

A meeting of the NHS Barnsley Clinical Commissioning Group Governing Body will be held on Thursday 20 January 2022 at 9.30 am via Microsoft Teams

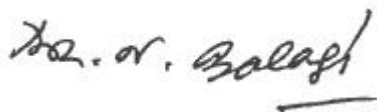
**AGENDA
(Public)**

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 22/01/05 Nick Balac	9.45 am 5 mins
6	Patient and Public Involvement Activity Report	Assurance	GB/Pu 22/01/06 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 11 November 2021	Approval	GB/Pu 22/01/08 Nick Balac	10.05 am 5 mins
9	Matters Arising Report	Note	GB/Pu 22/01/09 Nick Balac	10.10 am 5 mins
	Strategy			
10	Chief Officer's Report	Information	GB/Pu 22/01/10 Chris Edwards	10.15 am 10 mins
11	Covid-19 Response and Recovery Reset Update	Information & Assurance	GB/Pu 22/01/11 Jamie Wike Jeremy Budd	10.25 am 10 mins
12	Integrated Care at Place	Information & Assurance	GB/Pu 22/01/12 Jeremy Budd	10.35 am 10 mins

13	Cancer Assurance Report, including update on Community Diagnostic Hub		Information & Assurance	GB/Pu 22/01/13 Siobhan Lendzionowski	10.45 am 10 mins
14	Mental Health Update		Information & Assurance	GB/Pu 22/01/14 Patrick Otway	10.55 am 10 mins
15	Maternity Update		Information & Assurance	GB/Pu 22/01/15 Patrick Otway	11.05 am 10 mins
16	Assurance reports Continuing Health Care and Complex Cases (quarterly)		Information & Assurance	GB/Pu 22/01/16 Jayne Sivakumar Jo Harrison	11.15 am 10 mins
17	Outcomes of the Joint Local Area Inspection of Services for Children and Young People with Special Educational Needs in Barnsley		Information	GB/Pu 22/01/17 Jamie Wike	11.25 am 10 mins
	Quality and Governance				
18	Quality Highlights Report		Assurance	GB/Pu 22/01/18 Jayne Sivakumar	11.35 am 10 mins
19	Risk & Governance Exception Report		Assurance	GB/Pu 22/01/19 Richard Walker	11.45 am 10 mins
	Finance and Performance				
20	Integrated Performance Report inc QIPP		Assurance and Information	GB/Pu 22/01/20 Roxanna Naylor Jamie Wike	11.55 am 15 mins
	Committee Reports and Minutes				
21	21.1	Unadopted Minutes of the Audit Committee held on 25 November 2021	Assurance	GB/Pu GB/Pu 22/01/21.1 Nigel Bell	12.10 pm 10 mins
	21.2	Minutes of the Finance and Performance Committee held on: <ul style="list-style-type: none">4 November 20212 December 2021	Assurance	GB/Pu GB/Pu 22/01/21.2 Nick Balac	
	21.3	Assurance Report of the Primary Care Commissioning Committee held on 25 November inc adopted minutes 30 September 2021	Assurance	GB/Pu GB/Pu 22/01/21.3 Chris Millington	
	21.4	Minutes of the Quality and Patient Safety Committee held on 21 October 2021	Assurance	GB/Pu GB/Pu 22/01/21.4 Madhavi Guntamukkala	

	21.5	Assurance Report of the E&E Committee held on 18 November 2021 inc adopted minutes 12 August 2021	Assurance	GB/Pu GB/Pu 22/01/21.5 Chris Millington	
	General				
22	Reports Circulated in Advance for Noting: From the SYB ICS Health Executive Group held on 9 November 2021 <ul style="list-style-type: none"> • SYB ICS CEO Report (Enc B) 		Information & Assurance	Nick Balac	12.20 pm 5 mins
23	Reflection on how well the meeting's business has been conducted: <ul style="list-style-type: none"> • Conduct of meetings • Any areas for additional assurance • Any training needs identified 		Assurance	Nick Balac	
24	Date and Time of the Next Meeting: Thursday 10 March 2022 at 09.30 am Via Microsoft Teams				12.25 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

GOVERNING BODY

20 January 2021

Declarations of Interests, Gifts, Hospitality and Sponsorship Report

PART 1A – SUMMARY REPORT

1.	THIS PAPER IS FOR		
	<i>Decision</i>	<input type="checkbox"/>	<i>Approval</i>
	<input type="checkbox"/>	<i>Assurance</i>	<input checked="" type="checkbox"/>
	<i>Information</i>	<input type="checkbox"/>	
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		
	<p>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.</p> <p>The table below details what interests must be declared:</p>		

	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.
<p>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.</p> <p>Members should also declare if they have received any Gifts, Hospitality or Sponsorship.</p>		
6.	THE GOVERNING BODY IS ASKED TO:	
	<ul style="list-style-type: none"> 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	
	<ul style="list-style-type: none"> Appendix A – Governing Body Members Declaration of Interest Report 	

Agenda time allocation for report:	5 minutes
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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 <i>(these will be especially relevant where a proposal or policy is brought for decision or approval)</i>			
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 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	<ul style="list-style-type: none"> • GP Partner at Wombwell Chapelfields Medical Centre
		<ul style="list-style-type: none"> • The practice is a member of Barnsley Healthcare Federation which may provide services for Barnsley CCG
		<ul style="list-style-type: none"> • Clinical sessions with Local Care Direct Wakefield
		<ul style="list-style-type: none"> • Clinical sessions at IHeart
		<ul style="list-style-type: none"> • Member of the British Medical Association
		<ul style="list-style-type: none"> • Member Medical Protection Society

