved by NHS England at Apollo Court, Dearne tice and Priory Campus. These Local Vaccination Service d by BHF on behalf of the Primary Care Network/GP l vacination activity is coordinated via the 3 designated on models in place to deliver to residential settings, such as those who are homeless and to housebound GP practices have taken place to deliver vaccine to groups ay not have been able to access the vaccine at a local g methods are in place to ensure everyone is able to be a vaccine. This has included telephone calls, test e call centre and letter. ations on uptake levels have been achieved with all over cine by mid April and the remainder of the adult population e by the end of July 2021. menced to 16-17 year olds and eligible 12-15 year olds	Ongoing
Actions being taken to address gaps in control / assurance	

RISK REGISTER – August 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**	08/21	**Aug 2021** No further update. **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	09/21

			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**
													mitigations now in place. Our integrated health 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	**5**	**5**	**25**	• Health and care saw a resurgence of COVID in the Autumn, with OPEL3-4 being hit and recovery being slowed.	Director of Commissioning CCG Gold	COVID-19	**4**	**4**	**16**	08/21	**Aug 2021** No further update. **June 2021** No further update.	09/21

			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**
		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.				• National lockdown has seen COVID cases and OPEL level reduce. Plans in place to revisit recovery in a flexible way, including COVID-surveillance.	Command F&PC						**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. 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	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.	Chief Operating Officer (Finance & Performance Committee)	Contract and Performance Monitoring	5	4	**20**	08/21	**Aug 2021** UEC Plan in place, priorities identified. Care Closer to Home Board leading work against priorities for out of hospital services and linking to Primary Care dev/ PCN	09/21

			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**
		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.				A&E Delivery Board is established (Barnsley Urgent and Emergency Care Delivery Board) with responsibility for delivering improvements to urgent care services and achieving related targets. 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							**July 2021** Special meeting of the UEC Board planned held on 15th July to identify further partnership actions to manage /meet demand across the system. **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 reduce conveyance and provide direct access to community	

			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**
						Additional Primary Care Capacity is in place for same day appointments through 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.								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.	
18/02	1,2, 5,6	If the CCG and BMBC do not develop a collaborative commissioning approach underpinned by shared values there	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	Jeremy Budd (SSDG)	Added to the Corporate Risk register in context of long standing and frequently articulated	4	4	**16**	08/21	**Aug 2021** No further update. **June 2021** No further update. **April 2021** No further update.	09/21

			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**
		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.				Session (August 2018)		concerns with respect to a basket of BMBC commissioned services notably: 0-19 Health Checks Weight management & smoking cessation					**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 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	**3**	**3**	**9**	The Long Term Plan includes a section on workforce	Head of Primary	Governing Body	**4**	**4**	**16**	08/21	**August 2021** Recruitment is	09/21

			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**
		& 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 (c)Patients services could be further away from their home.				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 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	Care. (Primary Care Commissioning Committee)						behind schedule and poses a risk of not using the full allocation for this year. The 2021-22 ARRs recruitment template is due for submission at the end of August and again in October for recruitment plans for the remaining years. **July 2021** No further updates **June 2021** 2 wte FCP (Physio) have been recruited and work progresses with other recruitment.	

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						an Interim People Plan to support the workforce challenge. Links have been developed with the Medical School to enhance attractiveness of Barnsley to students								
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 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	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 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.	Chief Nurse Finance & Performance Committee And Quality & Patient Safety Committee	SMT discussion	4	4	**16**	08/21	**August 2021** All reviews are now on 'real time' with performance against the NHSEI KPI's still being achieved. LD Nurses is now a risk as one is on maternity leave and another has resigned from the post. This leaves a 0.8 WTE LD nurse. The post has gone out to advert with interviews scheduled for the 9th September. SMT have approved an agency LD nurse can be appointed for 8 weeks.	09/21

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		would not be meeting their health needs. This could also have implications on meeting the KPI's as set by NHSE.				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.							**June 2021** Training matrix / Plan in place and signed off. Both vacancies filled and nurses are 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	

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													Chief Nurse with comments made. To be signed off by 9th April. CHC process SOP approved and PHB SOP approved.	
14/15	1, 5, 6	There are two main risks: 1. Scant or absent information relating to why medication changes have been made. Poor communication of medication changes , even if changes are appropriately made for therapeutic/safety reasons, creates a patient safety risk when post discharge medicines reconciliation is being undertaken by the GP practice. The risk being that the GP practice may either accept inappropriate	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. BHNFT is arranging a meeting for the D1 Group.	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**
		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 the hospital is not reconciling medicines using the GP Practice											**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 affected (clinical risk and efficiency) by the quality of the	

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		Summary Care Record or that the reconciliation is not sufficiently robust.											discharge meds information. The mapping of hospital systems and audit work remains on hold due to impact of COVID-19.	

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Ref	**Domain**	**Risk Description**	**Likelihood**	**Consequence**	**Score**	**Mitigation/Treatment**	**Lead Owner of the risk**	**Source of Risk**	**Likelihood**	**Consequence**	**Score**	**Date Risk Assessed**	**Progress/ Update**	**Date for re-assessment**
CCG 19/05 *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**	08/21	**August 2021** BMBC Brokerage will be taking the role of brokering EOL packages of care on behalf of the CHC Team from September 2021. Work is still ongoing in Joint Commissioning with regards to the domi. care provider framework. **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	09/21 13

	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.							manager to scope out the possibility of one provider	
13/13	1,5, 6	If improvement in Yorkshire Ambulance Service (YAS) performance against the ARP response time targets is not secured and sustained, there is a risk that the quality and safety of care for some patients could be adversely affected.	4	5	**20**	July 2016 Regular consideration of YAS incident reporting by QPSC and GB to understand the frequency and severity of incidents associated with ambulance response.	Chief Nurse (Quality & Patient Safety Committee)	Risk Assessment	3	5	**15**	08/21	**August 2021** The risk has been increased due to concerns about current level demand and 2 serious incidents relating to Barnsley patients. **June 2021** Performance monitoring continues. For 999 calls, job	09/21

													cycle time encompassing ED handover remains a concern although this is more of a national problem with demand up particularly for Cat 1 and 2 calls. YAS has managed to keep the Cat 1 90th centile within target.	

Classification: Official
Publication approval reference: PAR628

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

22 July 2021

To:

- NHS accountable emergency officers
- NHS England and NHS Improvement:
  - Regional directors
  - Regional heads of EPRR
  - Regional directors of performance and improvement
  - Regional directors of performance
  - LHRP co-chairs

CC:

- NHS England and NHS Improvement Business Continuity team
- CCG accountable officers
- CCG clinical leads
- CSU managing directors
- Clare Swinson, Director General for Global and Public Health, Department of Health and Social Care
- Emma Reed, Director of Emergency Preparedness and Health Protection Policy Global and Public Health Group, Department of Health and Social Care

Dear Colleagues,

Emergency preparedness, resilience and response (EPRR) annual assurance process for 2021-22

I would like to reiterate my thanks to you and your teams for your leadership and delivery of patient care during the last 18 months. During this time the NHS has not only responded to the COVID-19 Pandemic, but also a number of concurrent incidents, through which the resilience of the NHS has been exceptional. Our ability to respond so effectively to so many concurrent issues is a direct result of the years of dedicated focus on Emergency Preparedness and the hard work of our EPRR teams.

As our work now moves from response to recovery, we will all be using this time to reflect on the last 18 months, so that we can identify lessons for the future. This work will lead to the development of local, regional and national workplans to ensure that we embed the lessons into practice at an appropriate pace.

NHS England maintains its statutory duty to seek formal assurance of both its own and the NHS in England's EPRR readiness. This is discharged through the EPRR annual assurance process. Due to the demands on the NHS, the 2020 process was much reduced and focused on learning from the first COVID-19 wave and the preparation for future waves and winter.

The 2021 EPRR assurance aims to return some of the previous mechanisms to the process, but also acknowledges the previous 18 months and the changing landscape of the NHS.

This letter notifies you of the start of the EPRR assurance process and the initial actions for organisations to take.

Core standards

The EPRR assurance process usually uses the NHS England Core Standards for EPRR. However, as a result of the events of 2020, these standards did not receive their tri-annual review and, as a consequence, not all standards reflect current best practice. We have, therefore, removed a small number of standards to accommodate this year's assurance process, until we undertake a full review. The adapted standards being used for this year's assurance process are attached to this letter.

Organisations are asked to undertake a self-assessment against individual core standards relevant to their organisation type and rate their compliance for each.

The compliance level for each standard is defined as:

Compliance level	Definition
Fully compliant	Fully compliant with core standard.
Partially compliant	Not compliant with core standard. The organisation's EPRR work programme demonstrates evidence of progress and an action plan to achieve full compliance within the next 12 months.
Non-compliant	Not compliant with the standard. In line with the organisation's EPRR work programme, compliance will not be reached within the next 12 months.

Deep dive

Through our response to the COVID-19 pandemic we have identified a number of factors that inhibit our ability to increase inpatient capacity. One of these factors is internal piped oxygen system capacity, which have a number of interdependent components to increasing volume and flow rates. In order that we better understand the resilience of our internal piped oxygen systems the 2021-2022 EPRR annual deep dive will focus on this area.

The deep dive will be applicable to all providers of NHS funded care that utilise internal piped oxygen systems, including acute, community and mental health trusts.

Organisational assurance rating

The number of core standards applicable to each organisation type is different. The overall EPRR assurance rating is based on the percentage of core standards the organisations assess itself as being 'fully compliant' with. This is explained in more detail below:

Organisational rating	Criteria
Fully compliant	The organisation if fully compliant against 100% of the relevant NHS EPRR Core Standards
Substantial compliance	The organisation is fully compliant against 89-99% of the relevant NHS EPRR Core Standards
Partial compliance	The organisation is fully compliant against 77-88% of the relevant NHS EPRR Core Standards
Non-compliant	The organisation is fully compliant up to 76% of the relevant NHS EPRR Core Standards

Action to take/next steps

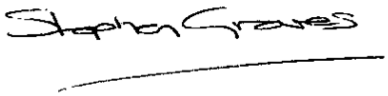
- All NHS organisations should undertake a self-assessment against the 2021 amended core standards (attached) relevant to their organisation. These should then be taken to a public board or governing body meeting for agreement.
- LHRPs to work with their constituent organisations to agree a process to gain confidence with organisational ratings and provide an environment to promote

the sharing of good practice. This process should be agreed with the NHS England and NHS Improvement regional Head of EPRR and ICS leaders.

- NHS England and NHS Improvement regional Heads of EPRR to work with LHRP co-chairs to agree a process to obtain organisation level assurance ratings and provide an environment to promote the sharing of good practice across their region.
- NHS England and NHS Improvement regional heads of EPRR to submit the assurance ratings for each of their organisations and description of their regional process to myself before Friday 31 December 2021.

If you have any queries, please contact your regional head of EPRR in the first instance.

Yours sincerely,



Stephen Groves
National Director of EPRR
NHS England and NHS Improvement

North East & Yorkshire Annual EPRR Assurance Process for 2021-22

Dear Colleagues

Please find below details in regard to this years annual EPRR Assurance Process within the North East & Yorkshire region.

Accompanying this letter, you will find three additional documents –

- B0628_2021 EPRR Annual Assurance Letter from Stephen Groves
- B0628_2021 EPRR Assurance Standards (excel document)
- NEY Regional Statement of Compliance template

You will note that this year we are collecting assurance on a reduced number of standards.

This does not replace your statutory responsibility to be compliant with the full set of standards applicable to your organisation, but in recognising the demands over the last 18 months, we will not be seeking to obtain assurance on your compliance against a number of those standards previously issued.

The timeline for submission of this year's standards within the North East & Yorkshire region will be as follows:

Colleagues are asked to send copies of the following back to myself (sarah.tomlinson8@nhs.net) by Friday 29th October 2021 in order that we can undertake the thematic reviews and prepare for our learning sessions in November 2021.

Many Thanks as always for your continued support

Paul Dickens
Regional Head of EPRR for the North East & Yorkshire and North West Regions

Yorkshire and the Humber Local Health Resilience Partnership (LHRP)
Emergency Preparedness, Resilience and Response (EPRR) assurance 2021-2022

STATEMENT OF COMPLIANCE

Barnsley CCG has undertaken a self-assessment against required areas of the EPRR Core standards self-assessment tool v1.0

Following self-assessment, the organisation has been assigned as an EPRR assurance rating of Full (from the four options in the table below) against the core standards.

Overall EPRR assurance rating	Criteria
Fully	The organisation is 100% compliant with all core standards they are expected to achieve. The organisation's Board has agreed with this position statement.
Substantial	The organisation is 89-99% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Partial	The organisation is 77-88% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Non-compliant	The organisation compliant with 76% or less of the core standards the organisation is expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months. The action plans will be monitored on a quarterly basis to demonstrate progress towards compliance.

I confirm that the above level of compliance with the core standards has been agreed by the organisation's board / governing body along with the enclosed action plan and governance deep dive responses.

Signed by the organisation's Accountable Emergency Officer

_____

Date signed

09/09/2021	09/09/2021	TBC – 2021/22
Date of Board/governing body meeting	Date presented at Public Board	Date published in organisations Annual Report

GB/Pu 21/09/18

NHS
Barnsley
Clinical Commissioning Group

Governing Body

9 September 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 July 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	Genna Miller/ Azariah Speed	Head of Finance (Management Accounts)/Contracts, Performance Intelligence Manager

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	2nd September 2021	Considered the paper and noted the actions

5.	**EXECUTIVE SUMMARY**
5.1	**2021/22 - Month 4 Finance Update** The detailed finance report, attached at Appendix 2, provides an assessment of the current financial performance of the CCG up to 31st July 2021, together with the forecasts for the year end. The report contains the headline messages along with monthly financial monitoring. As at 31st July 2021 the CCG is forecasting to achieve all yearend financial duties and planning guidance requirements, with an in-year balanced budget position, subject to further technical adjustments relating to the Hospital Discharge Programme (HDP) and Elective Recovery Fund (ERF). In-year pressures, emerging risks and under delivery of planned efficiency schemes are included within the reported position with a forecast underspend (after risk assessment in the 'most likely' scenario) of £56k. This position assumes reimbursement for costs in Month 5 and 6 relating to the Hospital Discharge Programme of £157k and Elective Recovery Fund of £33k. Continuing Healthcare continues to be a volatile area. The continuing healthcare forecast underspend of £200k relates, in the main, to growth in care packages not being as high as anticipated within the planning process, and the continuation of Hospital Discharge Programme costs (which continues to be funded outside of envelope). Pressures in complex cases continue to be assessed and reviewed, with progress being monitored through the weekly updates within the Quality Team. The forecast includes £387k relating to data recording updates required and uplift notifications from BMBC. A cost pressure of £179k has arisen in Month 4 relating to private providers/non contract activity and the Elective Recover Fund (ERF), due to ICS system wide forecasting not achieving Q2 activity threshold levels to attract additional allocations. This has been mitigated against from the private provider risk reserve (held by the CCG), with the potential for a further allocation from the retained ICS Elective Recovery Fund (ERF) of £1.7m (to be split system wide). However this is currently not assumed within the financial position. Further information on the CCG's financial performance targets is set out in section 2 of Appendix 2. The position as at 31st July 2021 is that planned efficiency schemes are forecast to deliver £6.8m against the £7.2m target, with £3.1m of confirmed in-year non recurrent budget reductions as contributing mitigation. Further non recurrent reductions are being managed through investment funding and risk reserves. As risks and mitigations emerge, the Governing Body will be updated through this report which is a standing agenda item of the committee.
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 4 (July 2021) where data is available.

Performance reporting to Governing Body is in the process of being updated to reinstate some of the performance metrics that were scaled back due to COVID.

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.

Urgent Care

A&E 4-hour performance continues to be below the target and has been impacted by significantly increased activity levels and challenges with flow due to COVID requirements in relation to social distancing.

The CCG performance is being driven in the main by A&E performance against the 4-hour standard at BHNFT remaining below target at 66.08%. Bed occupancy across BHNFT remains high and often exceeds 95%. The Trust is reviewing its current bed capacity as part of seasonal plans.

Ambulance response times and handover performance have further deteriorated in July. The CCG is working with BHNFT and Yorkshire Ambulance Service on a number of pathway changes that may support patients not requiring conveyance to hospital. Pathways direct to the Same Day Emergency Care (SDEC) units went live in August and will be monitored closely in the coming months.

Planned Care

Note: Due to the availability of data, Planned Care performance is reflected up to the end of June 21.

8-week RTT continues to improve in month from 85.18% to 86.76% in June. The number of 52-week waiters is continuing to decrease from 452 to 372.

The CCGs RTT performance is been driven mainly by further improved performance at BHNFT in the 92% referral to treatment standard. The Trust is currently achieving 87.74% even though there have been capacity pressures in critical care since mid-June which is impacting on elective performance.

Diagnostics performance has worsened in month from to 31.69% to 32.10% in June (Target of 1%). This performance is driven by longer waits for Colonoscopy and Gastroscopy at BHNFT and Non-Obstetric Ultrasound at Doncaster and Bassetlaw Teaching Hospitals

Mental Health and Learning Disabilities

With regards to IAPT performance, the number of people entering treatment against level of need met the 1.83% target year to date and performance has continued to improve on last month.

The proportion of people who complete treatment and are moving to recovery has slipped in July to 33.09% which is under the target of 50% for the first time this

	year. This is due to an 'opt in' initiative in which all clients on 1:1 waiting lists received opt in letters with a number of options for their treatment. It is expected that the target will recover very quickly, if not in August then by no later than September's figures. **<u>Cancer</u>** *Note: Due to the availability of data, Cancer performance is reflected up to the end of June 21.* Performance on most of the cancer pathways continues to be below the national standards including 2 week waiting times which have historically been strong. At BHNFT, there are known capacity issues within the Breast service due to increased referrals over the last two months. This has resulted in the overall non-compliance of the 14 day access standard for the Trust. Overall treatment volumes have increased in recent months due to backlog recovery. This continues to affect overall performance in the 62 day standards with the exception of the consultant upgrade in-month (local target of 85% for this measure).
6.	**THE GOVERNING BODY 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 M4 2021/22 **Finance Section** • Appendix 2 – Month 4 Finance update

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:	*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***

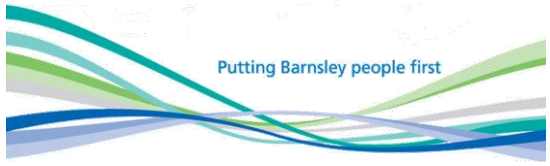
3.2 Management of Conflicts of Interest (s14O)

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***



NHS
Barnsley Clinical Commissioning Group

Performance & Delivery Report

2021/22 : Position statement using latest information

for the September 2021 meeting of the Governing Body

Produced by
Information and Intelligence Team, NHS Sheffield CCG

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 86.76%	Jun-21	Provisional 84.69%		Published Jun-21 87.74%	
	No patients wait more than 52 weeks for treatment to start	0		372	Jun-21	1394		182	
Diagnostic test waiting times	Patients waiting six weeks or more for a diagnostic test	1%		Provisional 32.10%	Jun-21			Published Jun-21 38.37%	
			Q1 21/22						
A&E Waits	Patients are admitted, transferred or discharged within 4 hours of arrival at A&E	95%	72.69%	68.03%	Jul-21	74.03%		66.08%	
	No patients wait more than 12 hours from decision to admit to admission	0		0	Jul-21			0	
			Q1 21/22						
Cancer Waits: From GP Referral to First Outpatient Appointment	2 week (14 day) wait from referral with suspicion of cancer	93%	89.68%	90.47%	Jun-21	89.68%		90.32%	
	2 week (14 day) wait from referral with breast symptoms (cancer not initially suspected)	93%	74.91%	78.57%	Jun-21	74.91%		84.62%	
Cancer Waits: From Diagnosis to Treatment	1 month (31 day) wait from diagnosis with suspicion of cancer to first treatment	96%	98.80%	98.60%	Jun-21	98.80%		100.00%	
	1 month (31 day) wait for second/subsequent treatment, where treatment is anti-cancer drug regimen	98%	97.69%	100.00%	Jun-21	97.69%		100.00%	
	1 month (31 day) wait for second/subsequent treatment, where treatment is radiotherapy	94%	98.36%	100.00%	Jun-21	98.36%			
	1 month (31 day) wait for second/subsequent treatment, where treatment is surgery	94%	86.36%	92.00%	Jun-21	86.36%		93.33%	
Cancer Waits: From Referral to First Treatment	2 month (62 day) wait from urgent GP referral	85%	76.70%	74.58%	Jun-21	76.70%		84.16%	
	2 month (62 day) wait from referral from an NHS screening service	90%	79.07%	63.64%	Jun-21	79.07%		77.78%	
	2 month (62 day) wait following a consultant's decision to upgrade the priority of the patient	(85% threshold)	93.33%	88.68%	Jun-21	93.33%		88.10%	
Cancer Waits: Faster diagnosis standard	Cancer 28 day waits - Told within 28 Days	75%	65.88%	64.71%	Jun-21	65.88%			
Ambulance response times	Category 1 (life threatening) calls resulting in an emergency response arriving within 7 minutes (average response time)	7 mins		8mins 31secs	Jun-21				8mins 31secs
	Category 2 (emergency) calls resulting in an emergency response arriving within 18 minutes (average response time)	18 mins		30mins 4secs	Jun-21				30mins 4secs

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 3 (urgent) calls resulting in an emergency response arriving within 120 minutes (90th percentile response time)	120 mins		3hrs37mins30secs	Jun-21				3hrs37mins30secs
	Category 4 (less urgent) calls resulting in an emergency response arriving within 180 minutes (90th percentile response time)	180 mins		5hrs36mins12secs	Jun-21				5hrs36mins12secs
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		23.24%	Jul-21	16.42%			23.24%
	Ambulance Handover - reduction in the number of delays over 1 hour in clinical handover of patients to A&E	Local Reduction		7.99%	Jul-21	4.52%			7.99%
	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		9.59%	Jul-21	10.25%			9.59%
	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		0.60%	Jul-21	0.56%			0.60%

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%		2.22%	Jul-21	7.02%			
	Improved Access to Psychological Services-IAPT: People who complete treatment, moving to recovery	50%		33.09%	Jul-21				
	Proportion of people waiting 18 weeks or less from referral to first IAPT treatment appointment	95%		100.00%	Jul-21				
	Proportion of people waiting 6 weeks or less from referral to first IAPT treatment appointment	75%		97.68%	Jul-21				

Performance Indicator	Target	CCG Quarterly	CCG Latest		CCG Performance	Latest Provider Total Monthly Position	
			Monthly Position	YTD Position		Barnsley Hospital	Yorkshire Ambulance Service

Performance Indicator	Target	CCG Quarterly	CCG Latest		CCG Performance	Latest Provider Total Monthly Position	
			Monthly Position	YTD Position		Barnsley Hospital	Yorkshire Ambulance Service

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Finance Report 2021/22

Month 4

1 Headline Messages and contents

Headline Messages	Contents	
• The financial information contained within this report relates to April to September 2021 only (referred to as H1 period) • As at the end of July 2021 the CCG is forecasting to achieve all year end financial duties and planning guidance requirements, with an in year balanced budget position, with the exception of outside of envelope allocation adjustments (relating to Hospital Discharge programme and Elective Recovery Fund). • The forecast position on CCG expenditure before mitigation show an overspend of £190k. Allocations are expected for Hospital Discharge Programme (HDP) of £157k and Elective Discharge Fund (ERF) of £33k. The balanced position is predicated on the assumptions outlined within the report. • The Finance and Performance Committee considered detail on the risks and mitigations with the current projections in the 'Most Likely' scenario indicating a potential net underspend of £56k. Should the forecast position materialise in the 'worst case' prediction further efficiency plans and other underspend positions of £298k would need to be developed and delivered to ensure financial duties and targets are achieved. The CCG continues to work to identify further opportunities against this risk to ensure that financial duties and targets can be achieved. • The continuing healthcare forecast underspend relates in the main to growth in care packages not being as high as anticipated within the planning process, and the continuation of Hospital Discharge Programme costs (which continues to be funded outside of envelope). Pressures in complex cases continue to be assessed and reviewed, with progress being monitored through the weekly updates within the Quality Team. The forecast includes £387k relating to data recording updates required and uplift notifications from BMBC. Continuing Healthcare continues to be a volatile area. • Primary Care prescribing data for Month 2 has been received, and the forecast position is under spent by £0.1m with prescribing overspend of £204k being offset against an underspend in Home Oxygen and Pharmacy claims. The Finance and Contracting team and Head of Medicines Management continue to meet to ensure any risks are captured within the financial position. No significant risks have been identified to date, with Category M drugs tariff changes from July 2021. Within the risks and mitigation analysis we have assumed some further pressure and movement in forecasts as changes in prescribing profiles are expected and given the limited data at this stage in reporting, which have been considered by the Finance and Performance Committee. • Private provider activity is a risk due to the forecast of the Q2 system wide Elective Recovery Fund thresholds not been achieved. The impact for Barnsley CCG is an future allocation reduction of £179k. This has been managed through the private provider risk reserve, but has resulted in additional strain on the financial position. There is potential for a further fair share allocation from the ICS Elective Recovery Fund (ICS total £1.7m).		

• The CCG's Efficiency Programme requires £7.2m to be delivered from April to September 2021 (H1 period). The unidentified QIPP target of £4.663m is being managed through mitigations within reserves (£2.5m) and Neighbourhood Team investment (£0.6m), with the balance of £1.6m to be offset against the remaining risk reserve and underspend position. • Planning guidance is expected in September 2021 for October 2021 to March 2022 (period called H2).		

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	256,145	256,145	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	256,125	256,125	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	2,075	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

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.