Name	Current position (s) held in the CCG	Declared Interest
Nick Balac	Chairman	<ul style="list-style-type: none"> • Partner at St Georges Medical Practice (PMS)
		<ul style="list-style-type: none"> • Practice holds AQP Barnsley Clinical Commissioning Group Vasectomy contract
		<ul style="list-style-type: none"> • Member of the Royal College of General Practitioners
		<ul style="list-style-type: none"> • Member of the British Medical Association
		<ul style="list-style-type: none"> • Member of the Medical Protection Society
		<ul style="list-style-type: none"> • The practice is a member of Barnsley Healthcare Federation which may provide services for Barnsley CCG
		<ul style="list-style-type: none"> • Two Partners at St Georges Medical Practice (PMS) are Partners on the Practice Contract at Kingswell Surgery (PMS).
		<ul style="list-style-type: none"> • Clinical Lead Primary Care South Yorkshire and Bassetlaw ICS (Commissioning).
Nigel Bell	Lay Member - Governance	<ul style="list-style-type: none"> • Lay Member representing South Yorkshire & Bassetlaw organisations on the Integrated Assurance Committee of South Yorkshire & Bassetlaw Integrated Care System
Chris Edwards	Chief Officer	<ul style="list-style-type: none"> • 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
		<ul style="list-style-type: none"> Maternity Lead at ICS
Madhavi Guntamukkala	Medical Director	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> GP Partner at Lundwood Medical Centre and The Kakoty Practice, Barnsley
		<ul style="list-style-type: none"> AQP contracts with the Barnsley Clinical Commissioning Group to supply Vasectomy, Carpal Tunnels and Nerve Conduction Studies services
		<ul style="list-style-type: none"> Owner/Director Lundwood Surgical Services
		<ul style="list-style-type: none"> Wife is Owner/Director of Lundwood Surgical Services
		<ul style="list-style-type: none"> Member of the Royal College of General Practitioners
		<ul style="list-style-type: none"> Member of the faculty of sports and exercise medicine (Edinburgh)
		<ul style="list-style-type: none"> 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
		<ul style="list-style-type: none"> Chair of the Remuneration Committee at Barnsley Healthcare Federation (ceased July 2021)
M Hussain Kadarsha	GP Governing Body Member	<ul style="list-style-type: none"> GP Partner in Hollygreen Practice
		<ul style="list-style-type: none"> GP Partner in Lakeside Surgey, Goldthorpe (Partner in Company Alliance Primary Care LTD)
		<ul style="list-style-type: none"> The practice is a member of Barnsley Healthcare Federation which may provide services to Barnsley CCG
		<ul style="list-style-type: none"> Member of the British Medical Association
		<ul style="list-style-type: none"> Director of YAAOZ Ltd, with wife
		<ul style="list-style-type: none"> Malkarsha Properties Ltd (Director)
		<ul style="list-style-type: none"> Partner (share holder) in Primecare LTD – holding the APMs contract for Lakeside Surgery and Goldthorpe
Jamie MacInnes	Governing Body Member	<ul style="list-style-type: none"> GP Partner at Dove Valley Practice
		<ul style="list-style-type: none"> 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
		<ul style="list-style-type: none"> • Shareholder in GSK
		<ul style="list-style-type: none"> • 3A Honorary Senior Lecturer
		<ul style="list-style-type: none"> • Wife has a position as a Consultant Breast Surgeon with Leeds Hospital Trust.
Chris Millington	Lay Member	<ul style="list-style-type: none"> • Partner Governor Barnsley Hospital NHS Foundation Trust (ceased July 2018) • Partner Governor Barnsley Hospital NHS Foundation Trust (since 6 February 2019) • Sits on the Cancer Alliance Patient Advisory Board
Roxanna Naylor	Chief Finance Officer	<ul style="list-style-type: none"> • Partner works at NHS Leeds Clinical Commissioning Group.
Mike Simms	Secondary Care Clinician	<ul style="list-style-type: none"> • Provider of Corporate and Private healthcare and delivering some NHS Contracts.
Mark Smith	GP Governing Body Member	<ul style="list-style-type: none"> • Senior Partner at Victoria Medical Centre also undertaking training and minor surgery roles.
		<ul style="list-style-type: none"> • Director of Janark Medical Ltd
		<ul style="list-style-type: none"> • Practice is a Member of Barnsley Healthcare Federation which may provide services to Barnsley CCG
Jayne Sivakumar	Chief Nurse	<ul style="list-style-type: none"> • Director of RJS Healthcare Ltd – a healthcare company which receives referrals from healthcare organisations.

Name	Current position (s) held in the CCG	Declared Interest
		<ul style="list-style-type: none"> Husband is a Consultant Surgeon at the Mid Yorkshire Hospital NHS Foundation Trust.

In attendance:

Richard Walker	Head of Governance and Assurance	<ul style="list-style-type: none"> Daughter is employed by Health Education England
Jamie Wike	Chief Operating Officer	<ul style="list-style-type: none"> Wife is employed by Barnsley Healthcare Federation as a Primary Care Network Manager
Jeremy Budd	Director of Commissioning	<ul style="list-style-type: none"> 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)

GOVERNING BODY

20 January 2022

Patient and Public Involvement Activity Report

PART 1A – SUMMARY REPORT

1.	THIS PAPER IS FOR											
	Decision	<input type="checkbox"/>	Approval									
		<input type="checkbox"/>	Assurance									
		<input checked="" type="checkbox"/>	Information									
		<input type="checkbox"/>										
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											
	<table border="1"> <thead> <tr> <th></th> <th>Name</th> <th>Designation</th> </tr> </thead> <tbody> <tr> <td>Executive</td> <td>Jeremy Budd</td> <td>Director of Strategic Commissioning and Partnerships</td> </tr> <tr> <td>Author</td> <td>Kirsty Waknell</td> <td>Head of communications, engagement and equality</td> </tr> </tbody> </table>				Name	Designation	Executive	Jeremy Budd	Director of Strategic Commissioning and Partnerships	Author	Kirsty Waknell	Head of communications, engagement and equality
	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											
	The matters relating to the mental health strategy raised in this paper have been subject to prior consideration in the following forums:											
	<table border="1"> <thead> <tr> <th>Group / Committee</th> <th>Date</th> <th>Outcome</th> </tr> </thead> <tbody> <tr> <td>Barnsley Mental Health Partnership Board</td> <td>Oct '21</td> <td>Noted progress</td> </tr> </tbody> </table>			Group / Committee	Date	Outcome	Barnsley Mental Health Partnership Board	Oct '21	Noted progress			
Group / Committee	Date	Outcome										
Barnsley Mental Health Partnership Board	Oct '21	Noted progress										
5.	EXECUTIVE SUMMARY											
5.1	<p><u>Inviting views and feedback on the draft all- age Mental Health and Wellbeing Commissioning Strategy for Barnsley by 26 January 2022</u></p> <p>We are currently working alongside our partners within Health and Social Care in Barnsley to develop an all age (i.e. children, working age adults and the elderly) local Mental Health and Wellbeing Commissioning Strategy to cover the next five years.</p>											

The development of this strategy has been overseen by the Barnsley Mental Health Partnership Board, whose members represent SWYPFT and other mental health service providers and practitioners (NHS and voluntary sector organisations), mental health service users and carers, Public Health, Commissioners, local authority, Barnsley Healthwatch, Barnsley Hospital, and South Yorkshire Police. The Mental Health Partnership Board reports directly into the Barnsley Health and Wellbeing Board.

We already have access to lots of feedback from local services and people about what works well and where there is room for improvement and the feedback already collected has been used to develop the draft version of the strategy to this point. The partners involved in drafting the strategy would now like to get wider feedback on the draft version of this to help them to shape the final version.

Between 17 December 2021 and 26 January 2022, we are inviting people from across Barnsley to share their thoughts and feelings about the vision and priorities for mental health and wellbeing set out within the current draft version of the strategy.

Further information can be found at www.barnsleyccg.nhs.uk/mentalhealthmatters including a link to the draft strategy document and more details on the various ways that people can provide their views and feedback including via the online and freepost survey, over the phone, via email or by attending one of three virtual feedback sessions to be held via Zoom.