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	13,112	134,206	89,455	89,562	106	134,501	295
Patient transport	1,214	0	1,214	810	762	(48)	1,181	(33)
Mental Health	20,360	979	21,339	14,226	14,232	6	21,341	2
Community Health	25,964	(1,327)	24,637	16,445	16,442	(3)	24,632	(5)
Continuing Health Care	15,430	0	15,430	10,286	10,303	17	15,229	(201)
Primary Care Other	31,683	(37)	31,646	21,191	20,985	(206)	31,441	(205)
Primary Medical Services (Co-Commissioning)	21,714	(58)	21,656	14,437	14,187	(250)	21,529	(127)
Other Programme Costs	1,856	(217)	1,639	1,092	1,104	11	1,663	25
TOTAL COMMISSIONING SERVICES (INCLUDING PRIMARY CARE RESERVES)	**239,314**	**12,452**	**251,766**	**167,943**	**167,577**	**(366)**	**251,517**	**(249)**
Corporate Costs - EMBED/DSCRO	76	0	76	51	51	0	76	0
Corporate Costs - IFR	22	0	22	15	15	0	22	0
NHS Property Services/Community Health Partnerships	377	0	377	251	261	10	393	15
Depreciation Charges	10	(10)	0	(0)	0	0	0	0
TOTAL CORPORATE COSTS	**485**	**0**	**475**	**317**	**327**	**10**	**490**	**15**
Coronavirus Costs - PrimCare	327	565	892	783	817	34	910	18
Coronavirus Costs - CHC - Hospital Discharge Programme (Outside of Envelope)	0	382	382	382	358	(24)	416	34
Coronavirus Costs - Community - Hospital Discharge Programme (Outside of Envelope)	0	108	108	108	110	2	152	43
Coronavirus Costs - Other Prog. - Hospital Discharge Programme (Outside of Envelope)	0	64	64	64	87	22	127	62
TOTAL CORONAVIRUS COSTS	**327**	**1,120**	**1,447**	**1,338**	**1,356**	**18**	**1,604**	**157**
TOTAL PROGRAMME COSTS (INCLUDING PRIMARY CARE RESERVES)	**240,126**	**13,572**	**253,688**	**169,598**	**169,260**	**(338)**	**253,612**	**(76)**
RUNNING COSTS								
Pay	1,308	(23)	1,285	857	807	(50)	1,235	(51)
Non Pay	1,133	(277)	856	570	594	24	841	(15)
TOTAL RUNNING COSTS	**2,441**	**(300)**	**2,141**	**1,427**	**1,401**	**(27)**	**2,075**	**(66)**
CCG Reserves - 0.5% Contingency	1,214	0	1,214	809	0	(809)	1,214	0
CCG Reserves - Ageing Well	0	671	671	671	0	(671)	671	0
CCG Reserves - Overseas Visitors	217	(217)	0	0	0	0	0	0
CCG Reserves - Risk Reserve	597	660	1,257	737	0	(737)	1,257	0
CCG Reserves - Risk Reserve - Private Providers (ERF risk)	0	545	545	545	0	(545)	545	0
CCG Reserves - Covid allocation currently not committed	0	1,083	1,083	722	0	(722)	1,083	0
CCG Reserves - unidentified QIPP	0	(4,663)	(4,663)	(3,109)	0	3,109	(4,663)	0
In year (over)/underspend	0	0	0	0	792	792	332	0
TOTAL RESERVES/CONTINGENCY (EXCL. PRIMARY CARE RESERVES)	**2,028**	**(1,922)**	**106**	**376**	**792**	**416**	**439**	**332**
TOTAL EXPENDITURE	**244,595**	**11,350**	**255,935**	**171,401**	**171,453**	**51**	**256,125**	**190**

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	207,501	25,321	232,822	155,992	155,992	0	232,822	0
Primary Care Co-Commissioning	20,672	0	20,672	13,781	13,781	0	20,672	0
Running Costs	2,441	0	2,441	1,627	1,627	0	2,441	0
RESOURCE ALLOCATIONS	**230,614**	**25,321**	**255,935**	**171,401**	**171,401**	**0**	**255,935**	**0**
SURPLUS/(DEFICIT)	**(13,981)**	**13,971**	**0**	**0**	**(51)**	**(51)**	**(190)**	**(190)**
Hospital Discharge Programme (HDP) - Month 4					18	18	157	157
Elective Recovery Fund (ERF) - Month 3 & 4					33	33	33	33
Total Technical Adjustments awaiting allocations			**0**	**0**	**51**	**51**	**190**	**190**
SURPLUS/(DEFICIT) after technical adjustments			**0**	**0**	**-0**	**-0**	**0**	**0**

Comments

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.

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
(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
Covid vaccinations for CCG Inequalities	M3		18	18
Blood pressure at home - Trailblazer funding	M3		33	33

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

RESOURCE ALLOCATIONS - PROGRAMME, RESERVES & SURPLUS		ALLOCATION RECURRENT (APRIL-SEPT - H1)	ALLOCATION NON RECURRENT (APRIL-SEPT - H1)	TOTAL £000
Description	Month	£	£	£
Primary Care: GP IT Infrastructure and Resilience	M4		15	15
Covid vaccinations for CCG Inequalities (Recovery)	M4		(18)	(18)
Diabetes Programme Transformation Fund H1	M4		35	35
Primary Care Covid Support/Expansion Fund (£120m)	M4		565	565
Online consultation software systems	M4		19	19
Ageing Well - additional community services	M4		671	671
Post Covid Assessment Clinic Funding 21/22	M4		112	112
Local Maternity Systems (LMS) - Continuity of Carer & Equity	M4		15	15
Local Maternity Systems (LMS) - Enhanced Continuity of Carer	M4		6	6
Palliative or End of Life Care (PEoLC) Match Funding - 1st tranche payment - 2021/22	M4		11	11
Elective Recovery Fund (ERF) Transfer From Lead (April and 90% May)	M4		227	227
Hospital Discharge Programme - Q1	M4		555	555
TOTAL RESOURCE ALLOCATION		**228,173**	**25,321**	**253,494**

RESOURCE ALLOCATIONS - RUNNING COSTS		ALLOCATION RECURRENT (APRIL-SEPT - H1)	ALLOCATION NON RECURRENT (APRIL-SEPT - H1)	TOTAL £000
Description	Month	£	£	£
TOTAL RESOURCE ALLOCATION		**2,441**	**0**	**2,441**

SUMMARY	£'000	£'000	£'000
Programme	207,501	25,321	232,822
Primary Care Co-Commissioning	20,672	0	20,672
Running Costs	2,441	0	2,441
TOTAL RESOURCE ALLOCATION	**230,614**	**25,321**	**255,935**

Comments

The above provides details of the allocations received by NHS Barnsley CCG to 31st July 2021.

NHS Barnsley Clinical Commissioning Group

Minutes of the Meeting of the NHS Barnsley Clinical Commissioning Group FINANCE & PERFORMANCE COMMITTEE held on Thursday 1 July 2021 at 10.30am via Microsoft Teams.

PRESENT:

Dr Nick Balac (Chair)	- Chair
Dr John Harban (From item 6)	- 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 (From item 6)	- Lay Member Governance
Jeremy Budd	- Director of Strategic Commissioning and Partnerships
Dr Adebowale Adekunle	- Elected Member Governing Body

IN ATTENDANCE:

Leanne Whitehead	- Executive Personal Assistant

APOLOGIES:

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

Agenda Item		Action & Deadline
FPC21/87	**QUORACY**	
	The meeting was declared quorate.	
FPC21/88	**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.	
FPC21/89	**MINUTES OF THE PREVIOUS MEETING HELD ON 6 MAY 2021** – Approved.	
FPC21/90	**MATTERS ARISING REPORT**	
	FPC21/70 Update on Recent and Expected Guidance ICS Narrative plan not been seen yet, action to share with Governing Body members still outstanding. **All other actions were completed. The Committee received and noted the report.**	
FPC21/91	**UPDATE ON RECENT PUBLISHED AND EXPECTED**	

	GUIDANCE	
	The Chief Finance Officer presented the update on recent published and expected guidance. It was reported that plans had been resubmitted to address the variations in the treatment of Elective Recovery Fund (ERF) income and expenditure within the financial plan submissions and the apparent misalignment between the finance plans and the activity / workforce plans which was captured as part of the plan assurance process for H1 2021/22. The submission timeline was shared with members. It was noted that CCG's and providers would benefit from receiving elective recovery funds and the accelerated funding would be in addition to that. Discussions were needed on how to support the Trust with backlog and how to support out of hospital would need some thought also. **The Committee received and noted the report.**	
FPC21/92	**UPDATE ON CONTRACTING CYCLE**	
	The Chief Finance Officer presented the update to members. It was reported that the Barnsley Integrated Diabetes Service (BIDS) would be presented to the Governing Body in July for update. It was noted that the Intermediate Care service was now live, there had a been a few issues in relation to medical oversight for a small number of patients but the Chief Nurse was working to resolve this. It was reported that the Breathe mobilisation was on track, there had been a meeting to discuss some perceived gaps but SWYPFT were on track to deliver the service from 1.7.21. A Yorkshire and Humber Finance Group has been set up to support the delivery of an Integrated Urgent and Emergency Care programme of work within the Integrated Commissioning Framework. The group will work alongside the Integrated Commissioning Forum to provide support and financial leadership in the development of the 3 – 5 year plan. Including: • Yorkshire and Humber 999 service • Yorkshire and Humber Integrated Urgent Care: 111 Call Handling and Core Clinical Advice Service • Patient Transport Services (PTS) where appropriate The establishment of this group is not expected to impact on governance relating to this contract that is already in place across South Yorkshire and Bassetlaw. **The Committee were asked to note the contents of the report including:** • **Update on Barnsley Integrated Diabetes Service** • **Update on Intermediate Care including medical oversight**	

	• **Update on BREATHE Mobilisation** • **Update on newly established Finance Group for Integrated Urgent and Emergency Care (YAS contracts)**	
FPC21/93	**APPROVAL AND OR UPDATE ON PROCUREMENTS**	
	It was reported that there were currently no live or planned procurements.	
FPC21/94	**INTEGRATED PERFORMANCE REPORT**	
	Finance The Chief Finance Officer presented the finance report which 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 Finance and Performance Committee are 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. Also included in Appendix 2 is detail of the CCGs underlying financial position with the current position for the 6 months ended 30 September 2021 showing a £13.8m underlying recurrent deficit. This underlying deficit position will be potentially subject to change depending on the national financial regime from September 2021 and beyond, but this position will continue to be updated as guidance emerges. The main driver of this underlying position relates primarily to the continuation of block contracts with NHS Providers and the lack of recurrent efficiency delivered due to the impact of the Covid-19 pandemic. Clearly this position will need to be addressed as we recover from the pandemic and start to unlock the efficiencies identified as part of place priorities and CCG work plan. The place-based Efficiency Executive Group and CCG QIPP Delivery Group has been reinstated from July 2021 to ensure programmes of work progress with agreement across the partnership. This will include (but is not limited to) discussion on adjusting payments to	

	NHS providers where costs can be taken out of the system. It was reported that all Chief Finance Officers were meeting regularly to discuss the Hospital Discharge Programme to ensure costs were managed within the envelopes set nationally. <u>Performance</u> The Chief Operating Officer presented an update on the performance sections 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 but there are real challenges. 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. **The Committee were 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** • **actions being taken forward to address the CCGs recurrent underlying position to support planning for 2022/23.**	
FPC21/95	**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 were 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.**	
FPC21/96	**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. The Chief Finance Officer raised the score of the CHC risk, but agreed to discuss this with the Chief Nurse. It was reported that plans were in place for the children's sections and things were moving on but seemed to be risks in the adults sections which are not part of the audit action plan. An in-depth discussion was had around CHC and the issues faced and noted that the Chief Nurse was due to give an update at the Governing Body following the task and finish group that had been established which Nigel Bell was involved in. There was also a Governing Body Development Session planned for the 22 July to discuss CHC in more detail with members to have more clarity on the issues and how members can support the developments. It was agreed to have the session on the 22 July before changing the risk score. Dr J MacInnes raised whether there needed to a new risk included on the the register around the changes from CCG to ICS. It was queried how this would best be described and scored. The Accountable Officer reported that a transition board had been set up now to oversee the process and that this should mitigate the risk but agreed to draft the narrative around this risk and share at the Private Governing Body in July for further discussion about the risk rating/score. Discussion was had around the Covid National Enquiries and work had begun to start pulling records together but no formal communications around this had been received by the CCG as yet, the Accountable Officer agreed to incorporate anything received on	

	this within the monthly Chief Officers report to Governing Body in Public. **Agreed Actions:** • **Chief Finance Officer to discuss CHC risk score with Chief Nurse prior to the Development Session on the 22 July.** • **Accountable Officer to draft risk narrative around changes from CCG to ICS and raise at the GB Private Session in July.** • **Accountable Officer agreed to incorporate anything received in relation to the national Covid Enquiry within the monthly Chief Officers report to Governing Body in Public.** **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**	**RN** **CE** **CE**
FPC21/97	**MINUTES OF THE BHNFT CONTRACT EXECUTIVE BOARD** – No meetings held.	
FPC21/98	**MINUTES OF THE SWYPFT CONTRACT EXECUTIVE BOARD** – No meetings held.	
FPC21/99	**MINUTES OF THE CHILDRENS EXECUTIVE COMMISSIONING GROUP – 26 April 2021** - The minutes were noted.	
FPC21/100	**MINUTES OF THE ADULTS JOINT COMMISSIONING GROUP** – no meetings held.	
FPC21/101	**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 May & June 2021: • Agency Nurse contract extension – SMT agreed that one of the existing agency nurse's contracts can be extended by 8 weeks to support the Continuing Health Care Team to complete all outstanding reviews (£14,000) **The Committee received and noted the report.**	

FPC21/102	**ANY OTHER BUSINESS**	
	No items were raised under this heading.	
FPC21/103	**ITEMS FOR ESCALATION TO GOVERNING BODY**	
	• CHC – Full development session on 22.7.21 to discuss these issues and have more clarity. • Procurements Update – GB private session • National Covid Enquiries – include in Chief Officers report • Transition CCG/ICS – CE to pick up narrative around this and share with members.	
FPC21/104	**REFLECTION ON HOW THE MEETINGS BUSINESS WAS CONDUCTED**	
	The meeting went well and all business was covered.	
FPC21/105	**DATE AND TIME OF NEXT MEETING**	
	Thursday 2 September 2021 at 10.30am via Microsoft Teams.	

NHS
Barnsley
Clinical Commissioning Group

GOVERNING BODY

9 September 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 5 August 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)	5 August 2021	Highlights agreed

5. EXECUTIVE SUMMARY

This report provides the September 2021 Governing Body with the agreed highlights from the public Primary Care Commissioning Committee held on 5 August 2021.

It was agreed at the meeting that the following would be highlighted:

1. **PDA**

   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 2021/22 Primary Care Schemes of the Practice Delivery Agreement is broken down into 7 core schemes, including Medicines Management:

- Plans for Delivery of Primary Care Services
- Estate Planning
- Staff trained as appropriate, and equipment updated
- Evidence Based Commissioning Policies
- Operational Planning Guidance
- IT and Digital Projects

The PCCC approved the proposed schemes with the associated finances for inclusion within the 2021/22 PDA

2. CQC

The CQC have informed the CCG that they are continuing to develop their approach to inspection activity, moving on from their transitional monitoring approach adopted during the COVID-19 pandemic, as outlined below:

From July 2021 a monthly review will be introduced of the information held on most of the services regulated.

The following CQC inspections have been undertaken:

- Rose Tree Practice

  The CQC have rated the practice as good overall and in all domains following their inspection on the 18 and 19 May 2021.

- Hoyland Medical Practice

  The CQC report following a remote inspection on 6 May 2021 found one breach of regulation. The provider must establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care and improve telephone access to the practice.

  The CCG are liaising with the practice and requested an action plan to confirm the steps being taken to meet requirements.

- Woodland Drive

  The CQC report following a remote inspection on 26 May 2021 found one breach of regulation. The provider must establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.

  The CCG are liaising with the practice and requested an action plan to confirm the steps being taken to meet requirements.

	• Royston High Street Practice. The CQC held a telephone monitoring call on the 16 July with Royston High Street Practice. The outcome will be shared within a future meeting. **3. COVID Capacity Expansion Fund** On the 19 March 2021 NHSE/I wrote to all CCGs and GPs setting out details of a second General Practice Covid Capacity Expansion Fund. Nationally this fund consists of £120 million of revenue funding to be allocated through ICS to CCGs for general practice, for the purpose of supporting the expanding general practice capacity up from April 2021 until the end of September 2021 based on the previous requirements of the first offer in November 2020. The letter encourages use of the fund to stimulate the creation of additional salaried GP roles that are attractive to practices and locums alike and for the employment of staff returning to help with COVID, or to increase the time commitment of existing salaried staff. The letter asks that CCGs do not introduce overly burdensome administrative processes for PCNs and practices to secure support to focus on simplicity and speed of deployment, within a number of parameters The PCCC approved the proposed payment of £1.90 weighted per head of patient population to practices and to note that it is non recurrent funding.
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 – PCCC Committee adopted minutes 27 May 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:	CCG 18/04 *CCG 15/03* CCG13/20

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

Minutes of the PUBLIC Primary Care Commissioning Committee meeting held on Thursday, 27 May 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 (joined the meeting at agenda item 11)
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
Rebecca Clarke	Senior Public Health Principal, BMBC
Ruth Simms	Assistant Finance Manager
Chris Lawson	Head of Medicines Optimisation (for agenda item 12 only)
Margaret Lindquist	Board Member, Healthwatch Barnsley

APOLOGIES:

Julia Burrows	Director of Public Health, BMBC
Roxanna Naylor	Chief Finance Officer

MEMBERS OF THE PUBLIC:

There were no members of the public present at the meeting.

Agenda Item	Note	Action	Deadline
PCCC 20/05/01	**HOUSEKEEPING**		
PCCC 20/05/02	**WELCOME AND APOLOGIES**		
	The Chair welcomed members to the meeting and apologies were noted as above.		
PCCC 20/05/03	**QUORACY**		
	The meeting was declared quorate.		

PCCC 20/03/04	**DECLARATIONS OF INTEREST RELEVANT TO THE AGENDA**		
	Dr Guntamukkala declared a direct financial interest in the following agenda items as her Practice would be receiving funding as set out in the papers:- • Agenda item 11, Contractual Issues Report 'In Year Contract Variation for Dodworth Medical Centre (Apollo Court) • Agenda item 12, Medicines Optimisation PDA Scheme • Agenda item 13, Covid Expansion Funding In addition the Chair noted that Dr Balac and Dr Smith also had a direct financial interest in items 12 and 13. The Chair agreed to allow the GP members to remain present for these items in order to provide their clinical view should the Committee require it, but they would not participate in the decision making.		
PCCC 20/05/05	**MINUTES OF THE LAST MEETING**		
	The minutes of the meeting held on 25 March 2021 were verified as a true and correct record of proceedings.		
PCCC 20/05/06	**MATTERS ARISING REPORT**		
	<u>PCCC 20/07/07 – GP Patient Survey 2020</u> The Head of Primary Care informed the Committee that the CCG would ensure appropriate support was provided to Practices if there were any issues highlighted in the GP Patient Survey 2020. Members noted the update provided.		
STRATEGY, PLANNING, NEEDS ASSESSMENT AND CO-ORDINATION OF PRIMARY CARE			
PCCC 20/05/07	<u>ICS Primary Care Collaborative</u> The Chair of Barnsley CCG provided members with a presentation and verbal update on the proposal to establish a South Yorkshire and Bassetlaw ICS Primary Care Collaborative. The presentation included information on the following themes:- • Why now • Aim of the proposal • Proposed role of a SYB ICS PC Collaborative • Proposed areas of responsibility • Formation of the SYB ICS PC Collaborative • Governance arrangements • Membership • Next Steps The Committee thanked the Chair of Barnsley CCG for the		

	information and update provided.		
PCCC 20/05/08	<u>Primary Care Strategy</u> The Head of Primary Care presented the Primary Care Strategy report that provided the Committee with an update on the work to date regarding the development of the Primary Care Strategy and transformational plans for work to deliver an integrated Primary Care Delivery Model. The Committee was informed that in order for primary care to resume normal working following the Covid pandemic the CCG had reviewed the primary care working groups and had established a Primary Care Strategy Group as a sub group of the PCCC and the Primary Care Delivery Group, to support operational delivery. The Primary Care Strategy Group Terms of Reference described the objectives and responsibilities of what and how the group would work together to deliver a model of primary care to ensure resilience and reflected the transformational changes taking place as the CCG and partner organisations move towards working together as part of an Integrated Care System. Membership of the group would include colleagues from the CCG, Primary Care Network, Barnsley Healthcare Federation and Community services. The Strategy Group had developed the Terms of Reference for the Group and for the Primary Care Operational Delivery Group. The Strategy Group had also reviewed and established the high-level Project Brief that set out the work plan and was reflected in the start of the Primary Care Strategy – Barnsley Primary Care Delivery Model. The Committee was informed that the documents would be reviewed and updated as work progressed and reported back to the PCCC. A lengthy discussion took place regarding the governance arrangements, primary care quality assurance reporting and remit of the Primary Care Strategy and Primary Care Operational Delivery Groups and how these groups would link in with other groups to avoid duplication. As part of the discussion it was confirmed that in terms of decision making around the primary care delegated functions, the Primary Care Commissioning Committee would remain the decision-making body. **Action**: The Head of Governance & Assurance and the Head of Primary Care would work together to strengthen the wording around the governance arrangements in the Primary Care Strategy Group Terms of Reference.	**RW/JF**	

	Subject to clarification of the discussions regarding governance, quality assurance and decision making, the Committee:- • **Approved the Terms of Reference for the Primary Care Strategy Group** • **Approved the Terms of Reference for the Primary Care Delivery Group** • **Approved the Project Brief** • **Noted the contents of the Primary Care Delivery Model**		
QUALITY AND FINANCE			
PCCC 20/05/09	**FINANCE UPDATE**		
	The Assistant Finance Manager presented the Finance Report that provided an update of the financial framework and highlighted the budget requirements for delegated Primary Care Co-Commissioning budgets for 2021/22 which was split April to September 2021 (H1) and October 2021 to March 2022 (H2). The Primary Care Co-Commissioning allocation for H1 was £20,672k with budget requirements being at £21,713k, a shortfall of £1,041k that would be funded from CCG programme costs. The shortfall was the result of national GP contract negotiations, planning requirements, the Primary Care Contract DES, and historical increases in premises. Additional core Primary Care Network funding totalling £396,225 (full year budget) had been allocated to the PCN DES which would also be funded from CCG programme costs. The second half of the financial year H2 - October 2021 to March 2022 was subject to further guidance. The paper also highlighted the six key financial areas of the new Primary Care Network Contract DES and expenditure expectations for the full financial year 2021/22. **The Committee:** • **Noted the update on the financial framework for 2021/22 and budgets set for the period April 2021 to September 2021.**		
PCCC 20/05/10	**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. The Committee was reminded that following the Care		

	Quality Commission (CQC) implementation of a Transitional Regulatory Approach that focussed on existing Key Lines of Enquiry, inspection activity had been limited to where there may be a serious risk of harm or where it supported the system's response to the pandemic. The report outlined the CQC inspection process for 2021/22 which had altered this year due to the move out of Covid and provided details of the CQC's approach to inspection activity from April 2021. The report also provided information on the following recent and upcoming inspections: <u>Rose Tree Practice</u> Following an inadequate rating in February 2019 and an improved rating of 'requires improvement' in October 2019 the practice had been inspected on 18 May 2021 as part of an ongoing review. The CCG were currently awaiting the latest report to be published. <u>Lakeside Surgery</u> Lakeside Surgery was due to be inspected in June 2021 as the practice does not have a current rating following the change in contract holder/registered manager. <u>The Kakoty Practice and High Street Practice</u> The Kakoty Practice and High Street Practice were due to be re-inspected later in 2021. Both practices were rated as 'Good' overall however they each had one indicator rated as 'requires improvement' which would be reviewed at the inspection. <u>Hoyland Medical Practice</u> A remote inspection had been carried out on 6 May 2021 in response to information received by the CQC that reached a threshold where contact with the practice was required. The Head of Primary Care informed the Committee that the CQC was a regulatory body for NHS contracted providers and concerns from members of the public, organisations or professionals could be raised with the CQC via a number of routes. Individual concerns would be directed back to the provider however, if a number of different concerns was received, this would trigger a remote or face to face inspection. The outcome of all inspections would be shared with the Committee at a future meeting when formal feedback had been received from the CQC. **The Committee noted:** • The CQC's inspection planning and approach for		

	2021-22 • The inspection of Rose Tree Practice • The upcoming inspections for Lakeside Surgery, The Kakoty Practice and High Street Practice • The remote inspection undertaken at Hoyland Medical Practice.		
CONTRACT MANAGEMENT			
PCCC 20/05/11	**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. **In Year Contract Variation** <u>Dodworth Medical Centre (Apollo Court)</u> The CCG had received an application to vary Dodworth Medical Centre (Apollo Court) PMS contract to remove Barnsley Healthcare Federation from 1 June 2021. The application required a contract variation amendment to the PMS contract which required approval from the Primary Care Commissioning Committee. The report recommended that the contract variation be approved It was noted that the CCG had also been approached regarding plans to merge this practice with The Grove Medical Practice. Further information would be brought to a future Committee meeting for consideration following receipt of a formal application. <u>Penistone Group Practice</u> The CCG had received an application to vary the Penistone Group Practice PMS contract in relation to a 24 hour retirement for Dr Morris on 1 April 2021. The 24 hour retirement did not require an amendment to the PMS contract and the item was for the Committee's information only. **GMS PMS Equalisation** In 2013 NHS England commenced a review of GMS and PMS practice contract funding due to the significant variation in approach to these contracts. Members were reminded that the Committee had previously approved a recommended approach for the CCG to continue to work towards the GMS/PMS equalisation and, after a considerable amount of work, the CCG had managed to achieve equalisation between the two contracts.		