We hope to still be able to link in with any existing face to face community meetings/ forums that are taking place between now and the closing date on the 26 January 2022 subject to the current coronavirus guidance in place at the time.

If you have or know of any groups/ forums that are meeting either in person or virtually during January and would welcome a discussion about a member of the team linking in directly to gain their feedback, please email us at barnccg.comms@nhs.net using the subject header 'Mental Health Strategy feedback'.

5.2 Reviewing Neuro – Rehab Services in Barnsley

We are currently assessing how the neuro rehabilitation services work for Barnsley people. We have been working closely with Headway, which is a charity for people affected by a brain injury. They are supporting us with helping to get views and feedback from current and former patients and their family members and/ or carers.

Neuro rehabilitation services are used by, and provide support to, a wide range of people who have a long-term neurological condition such as a brain injury.

Some examples are results of: violence; traffic collision; fall; and a stroke.

A significant amount of work has been done in relation to the stroke pathway and

5.3	<p>so we are now focusing on the first three examples above. Neuro rehabilitation is about a person, family members and/ or carers, receiving support to make plans and set goals that are important and appropriate to them. It looks at how their injury might affect them physically, emotionally, and behaviourally.</p> <p>An update on this work will be provided in a future report.</p> <p><u>Suspected Cancer Diagnostic Patient Experience Survey 2021</u></p> <p>We have been working in partnership with Barnsley Healthcare Federation to contact people who have recently visited their GP practice and following this their GP has arranged for further tests or to see a hospital doctor (specialist) urgently through a suspected cancer referral form. The aim of this referral is to investigate symptoms further and to carry out tests to find out what is wrong and whether or not it could be cancer.</p> <p>The aim of the brief survey that was sent out to a target group of patients between October and December 2021 was to help us to help us to understand from an individual's perspective how this feels, and to find out what works well and where there is room for improvement in the future.</p> <p>The feedback received will help us to monitor local progress on cancer care for people in the Barnsley area on their experience about their suspected cancer referral form as well as providing us with information to help drive local quality improvements and improve the experience for patients who have been suspected with a cancer and put on an urgent referral pathway.</p> <p>We received 65 responses in total and the results are currently being analysed by the cancer rapid diagnostic project team. An update on this work will be provided in a future report.</p> <p><u>Update from South Yorkshire and Bassetlaw Cancer Alliance</u></p> <p>What is a Cancer Alliance?</p> <p>Cancer Alliances bring together a range of organisations to help ensure the best possible cancer care in the assigned region. These include: NHS organisations, local councils, charities, and patient groups.</p> <p>The partnership aims to optimise the services and care provided by reducing health inequalities in the region, piloting innovative approaches and sharing best practice.</p> <p>Cancer Alliances are responsible, through NHS England, to the National Cancer Transformation Board. They determine how national funding should be directed to support their transformation programme.</p> <p>We have one Cancer Alliance covering the whole of South Yorkshire and Bassetlaw which is aligned to our local Integrated Care System (ICS) covering the same geographical area.</p>
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Involving patients, carers and members of the public

To fully understand how cancer services can be planned and delivered in the future, we need to understand our local population's experience and thoughts.

Involving the public in the design and delivery of cancer services is a key aspect of the communications and engagement strategies of the SYB ICS Cancer Alliance.

The communications and engagement steering group ensures that patients and the public are at the heart of anything we do.

The purpose of the group is to ensure our work is always working towards what patients want. By keeping record of the opinions of those involved in the steering group we can continually facilitate patient engagement at all levels of the Cancer Alliance.

The group is chaired by a patient representative (known as a lay representative) and they welcome anyone affected by cancer to join and share their opinion.

Meetings (currently virtual) are usually held every six weeks and to learn more, get involved or to find when the next meeting will be, please contact: sybndcancer.alliance@nhs.net

Let's Talk Cancer is the membership scheme and is for all those interested in shaping cancer care and services. We want people to come forward and help shape our services.

You can engage on a number of levels such as offering to take part in patient story videos, joining meetings or simply just taking the occasional survey.

To learn more about our membership and to join, please visit the cancer alliance website [here](#).

Current engagement priorities

Below is an update in relation to some of the current priority areas that the SYB ICS Cancer Alliance are focusing on in terms of their targeted patient engagement and experience activity.

- Continuing to broaden engagement within the behavioural science programme
- Working with a group to produce a survey for the optimal skin cancer pathway and opportunity for patients to have their say on skin cancer research priorities
- Developing a breast pain pathway with feedback from survey feedback (and planning focus groups) from our Let's Talk Health and Care members
- Systemic Anti-Cancer Therapy (SACT) and non-surgical oncology - speaking to patients and the public about how to provide a high quality service, any recent changes in oncology, and what is most important to them

	<ul style="list-style-type: none"> Harm minimisation - targeted community engagement/ understanding barriers and awareness work coming up <p>Further information about the work of the SYB ICS Cancer Alliance and how you can get involved can be found here - https://canceralliancesyb.co.uk/ and we will continue to provide a regular update of any current patient engagement/ experience activities via this report.</p>
6.	THE GOVERNING BODY / COMMITTEE IS ASKED TO:
	<ul style="list-style-type: none"> Note for assurance.
7.	APPENDICES / LINKS TO FURTHER INFORMATION
	NA

Agenda time allocation for report:	10 minutes
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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 (<i>place ✓ beside all that apply</i>):			
	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	
	3.2 Maximising Elective Activity		9.1 Digital and Technology	
	4.1 Mental Health	✓	10.1 Compliance with statutory duties	✓
	5.1 Integrated Care @ System		11.1 Delivery of Enhanced Health in Care Homes	
	5.2 Integrated Care @ Place		12.1 Delivering The Covid Vaccination Programme & Meeting The Needs of Patients with Covid-19	
	5.3 Implementing Population Health Management And Personalised Care			
	The report also provides assurance against the following red or amber risks on the Corporate Risk Register:			3.6, 3.5
2.	Links to statutory duties			
	This report has been prepared with regard to the following CCG statutory duties set out in Chapter A2 of the NHS Act (<i>place ✓ beside all that are relevant</i>):			
	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 (<i>these will be especially relevant where a proposal or policy is brought for decision or approval</i>)			
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 14Z2: 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
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

Minutes of the meeting of the Barnsley Clinical Commissioning Group Governing Body (PUBLIC SESSION) held on Thursday 11 November 2021, 9.30 am via Microsoft Teams

MEMBERS PRESENT

Dr Nick Balac	Chairman
Nigel Bell	Lay Member for Governance
Dr Adebowale Adekunle	Member
Chris Edwards	Chief Officer
Madhavi Guntamukkala	Medical Director & Member
Dr John Harban	Member (from minute reference GB/Pu 11/11/10)
Dr Hussain Kadarsha	Member
Dr Jamie MacInnes	Member
Chris Millington	Lay Member for Patient and Public Engagement & Primary Care Commissioning (from Minute GB/Pu 11/11/11)
Roxanna Naylor	Chief Finance Officer
Mike Simms	Secondary Care Clinician
Dr Mark Smith	Member

IN ATTENDANCE

Jeremy Budd	Director of Strategic Commissioning and Partnerships
Angela Fawcett	Designated Safeguarding Nurse for minute reference GB/Pu 11/11/17 and GB/Pu 11/11/19 only)
Jo Harrison	Specialist Clinical Portfolio Manager (for minute reference GB/Pu 11/11/14 only)
Kay Morgan	Governance and Assurance Manager (Minutes)
Patrick Otway	Head of Commissioning (Mental Health, Children's, and Maternity) (for minute reference GB/Pu 11/11/15 only)
Leanne Sparks	Commissioning and Transformation Manager for minute reference GB/Pu 11/11/17 only)
Kirsty Waknell	Head of Communications and Engagement
Richard Walker	Head of Governance and Assurance
Jamie Wike	Chief Operating Officer

APOLOGIES

Jayne Sivakumar	Chief Nurse
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The Chairman welcomed members of the public to the Governing Body meeting and notified all present that a 2 minutes silence will be held at 11.00 am for Remembrance Day.

Members were advised that the order of agenda items will differ slightly to that of the published agenda, item 20 'Risk and Governance Exception Report' will be taken directly after item 16 Commissioning of Children's Services. The original running order of the agenda will then resume.

Agenda Item		Action	Deadline
GB/Pu 11/11/01	HOUSEKEEPING		
	Members noted the etiquette for meetings held via Microsoft Teams.		
GB/Pu 11/11/02	QUORACY		
	The meeting was declared quorate.		
GB/Pu 11/11/03	PATIENT STORY		
	<p>The Head of Communications and Engagement introduced the patient story, reflecting a mother's experience of taking her baby to the new Children's Assessment Unit, the baby being diagnosed with a viral illness called RSV (Respiratory syncytial virus) and discharged the same day into the care and support the Children's Community Team. It was highlighted that the Patient Story linked to agenda item 17, 'Children's Community Nursing and Children's Assessment Unit Specification.'</p>		
	<p>The following comments were received from Governing Body Members in respect of the patient story.</p> <p>The numbers of Bronchiolitis cases increases at this time of year. RSV is a common virus but can be serious especially in infants and it is important to manage each patient according to the risk. The environment at the new Children's Assessment Unit provides a facility to observe and monitor babies and children longer than in A&E and the Children's Community Nursing Service provides support to parents and children whilst at home.</p> <p>Following the Covid-19 Pandemic, an increase in viruses is being noted and it is important to get the treatment and pathway right for patients.</p>		
	The Governing Body noted the Patient Story.		
GB/Pu 11/11/04	DECLARATIONS OF INTEREST, SPONSORSHIP, HOSPITALITY AND GIFTS RELEVANT TO THE AGENDA		
	The Governing Body considered the Declarations of Interests Report. No other new declarations were received.		

Agenda Item		Action	Deadline
GB/Pu 11/11/05	PATIENT AND PUBLIC INVOLVEMENT ACTIVITY REPORT		
	The Head of Communications and Engagement introduced the Patient and Public Involvement Activity Report to the Governing Body.		
	The Governing Body noted the report and the latest Patient and Public involvement activity, to help inform commissioning decisions and service development.		
GB/Pu 11/11/06	QUESTIONS FROM THE PUBLIC		
	The Head of Communications and Engagement informed the Governing Body that no questions had been received from Members of the public.		
GB/Pu 11/11/07	MINUTES OF THE MEETING HELD ON 9 SEPTEMBER 2021		
	The minutes of the Governing Body meeting held on 9 September 2021 were verified as a correct record of the proceedings.		
GB/Pu 11/11/08	MATTERS ARISING REPORT		
	The Governing Body received and noted the Matters Arising Report.		
STRATEGY			
GB/Pu 11/11/09	CHIEF OFFICER'S REPORT		
	The Chief Officer provided the Governing Body with an update on progress made in developing the governance arrangements for the establishment of statutory Integrated Care Systems on 1 April 2021. It was noted that the Governing Body will remain fully engaged with due diligence processes and progress towards the establishment of statutory Integrated Care Systems.		
	The Governing Body <ul style="list-style-type: none"> • Noted the progress and summary of the position • Noted and considered the key activities and timetable, Annex A 		

Agenda Item		Action	Deadline
	<ul style="list-style-type: none"> • Considered the published guidance on the functions and governance of an ICS and key elements of the Bill, Annexes B- G • Noted the legal responsibility of the CCG to propose the ICB Constitution to NHS England and Improvement • Noted the requirement to engage with partners on the ICB Constitution • Noted the step to engage with partners on specific issues relating to the constitution later in October 2021 • Noted the priority to recruit to the first two designate non-executive directors of the ICB • Noted boundary changes and name change of the Health and Care Partnership from 1 April 22. 		
GB/Pu 11/11/10	COVID-19 UPDATE		
	<i>Dr John Harban joined the meeting</i>		
	<p>The Chief Operating Officer provided the Governing Body with an update in relation to the current situation and the CCG's response to the Coronavirus Disease (COVID19) pandemic including case numbers, system pressures and the Covid-19 Vaccination Programme. The Governing Body noted that since the report was written:</p> <ul style="list-style-type: none"> • The case numbers in Barnsley have decreased and are now below 350 per 100,000 population. • The Barnsley Primary Care Network supported by the Barnsley Health Care Federation have delivered a further 6,000 vaccines. • There is a new requirement for frontline health and care workers to be fully vaccinated. A piece of work is ongoing to identify not only the actual numbers of health and care staff vaccinated but to support the unvaccinated workforce to access the vaccine. In care homes there is only a very small number of staff not vaccinated and it is hoped to see the same pattern in the health sector. 		
	<p>In response to questions raised the Chief Operating Officer advised that the Barnsley partnership is working to understand the numbers of staff who are Covid vaccinated, the potential scale of capacity issues and retention of workforce.</p>		

Agenda Item		Action	Deadline
	<p>All Practices are delivering the flu vaccinations with a higher uptake of the vaccine than based on the previous years uptake. Dr Mark Smith commented that the uptake of flu vaccination in people aged 65 and over at his Practice is slightly less than expected. It was clarified that the uptake of flu vaccination in the over 65's is just below 70% in Barnsley, though the ambition is to be higher. Some people may have had the vaccine at a pharmacy location. The Current figures for week 43 for the over 65's in Barnsley is at 69.5%, uptake of the flu vaccine in the over 50's is starting to pick up and the uptake of the nasal spray flu vaccine in Children is low.</p>		
	<p>The Governing Body noted the update provided in this paper including the progress in implementing the vaccination programme.</p>		
<p>GB/Pu 11/11/11</p>	<p>URGENT AND EMERGENCY CARE UPDATE</p>		
	<p>The Chief Operating Officer introduced his report, providing an update to Governing Body on Urgent and Emergency Care. The Governing Body noted delivery against the seven priorities for urgent and emergency care, A&E activity levels, the Urgent and Emergency Care logic model the Barnsley Strategic Winter Plan 2021/22, all overseen by the Barnsley Urgent and Emergency Care (UEC) Board.</p>		
	<p>The Governing Body was informed that Barnsley Hospital is unable to cover the pressures expected during winter to deliver against the plan and it is proposed to allocate £1,250k from H2 capacity funding to cover these increased costs and retain the balance of £119k to mitigate any future pressures arising over the winter period that cannot be funded from other funding streams.</p> <p>In response to questions raised, it was explained that it is important to note the £1,250k of non recurrent funding is to cover the costs of increase activity at the hospital (i.e., agency/ bank staff / ICP requirements) and to provide additional activity in operationalising the Winter Plan. There are no reporting requirements against the £1,250k.</p> <p>The Finance and Performance Committee will monitor financial sustainability of the health system in Barnsley and report to the Governing Body accordingly. The H2 funding is in part helping to treat financial sustainability. There is</p>		