	For 2021/22 the CCG had reviewed the variance between the GMS/PMS contracts and would not be applying any additional uplifts to PMS practices as equalisation still applied. From June 2021 the CCG would therefore be applying the national contract uplifts as set out in the April 2021 Guidance and would take the payment to £96.78 per patient. **Home Visiting contract Extension – Barnsley Healthcare Federation (BHF) – Extraordinary Meeting held on 29 April 2021** Following Committee approval of a Single Tender Waiver on 29 April 2021 for BHF to continue to provide Home Visiting services to Barnsley patients, it was noted the Home Visiting contract had been extended until 31 March 2022. **Online Consultation – Doctorlink** To ensure compliance with NHSE contractual arrangements all GP practices were required to offer online consultations by April 2020 and video consultations by April 2021. Following a joint procurement by Barnsley, Doncaster, Sheffield and Bassetlaw CCGs, Doctorlink, an online consultation platform had been selected due to its ability to provide a digital triage and advice tool for patients that could easily be integrated into practice systems. The contract had been awarded on 1 September 2019 for a 2 year period. Although all 32 Barnsley GP practices had installed and implemented the Doctorlink facility, only one practice was utilising all the functions of the platform as intended. Five practices were actually connected to the system although only four utilised the function. It was reported that since contracting with Doctorlink other platforms had been developed and the CCG would be liaising with practices to agree a system that would be acceptable to all practices. The Doctorlink contract would therefore not be extended at the contract end date of 31 August 2021 as it was felt it did not provide value for money nor support practices in the way it was envisaged. **Barnsley Healthcare Federation (BHF) Contracts Review** It was reported that discussions had recently taken place with BHF concerning a number of outstanding issues regarding the timeliness and accuracy of data relating to		

	contract reporting for 2020-21. The CCG had been supporting BHF to help resolve the outstanding issues to ensure a full reconciliation of all concerns in time for the 2021-22 contract negotiations to commence in June 2021. Following a brief discussion, the Committee raised its concerns regarding the amount of reporting issues outstanding and asked how confident the CCG was in BHF's ability to resolve these issues in a timely manner. The Head of Primary Care informed the Committee that following discussions a number of actions had been agreed with BHF to support confidence and trust in the performance data to be received in time for the June contract meeting that would allow the 2021-22 contract negotiations to commence, however it was acknowledged that a considerable amount time and effort would be required to achieve this. The Committee felt this issue was of concern and asked that an update on the BHF contracts review be brought to the July PCCC meeting. **The Committee:-** • Approved the removal of Barnsley Healthcare Federation from the Dodworth Medical Practice (Apollo Court) contract • Noted the 24 hour retirement request for Dr Morris at Penistone Group Practice • Noted the contractual uplifts and equalisation of GMS/PMS contractual payments • Noted the approval of the Single Tender Waiver for the Home Visiting service contract to 31 March 2022 • Noted the cessation of the Doctorlink contract from 31 August 2021 • Noted the contract review discussions with Barnsley Healthcare Federation for assurance <u>Dodworth Medical Centre (Apollo Court)</u> Following the report the Chairman of the CCG reminded the Committee of the huge dissatisfaction and amount of complaints the CCG had previously received from patients about the level of medical services provided by former contract holders of Apollo Court.	**JF**	**29.07.21**

	The Committee acknowledged, thanked and congratulated Dr Guntamukkala and BHF for their hard work and diligence on how quickly they had turned around Apollo Court. The practice was now rated "Good" by the CQC and continued to offer a first rate service to the people of Dodworth. It was noted that Barnsley had a strong Federation who had been delivering an outstanding Covid Vaccination service for Barnsley patients. <u>GMS/PMS Equalisation</u> The Chairman of the CCG also thanked the Head of Primary Care and the Primary Care Team for all their hard work and commitment in attaining equalisation between the GMS and PMS contracts which was quite an achievement.		
PCCC 20/05/12	**2021/22 PDA MEDICINES OPTIMISATION SCHEME** The Head of Medicines Optimisation presented the Practice Delivery Agreement for 2021/22 Medicines Optimisation Scheme for the Committee's approval. The Committee noted that the CCG had developed the draft Medicines Optimisation PDA section based on priorities and challenges facing the health of the population and the health service in general and included 4 core schemes that planned to deliver QIPP efficiencies within the 2021/22 financial year. A summary of each scheme had been included within the report. **The Committee:** • **Approved the 2021/22 Medicines Optimisation section of the Practice Delivery Agreement and budget.**		
PCCC 20/05/13	**COVID EXPANSION FUNDING** Following the national General Practice Covid Capacity Expansion Fund allocated to CCGs to support the expansion of general practice capacity up until the end of March 2021, NHSE had recently informed all CCGs and GPs of a second General Practice Covid Capacity Expansion fund. £120m would be allocated through ICS to CCGs for general practice to support expanding general practice capacity from April 2021 to 30 September 2021, based on the same requirements as the first allocation. Once the CCG receives the funding, the proposal would be that payment was made to practices on a monthly allocation basis. The funding is non-recurrent and would not be used to fund commitments running beyond this period.		

	The Committee: • **Approved the proposals and recommendations made within the report.**		
GOVERNANCE, RISK AND ASSURANCE			
PCCC 21/05/14	The Head of Governance & Assurance presented the risk and Governance report that provided the Committee with: • Assurance regarding the delivery of the CCG's annual strategic objectives, and • 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 which the Committee was 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. The Committee noted that the wording of risk reference 14/10 relating to primary care workforce had been reviewed and updated to more accurately reflect the current risks to the CCG. All risks continued to be reviewed and updated regularly. **The Committee:-** • **Reviewed and agreed that the risks were being appropriately managed and scored.**		
OTHER			

PCCC 21/05/15	**REFLECTION OF CONDUCT OF THE MEETING** The Committee agreed that the meeting had been conducted appropriately.		
PCCC 21/05/16	**QUESTIONS FROM MEMBERS OF THE PUBLIC RELEVANT TO THE AGENDA**		
	There were no questions received from the members of the public.		
PCCC 21/05/17	**ITEMS FOR ESCALATING TO THE GOVERNING BODY** It was agreed to escalate the following items to the Governing Body for information:- • Development of the Primary Care Strategy • Approval of the 2021/22 PDA Medicines Optimisation scheme		
PCCC 20/01/14	**DATE & TIME OF NEXT MEETING** Thursday, 29 July 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 17 June 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 Lawson (agenda items 21/06/18 & 21/06/19)	-	Head of Medicines Optimisation
Dr Adebowale Adekunle	-	GP Governing Body Member

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
Sheena Moreton	-	Continuing Healthcare Operational Lead

APOLOGIES:

Dr Shahriar Sepehri	-	Membership Council Representative
Chris Millington	-	Lay Member for Public and Patient Engagement and Primary Care Commissioning
Jo Harrison	-	Specialist Clinical Portfolio Manager

	Note	Action	Deadline
Q&PSC 21/06/01	**HOUSEKEEPING**		
	The Chair advised that everyone is responsible for their own safety within their environment during the meeting.		
Q&PSC 21/06/02	**APOLOGIES & QUORACY**		
	Apologies noted as above. The meeting was declared quorate.		
Q&PSC 21/06/03	**PATIENT STORY**		
	The Chief Nurse presented the patient story from the May 2021 Barnsley CCG Governing Body meeting which was about end of life care and the importance of care planning. The story highlighted the importance of communication between patients and care professionals and documenting requests. The Committee discussed the story acknowledging the		

	important role/responsibilities of Advanced Nurse Practitioners (ANPs). The Chief Nurse agreed to investigate if there are any reasons why ANPs are not able to complete and sign DNACPRs and report the findings at the next meeting.	**JS**	**August 2021**
	Actions agreed: Chief Nurse to investigate if there are any reasons why ANPs are not able to complete and sign DNACPRs.	**JS**	**August 2021**
Q&PSC 21/06/04	**DECLARATIONS OF INTEREST RELEVANT TO THE AGENDA**		
	No new declarations of interest relevant to the agenda were declared.		
Q&PSC 21/06/05	**MINUTES OF THE MEETING HELD ON 15 APRIL 2021**		
	Committee members approved the minutes of the previous meeting held on 15 April 2021 as an accurate record.		
Q&PSC 21/06/06	**MATTERS ARISING REPORT**		
	The Chair confirmed a number of actions were complete. The following updates were received against outstanding actions: **Minute reference Q&PSC 21/04/07 – Quality and Patient Safety Update Report -** The Primary Care and Transformation Manager agreed to provide an update on improving the accuracy of GP appointment data at the next meeting. Update provided as part of agenda item 21/06/07 - Primary Care Update Report. This action is now complete **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. Discussed at the July 2021 meeting. This action is now complete. **Minute reference Q&PSC 20/12/14 Minutes of the 14 October 2020 Area Prescribing Committee -** The Chief Nurse to follow up acutely ill patients being discharged from hospital to community. **Minute reference Q&PSC 20/12/17 Any Other Business -** Tom Davidson (BHNFT) to be invited to a	**Complete** **Ongoing** **Complete** **Ongoing**	

	future meeting to present Medway data capability. The Quality Administrator to ask the Lay Member for Public and Patient Engagement and Primary Care Commissioning to take this forward. **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. Update provided as part of agenda item 21/06/07 - Primary Care Update Report. This action is now complete	**Ongoing** **Complete**	
QUALITY AND GOVERNANCE			
Q&PSC 21/06/07	**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)** • ED Performance - Performance deteriorated in April 2021 to 75.6%. Attendance has risen to 2019 levels with a considerable number of walk-in patients. Efficiency is also impacted due to infection control measures and estate works. • Referral To Treatment (RTT) - Performance for March 2021 was 78.4%. The Trust is focused on treating urgent patients and 52 week+ waiters. • Diagnostic Waits - % of people waiting over 6 weeks for a diagnostic test improved to 35.3% in April 2021. The Trust is aiming to recover diagnostic waiting times by October 2021. • Cancer - Performance of 62 day standards fell below national target for March 2021 as the Trust continues to manage the COVID backlog. Performance in early stages of pathways was better even with a significant activity increase. • Outpatient DNA Rates – Performance has improved - 7.1% in April 2021 versus a target of 6.9%. The GP Practice Member Representative Contracting Lead raised if failed telephone consultations were included in the performance figures. The Quality Manager agreed to investigate this further with the Trust. • Mortality – The HSMR has increased. Reassurance was given at BHNFT CQB on 6 May	**HF**	**August 2021**

	2021 that this is probably due to the way patient records relating to Covid deaths have been coded. • StEIS Reportable Serious Incidents (SIs) – Trust reported 7 SIs between April 2020 and 7 June 2021 compared with 5 for 2019/20, and 1 Never Event in the same period. • Maternity Incidents – Ockenden Report - At the May 2021 CQB, the Trust presented the Maternity Services Board Measures Minimum Data Set report March 2021. The Trust Board will receive the minimum data measures monthly to ensure that maternity safety is a priority and transparent at Board level. • Staffing – Restriction on international recruitment from India has been lifted. However, there will be a delay in nurses taking up posts due to assessments and induction. Ten midwives will be taking maternity leave at the same time. Mitigation is in place for all risks however, ongoing assurance will be sought at CQB. **South West Yorkshire Partnership NHS Foundation Trust** • Patient Access – CAMHS RTT 34.4% of patients waiting more than 18 weeks. This has been linked to children returning to school. • StEIS Reportable Serious Incidents (SIs) – Trust reported 5 Sis between 1 April and 7 June 2021 compared with 2 for 2020/21. Following an internal audit by the Trust's Internal Audit service, some changes have been made to the grading processes. • Number of children & young people in adult ward – 3 service users were placed on adult wards in April 2021 for a total of 25 days. The Practice Member Representative Contracting Lead asked if the Trust reported if the patients experience was good? The Quality Manager agreed to explore this further at the next CQB. • Information Governance (IG) –7 IG breaches in April 2021 compared with 13 in, March 2021. This is in line with Trust's monthly target of 9 or less. • Pressure ulcers – Increase in Category 4 pressure ulcers, which is in line with patterns nationally. Agreed at CQB that further work across the local system needed. • Care Planning & Risk Assessment – 40.9% of clients on CPA offered a copy of their care plan	**HF**	**August 2021**

	against a target of 80%. 61.6% of inpatient records and 46.9% of community records had an up-to-date risk assessment versus target of 95%. This will be explored further at CQB. <u>Barnsley Child and Adolescent Mental Health Service</u> • Exceptionally high rate of referrals into the service in March 2021 following the return to school. • Crisis referrals particularly in relation to eating disorders are increasing. The CCG is working with SWYPFT to explore options to increase capacity. • Friends and Family Test (FFT) – results declined further in April 2021 to 65.9% versus a target of 80%. **Yorkshire Ambulance Service** SYB 999/IUC Clinical Quality Group had not met since the last Q&PSC meeting. However, Sheffield CCG, the Lead Commissioner for SYB has recently highlighted that: • 999 ED handover remains a concern with demand up particularly for Category 1 and 2 calls. • IUC – demand on 111 has increased with concerns raised that this is due to patients not being able to access their GP. This has resulted in patients being referred back to their GP with some patients then ending up in ED. YAS has reported a serious incident where a delay resulted in a patient missing the required treatment window. The Quality Manager asked members for comments about a recent complaint. A discussion took place around patient expectations and the inconsistency of 111 reports which GP practices receive and the impact that this is having on Practice staff. The Lead Commissioning and Transformation Manager to investigate what data is available to monitor patient 111 journey and feedback at the next meeting. <u>Primary Care Update</u> The Primary Care and Transformation Manager presented the Primary Care update for assurance highlighting: • <u>GP Appointments</u> – By 30 June 2021 all practices in the Primary Care Network (PCN) will have mapped all active appointment slot types to the new set of national appointment categories. • This will comply with August 2020 guidance on recording appointments.	**SL**	**August 2021**