Agenda Item		Action	Deadline
	quite a lot of work to be done before any costs can be taken out of the system.		
	The Chairman commented that the additional funding provided an opportunity in difficult times for the hospital to maintain electives and reduce long waits and manage A&E activity and as money flows throughout the system to support achievement and ambitions in the winter plan.		
	<p>The Governing Body</p> <ul style="list-style-type: none"> • Noted the update on the current position and plans on Urgent and Emergency Care. • Noted the Urgent and Emergency Care Board Winter Plan 2021/22 • Agreed the proposal to allocate £1,250k Capacity Funding in the financial plan to address pressures and related costs over the remainder of the year. <p><i>The Lay Member for Patient and Public Engagement & Primary Care Commissioning joined the meeting.</i></p>		
GB/Pu 11/11/12	ASSURANCE REPORT PRIMARY CARE		
	The Chief Operating Officer presented his Primary Care Assurance Report to Governing Body including progress with the Long Term Plan, the Network Contract DES (Directly Enhanced Service) and Primary Care Networks.		
	The Governing Body discussed the proposed improvements to Practice telephony services. It was confirmed that the cost for telephony will not increase for Practices accommodated in Lift Buildings. The Lay Member for Patient and Public Engagement & Primary Care Commissioning advised that investment and improvement in the telephony service will facilitate improved experience for patients, in being able to contact their Practice. The Chairman advised that although the telephony system will be improved, high quality trained staff are still required to answer calls and liaise with patients. Staff have worked through Covid, are pressured and tired, a realistic plan should be in place to ensure capacity in the workforce.		
	The Governing Body noted the information in the report providing assurance regarding the delivery of the priorities in Primary Care.		

Agenda Item		Action	Deadline
	Agreed action To ascertain with the Primary Care Team, the reason for disinvestment in the Primary Care 24 hour blood pressure monitoring service.	JW	
GB/Pu 11/11/13	ASSURANCE REPORT – DIGITAL AND IT		
	<p>The Director of Strategic Commissioning and Partnerships provided the Governing Body with an update on the IT/Digital projects and schemes currently being delivered across the CCG area. In response to a question raised about the shared care record the Director of Strategic Commissioning and Partnerships clarified that there are no firm dates as to when this will be operational. The South Yorkshire and Bassetlaw Integrated Care System is committed to working with the Yorkshire & Humber Shared Care Record Programme and it is sensible to deploy this collectively across the ICS.</p>		
	The Governing Body noted the Digital and IT Assurance Report for information.		
GB/Pu 11/11/14	ASSURANCE REPORT – CONTINUING HEALTH CARE AND COMPLEX CASES (QUARTERLY SUMMARY REPORT)		
	<p>The Specialist Clinical Portfolio Manager introduced the Continuing Health Care and Complex Case Assurance Report to the Governing Body.</p>		
	At this point in the meeting Governing Body Members observed a two minute silence for Remembrance Day.		
	<p>It was highlighted that the review of S117 cases has saved in the region of £11,000 per week but that the overall spend in this cohort has significantly increased with new cases. The Governing Body noted that the spend on Continuing Health Care and Complex Case is closely monitored by Finance and Performance Committee and included in the Integrated Performance Report to Governing Body.</p>		
	The Governing Body noted: <ul style="list-style-type: none"> The update and progress in the funding streams and agreed on the nature and content of future GB updates, given the various reporting mechanisms now in place. 		

Agenda Item		Action	Deadline
	<ul style="list-style-type: none"> The increase in numbers of patients in the systems highlighted and the issues with the provider market. <p>The Governing Body agreed to receive further assurance reports regarding Continuing Health Care and Complex Cases in January and March 2022.</p> <p><i>Agreed action</i> <i>To discuss discrepancies in efficiencies.</i></p>	<p>JS JH</p> <p>RN JH</p>	
GB/Pu 11/11/15	ASSURANCE REPORT – COMMISSIONING OF CHILDRENS SERVICES		
	The Head of Commissioning (Mental Health, Children's and Maternity) presented his report informing Governing Body members of the issues and challenges within children's services commissioned within the Borough.		
	<p>In response to a question raised the Head of Commissioning (Mental Health, Children's, and Maternity) clarified that a 20 year old patient with suspected Autism should currently be referred to the SWYPT adult service. The review of the new CAMHS specification will however look to increase the referral age range to 25 years.</p> <p>The Governing Body noted that the final SEND Inspection Report Letter is expected by the end of November 2021.</p>		
	<p>The Governing Body noted the report and the progress outlined.</p> <p><i>Agreed action</i> <i>To submit the final SEND Inspection Report Letter to the next meeting of the Governing Body on 20 January 2022.</i></p>	PO	
GB/Pu 11/11/16	RISK & GOVERNANCE REPORT		
	The Head of Governance & Assurance introduce the Risk and Governance Report to the Governing Body.		
	<p>The Governing Body</p> <ul style="list-style-type: none"> Reviewed the GBAF for 2021/22, and determined that the risks are appropriately described and 		

Agenda Item		Action	Deadline
	<p>scored, and there is sufficient assurance that they are being effectively managed</p> <ul style="list-style-type: none"> • Did not identify any additional positive assurances relevant to the risks on the GBAF • Reviewed the extract of the Corporate Risk Register and confirmed all risks are appropriately scored and described, and did not identify any potential new risks • Noted the Quarter 2 Workforce Report 2021/22. • Received the Governing Body work Plan & Agenda Timetable 2021/22 		
GB/Pu 11/11/17	CHILDREN'S COMMUNITY NURSING AND CHILDREN'S ASSESSMENT UNIT SPECIFICATION		
	<p>Dr Jamie MacInnes introduced a report outlining and seeking approval of new service specifications for the Children's Community Nursing Team and Children's Assessment Unit. He thanked the Designated Safeguarding Nurse and Commissioning & Transformation Manager for their work in developing the specifications.</p>		
	<p>Dr Jamie MacInnes provided clarification on questions raised by Governing Body Members. The Community Paediatric Nurses are supported by the Consultant paediatrician. The Children's Community Nursing specification links with Neighbourhood Teams but acknowledged that the specification could be further developed in future for integration as a Neighbourhood Teams Service.</p> <p>The Secondary Care Clinician commented that a significant proportion of patients in the service will be children with complex needs hence the need for strong connections to the hospital team.</p> <p>The importance of communicating the new specification to the health professionals who can refer patients to the Children's Assessment Service was highlighted, as practitioners other than GPs can refer into the service rather than patients having to see their GPs. Some health professional practitioners may need the appropriate skill set to make direct referrals to the Children's Assessment Unit as opposed to requesting GPs to undertake an urgent follow up and or referral.</p>		

Agenda Item		Action	Deadline
	The Chairman commented that should a child's illness persist the only route back into the Children's Assessment service is via A&E or their GP. Some conditions may require a longer period of monitoring in the unit before discharge. He further highlighted that there are no key performance indicators for the specification apart from the collection of available data. The objective of the specification is to reduce avoidable unnecessary admissions and how will this be known if there are no outcome measures. The data to be collected could be listed in the specification.		
	The Governing Body approved the two specifications for Children's Assessment Unity and Children's Community Nursing.		
QUALITY AND GOVERNANCE			
GB/Pu 11/11/18	QUALITY HIGHLIGHTS REPORT		
	The Medical Director provided the Governing Body with the agreed highlights of the discussions at the Quality & Patient Safety Committee on 21 October 2021.		
	<p>The Governing Body considered the issues relating to the Barnsley Hospice and Oncology provision.</p> <p>Barnsley Hospice</p> <p>The Chairman commented that the Hospice is very important and a respected service to the Barnsley community. He advised that the CCG has always supported the hospice and asked what plans are in place to continue supporting the Hospice following transition into the new Barnsley partnership organisation. The Chief Officer stated that the partnership is currently supporting the hospice, to establish robust corporate and information governance arrangements, including Board membership and organisational development plans. The support for the Hospice will continue for Barnsley place in the South Yorkshire Integrated Care Board.</p> <p>Oncology Provision</p> <p>The Chairman referred to the intention to add a new risk to the risk register around Oncology provision, commenting</p>		

Agenda Item		Action	Deadline
	<p>that there is no point in doing this unless there is a clear plan to mitigate against the risk and asked if the Quality & Patient Safety Committee have mitigation plans in place.</p> <p>In response to a question raised by Dr John Harban, the Chief Finance Officer confirmed that the Lymthodema Service is a separate contract and was never part of the main Hospice grant agreement.</p> <p>The Secondary Care Clinician commented that essential services such as Lifeboats and Air Ambulance are registered charities and what happens when charitable donations decline and or these services have to cease?</p> <p>The Chairman concluded discussion advising that the CCG outside of the meeting, should consider the future support for the Hospice and what the CCG creates as a legacy for the superseding Barnsley partnership organisation.</p>		
	The Governing Body noted the Quality Highlights identified for information and assurance.		
GB/Pu 11/11/19	ANNUAL REPORT – CHILDREN AND ADULT SAFEGUARDING		
	<p>The Designated Safeguarding Nurse introduced the Safeguarding Annual Reports for Children and Adults to the Governing Body. A common theme demonstrated from the annual report is that there has been increased referrals into both children and adult safeguarding since Covid-19 lockdowns and restrictions have eased and this reflects the national picture.</p> <p>In response to a question raised around the level of challenge and Scrutiny in safeguarding, the Designated Safeguarding Nurse advised that the children's Safeguarding Partnership had determined and strengthened the independent scrutiny of safeguarding effectiveness across the partnership.</p>		
	The Governing Body noted the Annual Report – Children and Adult Safeguarding.		
FINANCE AND PERFORMANCE			
GB/Pu	INTEGRATED PERFORMANCE REPORT		

Agenda Item		Action	Deadline
11/11/20			
	<p>Performance</p> <p>The Chief Operating Officer provided the Governing Body with an overview on the CCG's performance against key performance indicators up to month 6 (September 2021). It was noted that 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.</p> <p>The Governing Body noted that urgent care continues to be challenged with high attendances at the Accident and Emergency Department. There had been improvement in cancer waits.</p>		
	<p>Finance</p> <p>The Chief Finance Officer provided the Governing Body with an overview of the financial performance. As at 30 September 2021 the CCG achieved all 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 Non HNS H1 Uplift.</p> <p>The Governing Body noted the in-year pressures, emerging risks and under-delivery of planned efficiency schemes included within the reported position with a forecast underspend of £48k.</p> <p>The Chief Finance Officer advised that Continuing Health Care & Complex Cases continues to be a volatile area with the forecast overspend in the main relating to growth in care package costs.</p> <p>Members' attention was drawn to the H1 efficiency scheme outturn position which did not meet its target by £364k as at 30 September 2021, based on an underachievement of continuing healthcare and an overachievement on prescribing. The unidentified QIPP target of £4,663k was managed through mitigations from reserves and movements in budgets.</p> <p>A further report will be submitted to the next meeting of the Governing Body on 20 January 2021.</p>		

Agenda Item		Action	Deadline
	<p>The Governing Body noted the contents of the report including:</p> <ul style="list-style-type: none"> • Performance to date 2021/22 • projected delivery of all financial duties, predicated on the assumptions outlined in this paper and mitigating actions 		
GB/Pu 11/11/21	OPERATIONAL AND FINANCIAL PLAN 2021/22 – H2		
	<p>The Chief Finance Officer provided Governing Body with the final details on the CCGs financial plan for October to March of 2021/22 known as H2. Governing Body were requested to approve the plan to allow financial monitoring and reporting to recommence in Month 8 in line with NHS England requirements.</p> <p>In response to a question raised the Chief Finance Officer clarified that there was expected to be a further allocation Re Primary Care and delivery of Winter pressures resilience</p>		
	<p>The Governing Body noted the contents of the report including:</p> <ul style="list-style-type: none"> • Noted the details on allocation received in H2 • Noted the efficiency requirement for H2 • Approved the budgets for H2 • Noted the full year budget for 2021/22 		
COMMITTEE REPORTS AND MINUTES			
GB/Pu 11/11/22	COMMITTEE REPORTS AND MINUTES		
	<p>The Governing Body received and noted the following Committee minutes & assurance reports:</p> <ul style="list-style-type: none"> • Unadopted Minutes of the Membership Council held on 8 September 2021 • Unadopted Minutes of the Audit Committee held on 16 September 2021 		