	Post meeting note: The Primary Care and Transformation Manager has confirmed that the deadline to map all active appointment slot types to the new set of national appointment categories has been extended to 31 July 2021. • Care Quality Commission (CQC) - CQC have commenced their April 2021 inspection programme with evidence gathered in different ways. So far, the CQC has remotely reviewed 2 practices. Both practices have low level regulatory action but the CQC has no concerns. From July 2021 the CQC will be updating their website and marking practices with a banner to identify no concerns. • Out of Hours/Extended Hours Access - Some data anomalies are still being investigated. Improvements have been made to the report to include serious incidents and further detail on complaints. Committee members were asked to note the additional pressures and challenges Barnsley Healthcare Federation staff have been under to deliver the Covid vaccination programme. **The Head of Medicines Optimisation joined the meeting at 14:00pm.**		
	Actions agreed: The Quality Manager to investigate if failed telephone consultations are included in the Trusts Outpatient DNA performance figures. The experience of children & young people in adult wards to be explored with the Trust. Lead Commissioning and Transformation Manager to investigate what data is available to monitor patient 111 journey and feedback at the next meeting.	**HF** **HF** **SL**	**August 2021** **August 2021** **August 2021**
Q&PSC 21/06/18	**APC PRESCRIBING COMMITTEE REPORTING**		
	Due to the Head of Medicines Optimisation's prior commitments the Chair agreed to bring this item forward in the meeting. The Head of Medicines Optimisation reported that within Barnsley a scheme had been developed to report medicine incidents over and above the existing reporting systems. Themes are reported at the APC Prescribing Committee Reporting meeting. During the Covid pandemic the Local Medical Council (LMC) requested the reporting to be wider than medicines. The Head of Optimisation asked for agreement to present the yearly Barnsley APC Report at the next meeting.	**CL**	**August 2021**

	Actions agreed: The Head of Medicines Optimisation to present the yearly Barnsley APC Report at the next meeting.	**CL**	**August 2021**
COMMITTEE REPORTS AND MINUTES			
Q&PSC 21/06/19	**MINUTES OF 14 APRIL 2021 AREA PRESCRIBING COMMITTEE**		
	Due to the Head of Optimisation's prior commitments the Chair agreed to bring this item forward in the meeting. The Head of Medicines Optimisation presented the minutes highlighting an approved amendment to the Barnsley CCG Vitamin D Policy. The Secondary Care Clinician asked for an update on the previous issues raised around accuracy of D1s. The Head of Optimisation confirmed that a meeting has taken place with the BHNFT's Medical Director and Chief Pharmacist. A pilot scheme has been suggested which will involve hospital pharmacists handing over patients to GP practice clinical pharmacists. Due to staff challenges this has not yet been put in place. The Trust are also looking to restart the D1 Task and Finish Group.		
Q&PSC 21/06/20	**MINUTES OF 24 MARCH 2021 AND 28 APRIL 2021 PRIMARY CARE QUALITY & COST EFFECTIVE PRESCRIBING GROUP MEETING**		
	Due to the Head of Optimisation's prior commitments the Chair agreed to bring this item forward in the meeting. The Head of Medicines Optimisation presented the minutes for information. No comments were raised.		
Q&PSC 21/06/08	**BARNSLEY HOSPICE CQC VISIT**		
	The Chief Nurse updated the Committee on the outcome of a recent unannounced CQC inspection and the subsequent warning notices. CCG colleagues are supporting the hospice with developing and implementing an action plan to meet the regulation compliance dates of 20 September 2021 and 20 August 2021 respectively. Assurance was given that the hospice is on track to comply with the notice compliance dates. **The Head of Optimisation left the meeting at 14.17pm**		
Q&PSC 21/06/09	**SWYPFT COMMUNITY SERVICES WAITING LISTS**		
	The Lead Commissioning and Transformation Manager presented for assurance reports on the numbers of patients currently on waiting lists.		

	The Chief Nurse advised that the information provided at the last Clinical Quality Board (CQB) did not provide assurance on the clinical prioritisation of waiting lists. Further information on data cleansing and validation of waiting lists has been requested for the next CQB meeting due to be held on 22 July 2021. Members were assured a detailed update will be provided at the next meeting.	**SL**	**August 2021**
	Actions agreed: Detailed update of SWYPFT Community Services waiting lists to be presented	**SL**	**August 2021**
Q&PSC 21/06/10	**SWYPFT BARNSLEY INTEGRATED COMMUNITY STROKE TEAM ANNUAL REPORT 2020/21**		
	The Chief Nurse presented for assurance the annual report. The report demonstrated that Barnsley patients have benefited from the service. The Head of Contracting, BCCG is working with the service to establish the number of patients who would benefit from two further proposed service developments. Committee members agreed the report provided assurance showing very positive outcomes for patients.		
Q&PSC 21/06/11	**NEURO REHAB REVIEW UPDATE**		
	The Lead Commissioning and Transformation Manager provided a verbal update on the progress of the review. The Chief Nurse highlighted that due to the impending structural changes to CCGs the latest a paper on the service review can go to the Governing Body is September 2021. The Chief Nurse agreed to pick this up outside of the meeting.	**JS/SL**	**August 2021**
	Actions agreed: The Chief Nurse to meet with the Lead Commissioning and Transformation Manager to discuss the feasibility of gathering all the data to present the Neuro Rehab review update at Governing Body by September 2021.	**JS/SL**	**August 2021**
Q&PSC 21/06/12	**LeDeR UPDATE**		
	The Chief Nurse presented an update on the themes identified from LeDeR reviews. Committee members were asked to note the high-level themes identified, the formation of the Barnsley Learning Disability Health and Social Care Strategic Health Improvement LeDeR Sub Group. An Annual report will be presented at a future meeting.		
Q&PSC 21/06/13	**CONTINUING HEALTH CARE UPDATE**		
	The Barnsley Continuing Healthcare Operational Lead presented an update on the current position for assurance. The main points highlighted were:		

	• Barnsley CHC has zero number of Covid 19 backlog cases. • Adult review trajectory is reducing and by the end of July 2021 the team will be working in real time. • Patient experience surveys are due to commence following the up to date position of reviews. It was agreed that CHC patient experience trends and themes to be included in the BCCG Patient Experience reporting and the End of Life Steering Group. The Chief Nurse highlighted that a task and finish group has been set up to the Internal Audit action plan relating to Adult and Children's Continuing Care and Complex cases. The Chief Nurse acknowledged and thanked the team for the hard work in completing the backlog of reviews and assessments.	**SM**	**August 2021**
	Actions agreed: CHC Patient experience themes to be included in the BCCG Patient Experience reporting and End of Life Steering Group.	**SM**	**August 2021**
Q&PSC 21/06/14	**PATIENT EXPERIENCE ANNUAL REPORT 2020/21**		
	The Quality Manager presented the 2020/21 Annual Patient Experience Feedback report for assurance, giving members all the main points from the report and key learning that the CCG had identified. The Chief Nurse thanked the team for their continued work particularly noting the increase in activity. The Chair informed committee members following the identified theme around Primary Care services in the report work has commenced to look at communicating appointment and access information to patients. **The Secondary Care Clinician left the meeting at 15:00pm**		
Q&PSC 21/06/15	**BCCG IVF POLICY AMENDMENT**		
	The Lead Commissioning and Transformation Manager presented amendments to the Yorkshire and Humber Access to Infertility Treatment Policy for approval intended to provide clarity in the section on the immigration health surcharge. It was highlighted that the current policy is not written in a patient user friendly manner but written for clinicians with legal terminology. The Quality Manager suggested BCCG develop a more accessible document for the public. A discussion took place around the criteria wording and adopting a consistent policy across the Integrated Care System along with a supplementary user-friendly guide.		

	At this point in the meeting the Head of Governance and Assurance advised committee members that due to the Secondary Care Clinician leaving the meeting going forward the meeting was no longer quorate for decision making. The Committee members present agreed in principle to adopt the amended wording with a supplementary user-friendly guide for Barnsley patients. **Post meeting note: The Quality Administrator requested virtual approval from members not present at the meeting.**	**SL**	**August 2021**
	Actions agreed: Lead Commissioning and Transformation Manager to develop a supplementary user-friendly guide for Barnsley patients to support the Yorkshire and Humber Access to Infertility Treatment Policy.	**SL**	**August 2021**
Q&PSC 21/06/16	**INFORMATION GOVERNANCE UPDATE – (1/2 YEARLY)**		
	The Head of Governance and Assurance presented the half yearly Information Governance update for assurance and approval. The main points highlighted were • DSP Toolkit – 99% of evidence now populated into the toolkit along with independent audit of sample evidence completed by 360 Assurance. • Relative minor changes to providers of services • Email policy expanded to reflect the new ways of working. • Adoption of the Sheffield CCG Network Security Policy following the change of provider. • Extend the review date for the Records Management Policy and the Remote Working and Portable Devices Policy to November 2021 until national policies are issued. Due to the meeting not being quorate the committee members present agreed in principle to approve the updated policies. **Post meeting note: The Quality Administrator requested virtual approval from members not present at the meeting.**	**JA**	**July 2021**
	Actions agreed: The Quality Administrator to set up a meeting to discuss further email encryption.	**JA**	**July 2021**
Q&PSC 21/06/17	**RISK REGISTER AND ASSURANCE FRAMEWORK (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 21/01 (rated score 16 'extreme') Children's Continuing Care Risk CCG 20/02 – LeDeR to be removed from the register. Risk CCG 19/03 – White Rose Medical Practice to be removed from the register. Due to the meeting not being quorate the committee members present agreed in principle to approve the removal of the risks from the register. **Post meeting note: The Quality Administrator requested virtual approval from members not present at the meeting.**		
COMMITTEE REPORTS AND MINUTES			
Q&PSC 21/06/21	**CLINICAL QUALITY BOARDS** • **BHNFT – MINUTES 26 FEBRUARY 2021** • **SWYPFT – MINUTES 01 APRIL 2021**		
	The Chief Nurse presented the minutes for information and assurance. No comments were raised.		
Q&PSC 21/06/22	**PRIMARY CARE QUALITY IMPROVEMENT GROUP**		
	The Primary Care and Transformation Manager provided a verbal update for information and assurance. Minutes of the meetings will be presented going forward. The main points were: • Zero tolerance within practices - a communication will be included in the Primary Care newsletter to support practice staff. A video has also been shared with practices to include on their websites. • Quality Dashboard – the use of this will resume. A decision on sharing the information with practices has not been agreed. • E-Dec – all practices have now completed the national tool.		
GENERAL			
Q&PSC 21/06/23	**SYB ICS SYSTEM QUALITY DEVELOPMENT**		
	The Chief Nurse presented the slides from the South Yorkshire & Bassetlaw Integrated Care System –		

	System Quality Development Task & Finish Group. The Chief Nurse offered to provide a further update of progress to members at the next meeting.	**JS**	**August 2021**
	Actions agreed: The Chief Nurse to provide an update on progress of South Yorkshire & Bassetlaw Integrated Care System – System Quality Development Task & Finish Group.	**JS**	**August 2021**
Q&PSC 21/06/24	**ANY OTHER BUSINESS**		
	The Chair raised how Medical Examiners who will be working with GP practices can access patient records. It was agreed to discuss this further with the Head of Governance and Assurance outside of the Committee. The GP Governing Body Member raised a safety issue regarding Spectrum who operate a contraception service for Barnsley patients. The Lead Commissioning and Transformation Manager to discuss further with the Head of Commissioning (Mental Health, Children and Maternity).	**RW** **SL**	**August 2021** **August 2021**
	Actions agreed: The Chair to meet with Head of Governance and Assurance to discuss how Medical Examiners gain access to read only patient records. The Lead Commissioning and Transformation Manager to discuss the Spectrum contract issues with Head of Commissioning (Mental Health, Children's and Maternity).	**RW** **SL**	**August 2021** **August 2021**
Q&PSC 21/06/25	**AREAS FOR ESCALATION TO THE GOVERNING BODY via the QUALITY HIGHLIGHT REPORT**		
	Items for escalation are • Barnsley Integrated Community Stroke Team • Annual Patient Experience Report • Removal of LeDeR from Risk Register • Primary Care Update • Barnsley Hospice • SWYPFT Community Services Waiting Lists		
Q&PSC 21/06/26	**REFLECTION ON HOW WELL THE MEETING'S BUSINESS HAS BEEN CONDUCTED**		
	Members agreed that it had been a good informative meeting.		
Q&PSC 21/06/27	**DATE AND TIME OF NEXT MEETING** 19 August 2021, 1pm via MS Teams		

GOVERNING BODY

9 September 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	Carol Williams	Project Coordinator/Committee Secretary

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 there were no specific items to highlight following from the 12 August 2021 Equality & Engagement Committee meeting: The unadopted minutes from the meeting have been included in this report - Appendix B.						
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 – Adopted Equality & Engagement Committee Minutes from 20 May 2021 • Appendix B – Unadopted Equality & Engagement Committee Minutes from 12 August 2021

Agenda time allocation for report:	5 minutes

APPENDIX A

NHS
Barnsley
Clinical Commissioning Group

ADOPTED 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 the meeting.	**AT**	12/08/21
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**	12/08/21
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. • This will help us as a guiding principle 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 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	**KW**	12/08/21

	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.		
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: 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 blueprint 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 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 • 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	**CBB**	12/08/21

	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.		
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. 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. Equality objectives – bring wording to next committee.	**ALL** **CBB**	12/08/21 12/08/21
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 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**	12/08/21

EEC 21/05/12	**ANY OTHER BUSINESS**		
	Reciprocal mentoring – to be put on the WRES 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**	12/08/21
EEC 21/05/13	**ITEMS TO HIGHLIGHT IN THE GOVERNING BODY ASSURANCE REPORT**		
	Committee members agreed to highlight the following areas: • To take a summary of the equality objectives as these have not gone previously to GB.	**KW**	12/08/21
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. 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. 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.		