Agenda Item		Action	Deadline
	<ul style="list-style-type: none"> Minutes of the Finance and Performance Committee held on 2 September 2021, 7 October 2021 and 21 October 2021. Assurance Report from the Primary Care Commissioning Committee held on 30 September 2021 including adopted minutes dated 5 August 2021. Adopted Minutes of the Quality and Patient Safety Committee held on 19 August 2021. Unadopted Minutes of the Health and Wellbeing Board held on 7 October 2021 		
GB/Pu 11/11/23	REPORTS CIRCULATED IN ADVANCE FOR NOTING		
	<p>The Governing Body noted the reports circulated in advance of the meeting:</p> <p>From the SY&B ICS Health Executive Group held on 14 September 2021</p> <ul style="list-style-type: none"> SYB ICS CEO Report (Enc B) <p>From the SY&B ICS Health Executive Group held on 12 October 2021</p> <ul style="list-style-type: none"> SYB ICS CEO Report (Enc B) ICB Development Update (Enc C) 		
GB/Pu 11/11/24	REFLECTION ON HOW WELL THE MEETING'S BUSINESS HAS BEEN CONDUCTED		
	The Governing Body agreed that the business of the meeting had been well conducted and achieved.		
	<p>The Chairman thanked Barnsley people for viewing the meeting.</p> <p>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.</p>		
GB/Pu 11/11/25	DATE AND TIME OF THE NEXT MEETING		

Agenda Item		Action	Deadline
	Thursday 20 January 2022 at 09.30 am via Microsoft Teams		

UNADOPTED

**GOVERNING BODY
(Public session)**

20 January 2022

MATTERS ARISING REPORT

The table below provides an update on actions arising from the previous meeting of the Governing Body (public session) held on 11 November 2022

Table 1

Minute Ref	Issue	Action	Outcome/Action
GB/Pu 11/11/12	ASSURANCE REPORT PRIMARY CARE To ascertain with the Primary Care Team, the reason for disinvestment in the Primary Care 24 hour blood pressure monitoring service.	JW	Complete - 5 year licenses were purchased in 2015. The licences have not been renewed as practices have now all been supplied with new BP at home equipment.
GB/Pu 11/11/14	ASSURANCE REPORT – CONTINUING HEALTH CARE AND COMPLEX CASES (QUARTERLY SUMMARY REPORT) To discuss discrepancies in efficiencies	RN JH	Complete - process now in place to ensure consistency.
GB/Pu 11/11/15	ASSURANCE REPORT – COMMISSIONING OF CHILDRENS SERVICES To submit the final SEND Inspection Report Letter to the next meeting of the Governing Body on 20 January 2022.	PO JW	Complete - Paper included on January 2022 Agenda

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 October 2021.
GB/Pu 21/01/15 & GB/Pu 21/05/08	SUICIDE PREVENTION AND BEREAVEMENT SUPPORT UPDATE To provide assurance that information re Suicide Prevention and Bereavement Support Services is relevant and available to practice staff	PO MSm	Ongoing - PO liaising with Public Health colleagues to see how the MH information can be best shared. 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.

	<p>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.</p>	PO MSm	<p>Additional funding for mental health is to be received into the CCG via Mental Health Recovery funds and Service Development Funding.</p> <p>Work is progressing to ensure that the attempted suicide follow up service is part of the Single point of access (SPA).</p> <p>All of this will be considered within the Mental Health Investment paper that will be presented to the private session of Governing Body on 9th September 2021</p>
GB/Pu 21/05/16 & GB/Pu 21/07/08	ASSURANCE REPORT – MENTAL HEALTH UPDATE <p>To schedule a review of CAMHS at a future BEST meeting.</p>	PO	<p>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.</p>
GB/Pu 21/07/12	ASSURANCE REPORT LOCKED REHAB <p>To undertake a detailed review of Out of Area Locked Rehabilitation services at a future Governing Body Development Session</p>	JS JHarri	Complete - GBDS 16 December 2021 meeting

**GOVERNING BODY
Public Session**

20 January 2022

REPORT OF THE CHIEF OFFICER

PART 1A – SUMMARY REPORT

1.	THIS PAPER IS FOR											
	<table border="1"> <tr> <td><i>Decision</i></td> <td><input type="checkbox"/></td> <td><i>Approval</i></td> <td><input type="checkbox"/></td> <td><i>Assurance</i></td> <td><input type="checkbox"/></td> <td><i>Information</i></td> <td><input checked="" type="checkbox"/></td> </tr> </table>			<i>Decision</i>	<input type="checkbox"/>	<i>Approval</i>	<input type="checkbox"/>	<i>Assurance</i>	<input type="checkbox"/>	<i>Information</i>	<input checked="" type="checkbox"/>	
<i>Decision</i>	<input type="checkbox"/>	<i>Approval</i>	<input type="checkbox"/>	<i>Assurance</i>	<input type="checkbox"/>	<i>Information</i>	<input checked="" type="checkbox"/>					
2.	PURPOSE											
	This report provides the Governing Body with the 2022/23 priorities and operational planning guidance.											
3.	REPORT OF											
	<table border="1"> <tr> <th></th> <th>Name</th> <th>Designation</th> </tr> <tr> <td>Executive / Clinical Lead</td> <td>Chris Edwards</td> <td>Chief Officer</td> </tr> <tr> <td>Author</td> <td>Kay Morgan</td> <td>Governance & Assurance Manager</td> </tr> </table>				Name	Designation	Executive / Clinical Lead	Chris Edwards	Chief Officer	Author	Kay Morgan	Governance & Assurance Manager
	Name	Designation										
Executive / Clinical Lead	Chris Edwards	Chief Officer										
Author	Kay Morgan	Governance & Assurance Manager										
4.	SUMMARY OF PREVIOUS GOVERNANCE											
	<p>The matters raised in this paper have been subject to prior consideration in the following forums:</p> <table border="1"> <tr> <th>Group / Committee</th> <th>Date</th> <th>Outcome</th> </tr> <tr> <td>N/A</td> <td></td> <td></td> </tr> </table>			Group / Committee	Date	Outcome	N/A					
Group / Committee	Date	Outcome										
N/A												
5.	EXECUTIVE SUMMARY											
	<p>The 2022/23 priorities and operational planning guidance was issued on 24 December 2022.</p> <p>Members should note that the Health and Care Bill, which intends to put ICSs on a statutory footing and create integrated care boards (ICBs) as new NHS bodies, is currently being considered by Parliament. To allow sufficient time for the remaining parliamentary stages, a new target date of 1 July 2022 has been agreed for new statutory arrangements to take effect and ICBs to be legally and</p>											

operationally established. This replaces the previously stated target date of 1 April 2022. This new target date will provide some extra flexibility for systems preparing for the new statutory arrangements and managing the immediate priorities in the pandemic response, while maintaining momentum towards more effective system working. An implementation date of 1 July will mean the current statutory arrangements will remain in place until then, with the first quarter of 2022/23 serving as a continued preparatory period.