APPENDIX B

NHS
Barnsley
Clinical Commissioning Group

UNADOPTED Minutes of the Meeting of the EQUALITY AND ENGAGEMENT COMMITTEE held on Thursday 12 August 2021 at 1pm via Microsoft Teams

PRESENT:

Martine Tune (Deputy Chair) (MT)	Deputy Chief Nurse, 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
Dr Adebowale Adekunle (AA)	Elected Governing Body Member, CCG

IN ATTENDANCE:

Ellie Roche (ER)	Senior HR & OD Advisor CCG
Emma Bradshaw (EB)	Engagement Manager, CCG
Roya Pourali (RO)	Equality, Diversity, Inclusion, BHNFT
Angela Musgrave	Executive Personal Assistant, CCG

APOLOGIES:

Chris Millington (CM)	Lay Member for Patient & Public Engagement, CCG
Carol Williams (CW)	Project Coordinator, CCG
Esther Short (ES)	HR&OD Business Partner, CCG
Julie Frampton (JF)	Head of Primary Care, CCG
Jayne Sivakumar (JS)	Chief Nurse, CCG
Healthwatch Barnsley Manager	Healthwatch Barnsley (Manager currently not in post)

Agenda Item	Note	Action	Deadline
EEC 21/08/01	**HOUSEKEEPING / APOLOGIES**		
	The Chair welcomed everyone to the meeting and reminded members that the underlying business of the Committee was to promote equality, address health inequalities and to promote the NHSE values and drive for patient and public participation. Apologies were received as above.		

Agenda Item	Note	Action	Deadline
EEC 21/08/02	**QUORACY**		
	The Chair informed members that on this occasion the meeting was not quorate, however in line with the Committee's terms of reference; there was the option to approve any items outside of the meeting and take any comment prior to the meeting.		
EEC 21/08/03	**DECLARATIONS OF INTEREST RELEVANT TO THE AGENDA**		
	The Committee considered the declarations of interest report. There were no new declarations of interest relevant to the agenda. The Chair noted she was not included on the declarations of interest report and confirmed she did not have anything to declare. **Action**: Declarations of Interest report to be updated to include the Deputy Chief Nurse, CCG. It was noted that re-procurement of Primary Medical services at Brierley Medical Centre was included in the meeting papers. The report was however for the Committee's assurance and a decision was not required, there was therefore no conflict of interest.	**MT**	18/11/21
EEC 21/08/04	**MINUTES OF THE PREVIOUS MEETING HELD ON 20 MAY 2021**		
	The minutes of the meeting held on 20 May 2021 were adopted and verified as a correct record of the meeting. A query had been received regarding clarification of minute item 21/05/09. **Action**: KW to tweak the wording relating to minute item 21/05/09 for accuracy.	**KW**	18/11/21
EEC 21/08/05	**MATTERS ARISING REPORT**		
	The Committee noted the actions from the 20 May 2021 meeting had all been closed.		
PATIENT AND PUBLIC ENGAGEMENT			
EEC 21/08/06	**PATIENT AND PUBLIC INVOLVEMENT REPORT**		
	EB presented the Patient and Public Involvement report to the Committee.		

Agenda Item	Note	Action	Deadline
	The Committee were informed that since their successful bid, Barnsley Healthcare Federation (BHF) had held the contract for delivery of primary care medical services (PMS) to the registered list of patients at Brierley Medical Centre since December 2015. Following virtual agreement by the Primary Care Commissioning Committee, plans were now being progressed for the procurement of the Brierley Medical Centre PMS contract with a view for the new contract term to commence on 1 December 2021. The procurement proposal approach had been received and approved by the Overview and Scrutiny Committee. Prior to the procurement process the CCG would be undertaking a brief (2 week) period of engagement from 4 August to 19 August 2021 in order to inform and provide patients of the practice and other key stakeholders with up to date information and opportunities for them to provide their views and feedback to help shape the process. The practice had written to all its registered patients informing them of the intended procurement and encouraged feedback on their views and concerns. To date 113 responses had been received. The practice had also sent out the information to all over 18 year olds. The CCG had arranged a drop-in session during w/c 16 August 2021 at Brierley Methodist Church to answer queries and provide information for anyone who preferred face to face contact. It was noted that the Practice had a Patient Participation Group who had given their consent for the CCG to contact them directly with an invitation to the drop in session or on a 1:1 basis to receive their feedback. A feedback report would be shared virtually with the Committee and updates, contact details etc would be provided on the CCGs website for members of the public.		
EEC 21/08/07	**INTEGRATED CARE DEVELOPMENT**		
	KW provided a verbal update on Integrated Care System (ICS) developments in Barnsley and across SY&B relating to Comms, Engagement and Equality.		

Agenda Item	Note	Action	Deadline
	The Barnsley Equality & Engagement (BE&EG) group made up of partner organisations had developed good communication links and a way of working; lots of positive work was taking place within the group around comms and engagement. The group was currently working on an action plan that would support the Barnsley Health & Care Plan to ensure appropriate reference to engagement, equality and comms. It was noted that across SY&B similar conversations had not yet taken place. **CBB** commented that the engagement work carried out in Barnsley was extremely impressive. At an ICS level, a meeting had taken place with Health and Wellbeing Leads that included interconnection with the ADI and H&WB. A number of Trusts had been asked to employ a Health & Wellbeing Health Inequalities Lead and a Health Inequalities Lead for ICS as a whole to address health inequalities. Barnsley Hospital was also recruiting for a Specialist Trauma Councillor. CBB felt there was a real sense of everything now becoming to come together.		
EEC 21/08/08	**MINUTES OF THE PATIENT COUNCIL MEETINGS HELD IN JUNE AND JULY 2021**		
	The Patient Council minutes were shared for information (May meeting was cancelled). **Patient Council Minutes – 30 June 2021** **EB** informed the Committee that Jeremy Budd, Director of Strategic Commissioning and Partnerships had attend the Patient Council meeting on 30 June and provided an overview on the developing Integrated Care Systems (ICS). The presentation focussed on what an ICS was, what it did and how people could get involved in shaping the work going forward. Following the presentation there had been a question and answer session and a summary of the questions, comments, observations and answers had been included in the minutes. Jeremy had agreed to attend the Patient Council meeting in September or October to provide a further update when information in terms of what the ICS will look like would be available. **Patient Council – 28 July 2021** **EB** provided a verbal update on the Patient Council meeting		

Agenda Item	Note	Action	Deadline
	held on 28 July 2021. The Committee had welcomed Jo Ekin, Senior Commissioning and Carers Commissioning Lead for Barnsley Council. Jo had provided an overview of carer support in Barnsley and in particular the support that had been available during the pandemic. Jo had informed of what and how support services had been put in place and delivered throughout the pandemic and now, with the relaxation of restrictions, how services were getting back to normal. Jo had also provided feedback on the development of the new Barnsley Carers Strategy and gave feedback as to how members of the Patient Council could get involved in some of this work through the Carers Strategy Working Group at the Council. The CCG had provided contact details for members of Patient Council who were carers or had been carers and had expressed an interest in feeding into that work. Jo had agreed to attend a future Patient Council meeting towards the end of the year to provide a further update on the work taking place.		
QUALITY GOVERNANCE			
EEC 21/08/09	**CCG Risk Register and Assurance Framework**		
	The Committee reviewed the CCG Risk Register and Assurance Framework. **Governing Body Assurance Framework (GBAF).** The Committee noted that there were no risks on the Assurance Framework where the Equality and Engagement Committee provided assurance. **Risk Register** There were currently two 'amber' rated risks on the corporate risk register for which the Equality and Engagement Committee are responsible for managing: • Risk Reference 13/13b (rated 8, amber high) – Potential failure of the CCG to engage with patients and the public in the commissioning of services. • Risk Reference CCG 14/16 (rated 8, amber high) – If a culture supportive of equality and diversity is not embedded across the CCG there is a risk that the CCG will fail to discharge its statutory duties as an employer and will not adequately consider issues of equality within the		

Agenda Item	Note	Action	Deadline
	services we commission. The Committee reviewed and were assured that the risks were being appropriately managed and scored. **KW** commented that due to only having one member instead of two from Membership Council currently attending the Equality and Engagement Committee, would this need adding to the risk register. **RW** advised that currently all the CCG's Committees had vacancies from Membership Council but it was felt the only risk would be Committee meetings may not be quorate, though most of the Committees would still able to carry out their function. The CCG were currently looking at multiple ways of engaging with the wider membership. **Action: RW agreed to discuss this issue with the Chairman of the CCG.** **Action: KW agreed to provide wording for consideration on the risk register.** The Chair queried, in the context of the wider world and new ways of working, whether there were any new issues for the Committee to consider around inequalities and engagement. An issue in the news and forums recently had been around the menopause with a few related cases linked to tribunals for employment. The question was raised whether the CCG needed to consider having a policy on this issue from an equality point of view or consideration being given to support groups at an ICS level **ER** informed the Committee that internally Sheffield CCG was working on introducing a page on the intranet that provided a signpost to where support could be accessed in the community. The CCG was also considering asking a speaker to deliver a patient story to staff to make this issue more visible to people. **ER** was in conversation with **ES** regarding the possibility of replicating this at Barnsley CCG. **Action: ER agreed to discuss this in more details with ES.**	**RW** **KW** **ER/ES**	18/11/21 18/11/21 18/11/21
EQUALITY			

Agenda Item	Note	Action	Deadline
EEC 21/08/10	**EQUALITY OBJECTIVES ACTION PLAN 2019 – 2021 PERFORMANCE**		
	CBB informed the Committee that he had met with **RP** to update the Equality Objectives Action Plan. No feedback had been received regarding the Equality Delivery System 2 (EDS2) within the ICS and it was assumed everyone would continue as normal. **RP** would be meeting with **ES** to follow up on this. The Equality, Diversity and Inclusion Working Group (EDI) had been looking at the possibility of including the Health Inequalities and Health Equity Toolkit alongside the Equality Impact Assessment Tool as these may help to address some of the health inequalities as guidance when considering different characteristics. **KW** and **EB** commented that conversations had taken place regarding the possibility of having a Barnsley-wide approach for Equality and Quality Impact Assessments across partner organisations that would help to ensure a consistent approach. These conversations would be shared with colleagues and the CCGs Senior Management Team to consider how to simplify the process and look at what training would be needed to reinforce the importance of why this process was required. It would also be important to have similar conversations with wider regional SY&B colleagues to try and reach a point where everyone was working on the same suite of documents and definitions. **Action: KW to discuss further with colleagues and the SMT.**	**KW**	18/11/21
GENERAL			
EEC 21/08/11	**HR Policies**		
	The Committee was asked to approve the proposed changes to the following policies as summarised below: • Relocation Policy • Service Award Policy • Whilstleblowing policy **RW i**nformed the Committee that the HR team continually reviewed and captured any changes in legislation relating to HR policies and procedures. These changes were shared with the CCG, Counter Fraud and staff for comments or feedback.		

Agenda Item	Note	Action	Deadline
	All three policies detailed above had gone through this process and had been circulated with the meeting papers for Committee to approve the changes. As the Committee was not quorate it was agreed to circulate the policies to full Committee members requesting approval of the changes. **Action: RW to circulate the policies to all Committee members for virtual approval.** **RW** commented that the HR team would be looking at all the HR policies to ensure they were in line with legislation requirements once the CCG moved to an ICS organisation. **Post Meeting Note:** The HR policies had been circulated to all Committee members and virtual approval had been received from all members.	**RW**	18/11/21
EEC 21/08/12	**REVIEW OF COMMITTEE WORKPLAN**		
	RW shared the Committee Workplan with members for information.		
EEC 21/08/13	**ANY OTHER BUSINESS**		
	CCG Staff Survey **KW** informed the Committee that results from the CCG Staff Survey had been received. A summary report would be shared at the CCGs Senior Management Team and the Radiators Group before being shared with the Equality and Engagement Committee for comments and assurance. The report would then be shared with the Governing Body. The CCG had received an overall 72% rate with 105 responses submitted of a possible 145. Overall findings were generally quite positive and in particular over nine-tenths (**93%**) of staff said they would be likely to recommend NHS Barnsley CCG as a place to work for friends and family. **Colin Brotherton-Barnett** **KW** thanked **CBB** on both a personal level and on behalf of the Committee for his immense contribution to the CCG and for his help and guidance in making quite challenging conversations with people less onerous. The Committee welcomed Roya Pourali to the meeting. Roya		

Agenda Item	Note	Action	Deadline
	was the Equality, Diversity & Inclusion Lead at Barnsley Hospital and would be taking over from Colin.		
EEC 21/08/14	**ITEMS TO HIGHLIGHT IN THE GOVERNING BODY ASSURANCE REPORT**		
	There was nothing to highlight in the Governance Body Assurance Report.		
EEC 20/08/15	**REFLECTION ON HOW WELL THE MEETING'S BUSINESS HAD BEEN CONDUCTED**		
	The Chair thanked the Committee 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.		
EEC 21/08/16	**DATE AND TIME OF THE NEXT MEETING**		
	The next meeting of the Equality and Engagement Committee will be held on Thursday 18 November 2021 at 9am – 11am via Microsoft Teams.		

BARNSLEY Metropolitan Borough Council

MEETING:	Health and Wellbeing Board
DATE:	Thursday, 10 June 2021
TIME:	2.00 pm
VENUE:	Assembly Room - Barnsley Civic

MINUTES

Present

Councillor Jim Andrews BEM, Deputy Leader (Chair)
Dr Nick Balac, Chair, NHS Barnsley Clinical Commissioning Group (Chair)
Councillor Trevor Cave, Cabinet Spokesperson - Childrens Services
Councillor Jenny Platts, Cabinet Spokesperson - Adults and Communities
Wendy Lowder,
John Marshall
Chris Edwards
Mark Janvier
Adrian England
Julie Tolhurst
Bob Kirton
Rob Webster
Salma Yasmeen
Amanda Garrard
Jeremy Budd
Andrew Deniff
Diane Lee,
Christus Ferneyhough
Emma Robinson

11 Declarations of Pecuniary and Non-Pecuniary Interests

There were no declarations of pecuniary or non-pecuniary interest.

12 Minutes of the Board Meeting held on 4th February 2021

The meeting considered the minutes of the previous meeting held on 4th February 2021.

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

13 Public questions

The meeting noted that no public questions had been received for consideration at the meeting.

14 Poverty Needs Assessment - Emma Robinson

Emma Robinson was welcomed to the meeting and provided a detailed update with regard to the refreshed Poverty Needs Assessment for 2020/21, outlining both the

local and national pictures in terms of healthy life expectancy, employment, child poverty, food poverty and digital poverty.

It was highlighted that Barnsley is now starting to see the emerging impact of Covid-19. Levels of poverty have risen in both Summer and Winter, with more people dropping below the poverty line. This trend is likely to continue as measures such as the furlough scheme and enhanced Universal Credit are removed. In Barnsley the Healthy Life Expectancy picture is worsening, with people in deprived areas spending more of their lives in poor health.

More than two in five families nationally have fallen into poverty in 2020, meaning hundreds of thousands were struggling to pay bills and cover costs for their child in lockdown, with an associated impact on children's wellbeing. More than 70 per cent of children facing hardship have at least one parent who works.

Disadvantaged children are more likely to develop mental health problems, have poor educational attainment, increased worries, frustrations, aspirations etc. 33% of Barnsley children live in poverty, an increase from around 28%. This is higher in some areas such as the Dearne, Worsborough and St Helens, with lower rates in Penistone.

Benefit claimant rates and youth unemployment is also increasing. Male life expectancy is static but is lower than national and regional rates. Healthy life expectancy shows a decrease for both men and women, in line with national trends. The Healthy Life Expectancy for males in Barnsley is 57.5 years, 5.7 years lower than the England average and for females it is 61.5 years, 2 years lower than the England average.

The number of homes in fuel poverty in Barnsley is increasing and is higher than the regional and national average. Fuel poverty contributes to Excess Winter Deaths (EWDs) as the risk of death and ill health is associated with living in a cold home when the outdoor temperature drops to below 6°C. The highest number of EWDs are in Penistone and Darton which may be due to the older population and the number of care homes in the area. The North Area Council has been doing work around winter warmer packs/sloppy slippers. Berneslai Homes is working with its tenants to reduce poverty and is picking up information around damp and condensation as this is linked to health.

A discussion took place around the need for the Board to carefully examine the data, look at the 'must-do's' and challenges and identify how to tackle them with partners. The timescale for this work has not yet been determined as the intelligence team has been working on Covid projects. Finance data will also need to be incorporated into it. The issue of Digital poverty needs more insight.

RESOLVED

(i) that Emma be thanked for her attendance and contribution;

(ii) that a household level ‘Poverty Index’ for the Borough be developed using similar methodology to the vulnerability model, focusing on financial hardship and poverty ‘flags’, to inform targeting of preventative work.

(iii) Better capturing of data at an area level in our 'business as usual' work, ensuring the right questions are asked at the start of contact with residents to collect data on the situation of people in the Borough.

(iv) that Wider boards should receive the findings and consider key actions/outcome proposals for reducing poverty in the Borough as findings from the needs assessment suggest that tackling poverty and inequalities will need a co-ordinated partnership response with place-based initiatives to support and promote employment, educational achievement, better health and improved social mobility.

(v) that a mapping exercise be undertaken in terms of our resources to tackle poverty to help us identify the opportunities and gaps. This would also act as a "sense check" of current funding streams against the intelligence in the needs assessment to ensure we are spending the money in the right areas.

(vi) to incorporate the findings/intelligence from this needs assessment into the development of the Council plan and Barnsley 2030 vision, and

(vii) A Poverty Needs Assessment All Member Information Brief (AMIB) be arranged for Elected Members.

15 Integrated Care System Compact - Andrew Osborn

Jeremy Budd, NHS Barnsley Clinical Commissioning Group, was welcomed to the meeting to update the Board regarding the ongoing development of the Integrated Care System. It was explained that the draft governance arrangements will shape the next phase of the ICS development during transition to becoming a statutory authority from April 2022.

The Governance model, areas of focus for 2021/22 (which will inform delivery plans) and terms of reference were outlined, together with the timetable for the new system. Further legislation is expected in July. The Health and Care Plan will be brought to a future meeting.

RESOLVED that

(i) Jeremy be thanked for his attendance and contribution, and

(ii) The Board note the contents of this paper, accompanying documents and supporting presentation and are assured that appropriate, place-based feedback is being provided by the Barnsley Design Group, which consists of key local stakeholders.

16 Barnsley Sustainability - David Malsam/ Sarah Cartwright

David Malsam and Sarah Cartwright were welcomed to the meeting to update the Health and Wellbeing Board on activity around sustainability; to introduce the decision-making wheel and to secure support for future engagement and consultation activity.

Barnsley's aims and ambitions were highlighted, together with the relationship between climate and health as it is well documented that access to greenspace has a positive impact on health and wellbeing. The sustainable energy action plan (SEAP) and Zero Carbon update were outlined along with governance structures and the types of projects which will be developed
AMIB to be arranged.

The next stage is to get the Barnsley community to commit to reducing their carbon footprint, as BMBC has done. A hearts and minds approach and behavioural change is necessary to secure the future of our young people. Some positives can be seen from the Covid experience, which we need to build on. The Government has set a target of 'C' for properties in Barnsley, which means that around 80,000 homes will need to be brought up to that standard, with associated issues around cost and supply chains.

RESOLVED that:

(i) David and Sarah be thanked for their attendance and contribution;

(ii) the contents of the report be noted;

(iii) the Barnsley's Zero45 programme and associated projects continue to be supported;

(iv) the appointed consultant and BMBC be supported with the delivery of the consultation and engagement element of the route-mapping work;

(v) Sustainability and Climate Change return to a future Health and Wellbeing Board to report back on the results of the consultation, and

(vi) An All Member Information Brief (AMIB) be arranged for Elected Members.

17 Healthy Weight Declaration - Christus Ferneyhough

Christus Ferneyhough was welcomed to the meeting and delivered a presentation to update the Board on the adoption of the Local Authority Declaration on Healthy Weight (HWD), which is a strategic, systemwide commitment to promote healthy weight and good overall health and wellbeing in communities.

The HWD includes 16 commitments whereby local authorities (or areas) pledge to achieve action on improving policy and healthy weight outcomes. All partners are fully supportive of the HWD - sign-up is required from schools and leadership teams. The HWD is important as in Barnsley 1 in 5 children start primary school overweight or obese, 1 in 3 leave primary school overweight or obese and 2 in 5 of 5 year olds have visible dental decay. In Barnsley, 2 in 3 adults are overweight or obese, leading to health issues later in life.

A whole systems approach is required to tackling this, with the Board taking ownership. It was reiterated that consultation on the HWD will include young people and that Barnsley's food plan, which is currently up for a refresh, will incorporate the views of the Youth Council.

RESOLVED that

(i) Christus Ferneyhough be thanked for his attendance and contribution;
(ii) the Board approves and endorses the adoption of the HWD as a Barnsley declaration;
(iii) a progress report be submitted and presented to the Board in October 2021 and
(iv) Members of the Board work with us in identifying priorities and ways in which we can work beyond the pledges to make change.

18 Collaborative Cold Weather Planning - Julie Tolhurst

Julie Tolhurst was welcomed to the meeting and provided an update on Excess Winter Deaths (EWDs) and the cold weather plan. The collaborative cold weather planning group met on the 19th May and agreed membership and Terms of Reference and identified key actions and resources. A further analysis of data is required to produce the draft Cold Weather Plan, with thematic prevention work linked to underlying causes of EWD, alongside the practical sector based plan. Gaps and priorities need to be agreed. The group will meet again on 1st July and the draft plan will be brought to the next meeting of the Board.

RESOLVED that

(i) Julie be thanked for her attendance and contribution;

(ii) the Board supports the direction of travel and how organisations can contribute to this agenda particularly around data, community insight and any shared actions and

(iii) interested parties should email Julie Tolhurst with expressions of interest.

19 Key points from the Children and Young People's Trust Executive Group held on 18th March, 2021

The meeting considered the minutes from the Children and Young People's Trust Executive Group held on 18th March 2021.

RESOLVED that the minutes be received.

20 Key points from the Safer Barnsley Partnership held on 8th March, 2021 - Wendy Lowder

The meeting considered the minutes from the Safer Barnsley Partnership held on 8th March 2021. It was also reported that a new Chief Superintendent is starting on 14th June 2021 and that the Annual Plan is being refreshed.

RESOLVED that the minutes be received.

21 Key points from the Mental Health Partnership 17th May, 2021 - Adrian England

The meeting considered the minutes from the Provider Forum meeting held on 17th May 2021. Adrian England reported that since the last Health and Wellbeing Board meeting the Mental Health Partnership has: Submitted a joint response to Government's consultation on the Mental Health Act reforms; begun tackling complex, system issues (e.g. issue around Section 136s, and Learning Disabilities and MH); agreed and begun work on a range of priorities, including employment of those with a serious mental illness, self-harm, suicide prevention and perinatal mental health; commenced development of a system wide MH Strategy, which aims to be complete and presented to the HWB in October 2021; established a multi-agency task and finish group looking at system wide Mental Health Transformation and ensured service users' voices are heard throughout the process, with service user representation on the Delivery Group (through the MH forum) and regular consultation with the Recovery College.

Development of local Crisis Care alternatives is underway, working with potential providers such as Touchstone, to develop a Wellbeing Café model. The MHP has overseen Children and Young People mental health transformation work, which will continue to report to the Partnership and agreed to and launched the Zero Suicide Ambition for Barnsley, with a video available on YouTube. Adrian thanked Officers from the Local Authority and partners for the hard work they have done and for adding value to the work that is being done.

RESOLVED that

(i) Adrian be thanked for his attendance and contribution,
(ii) The minutes and update be received, and
(iii) The Zero Suicide Ambition be endorsed by the Board.

22 Key points from the Stronger Communities Partnership - Councillor Platts

Councillor Platts updated the Board with regard to the work of the Stronger Communities Partnership. The Partnership Plan has been reviewed. It was highlighted that there is still a need to focus on prevention and early help. The partnership will no longer oversee worklessness, jobs and skills. Priorities will include a focus on 'Age Friendly' Barnsley, poverty, good food, support for carers and community engagement.

RESOLVED that the update be noted.

23 A Day in the Life of - Diane Lee

Diane Lee was welcomed to the meeting and delivered a presentation on the Director of Public Health's Annual Report for 2020, entitled 'A day in the life of – Tuesday 3rd November 2020'. Over 320 'diaries' from Barnsley residents were received and will be used to inform COVID-19 recovery plans and what issues should be focussed on in the future. The Board was urged to share the presentation amongst networks and within communities.

RESOLVED that Diane be thanked for her attendance and contribution and the presentation be noted

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Chair

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