The objectives set out in the planning guidance are based on a scenario where COVID-19 returns to a low level and ability to make significant progress with the challenge of restoring services and reducing the COVID backlogs

Systems are asked to focus on the following priorities for 2022/23:

- A. Invest in our workforce – with more people (for example, the additional roles in primary care, expansion of mental health and community services, and tackling substantive gaps in acute care) and new ways of working, and by strengthening the compassionate and inclusive culture needed to deliver outstanding care.
- B. Respond to COVID-19 ever more effectively – delivering the NHS COVID-19 vaccination programme and meeting the needs of patients with COVID-19.
- C. Deliver significantly more elective care to tackle the elective backlog, reduce long waits and improve performance against cancer waiting times standards.
- D. Improve the responsiveness of urgent and emergency care (UEC) and build community care capacity– keeping patients safe and offering the right care, at the right time, in the right setting. This needs to be supported by creating the equivalent of 5,000 additional beds, in particular through expansion of virtual ward models, and includes eliminating 12-hour waits in emergency departments (EDs) and minimising ambulance handover delays.
- E. Improve timely access to primary care – maximising the impact of the investment in primary medical care and primary care networks (PCNs) to expand capacity, increase the number of appointments available and drive integrated working at neighbourhood and place level.
- F. Improve mental health services and services for people with a learning disability and/or autistic people – maintaining continued growth in mental health investment to transform and expand community health services and improve access.
- G. Continue to develop our approach to population health management, prevent ill-health and address health inequalities – using data and analytics to redesign care pathways and measure outcomes with a focus on improving access and health equity for underserved communities.
- H. Exploit the potential of digital technologies to transform the delivery of care and patient outcomes – achieving a core level of digitisation in every service across systems.

	<p>I. Make the most effective use of our resources – moving back to and beyond pre-pandemic levels of productivity when the context allows this.</p> <p>J. Establish ICBs and collaborative system working – working together with local authorities and other partners across their ICS to develop a five-year strategic plan for their system and places.</p>
6.	<p>Better Care Fund 2021-22 approval letter</p> <p>The assurance process submitted by Barnsley CCG has been classified as 'Approved'. The Clinical Commissioning Group (CCG) BCF funding can therefore now be formally released subject to the funding being used in accordance with the final approved plan, and the conditions set out in the BCF policy framework for 2021-22 and the BCF planning guidance for 2021-22, including transfer of funds into a pooling arrangement governed by a Section 75 agreement. Further detail in appendix 2 of this report.</p>
7.	<p>THE GOVERNING BODY / COMMITTEE IS ASKED TO:</p>
	<ul style="list-style-type: none"> • Note the 2022/23 priorities and operational planning guidance issued on 24 December 2022. • Note the Better Care Fund 2021-22 approval letter.
8.	<p>APPENDICES / LINKS TO FURTHER INFORMATION</p>
	<ul style="list-style-type: none"> • Appendix 1 – 2022/23 priorities and operational planning guidance issued on 24 December 2022. • Appendix 2 - Better Care Fund 2021-22 letter

Agenda time allocation for report:	<i>10 mins</i>
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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 (<i>place ✓ beside all that apply</i>):	
	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
	3.2 Maximising Elective Activity	9.1 Digital and Technology
	4.1 Mental Health	10.1 Compliance with statutory duties
	5.1 Integrated Care @ System	11.1 Delivery of Enhanced Health in Care Homes
	5.2 Integrated Care @ Place	12.1 Delivering The Covid Vaccination Programme & Meeting The Needs of Patients with Covid-19
	5.3 Implementing Population Health Management And Personalised Care	
	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 (<i>place ✓ beside all that are relevant</i>):	
	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 (<i>these will be especially relevant where a proposal or policy is brought for decision or approval</i>)	
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) <table border="1"> <tr> <td data-bbox="279 235 1260 302">Have any financial implications been considered & discussed with the Finance Team?</td> <td data-bbox="1260 235 1412 302">NA</td> </tr> <tr> <td data-bbox="279 302 1260 369">Where relevant has authority to commit expenditure been sought from Management Team (<£100k) or Governing Body (>£100k)?</td> <td data-bbox="1260 302 1412 369">NA</td> </tr> <tr> <td colspan="2" data-bbox="279 369 1412 392"></td> </tr> </table>	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				
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3.4	Improving quality (s14R, s14S) <table border="1"> <tr> <td data-bbox="279 470 1260 504">Has a Quality Impact Assessment (QIA) been completed if relevant?</td> <td data-bbox="1260 470 1412 504">NA</td> </tr> <tr> <td data-bbox="279 504 1260 571">Have any issues or risks identified been appropriately addressed having taken advice from the Chief Nurse (or Deputy) if appropriate?</td> <td data-bbox="1260 504 1412 571">NA</td> </tr> <tr> <td colspan="2" data-bbox="279 571 1412 593"></td> </tr> </table>	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				
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3.5	Reducing inequalities (s14T) <table border="1"> <tr> <td data-bbox="279 672 1260 705">Has an Equality Impact Assessment (EIA) been completed if relevant?</td> <td data-bbox="1260 672 1412 705">NA</td> </tr> <tr> <td data-bbox="279 705 1260 772">Have any issues or risks identified been appropriately addressed having taken advice from Equality Diversity & Inclusion Lead if appropriate?</td> <td data-bbox="1260 705 1412 772">NA</td> </tr> <tr> <td colspan="2" data-bbox="279 772 1412 795"></td> </tr> </table>	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				
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3.6	Public Involvement & Consultation (s14Z2) <table border="1"> <tr> <td data-bbox="279 873 1260 907">Has a s14Z2: Patient and Public Participation Form been completed if relevant?</td> <td data-bbox="1260 873 1412 907">NA</td> </tr> <tr> <td data-bbox="279 907 1260 974">Have any issues or risks identified been appropriately addressed having taken advice from the Head of Comms & Engagement if appropriate?</td> <td data-bbox="1260 907 1412 974">NA</td> </tr> <tr> <td colspan="2" data-bbox="279 974 1412 996"></td> </tr> </table>	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				
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3.7	Data Protection and Data Security <table border="1"> <tr> <td data-bbox="279 1075 1260 1108">Has a Data Protection Impact Assessment (DPIA) been completed if relevant?</td> <td data-bbox="1260 1075 1412 1108">NA</td> </tr> <tr> <td data-bbox="279 1108 1260 1176">Have any issues or risks identified been appropriately addressed having taken advice from the SIRO, IG Lead and / or DPO if appropriate?</td> <td data-bbox="1260 1108 1412 1176">NA</td> </tr> <tr> <td colspan="2" data-bbox="279 1176 1412 1198"></td> </tr> </table>	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				
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3.8	Procurement considerations <table border="1"> <tr> <td data-bbox="279 1276 1260 1344">Have any issues or risks identified been appropriately addressed having taken advice from the procurement Shared Service if appropriate?</td> <td data-bbox="1260 1276 1412 1344">NA</td> </tr> <tr> <td data-bbox="279 1344 1260 1377">Has a Single Tender Waiver form been completed if appropriate?</td> <td data-bbox="1260 1344 1412 1377">NA</td> </tr> <tr> <td data-bbox="279 1377 1260 1444">Has a Primary Care Procurement Checklist been completed where GPs, networks or Federations may be a bidder for a procurement opportunity?</td> <td data-bbox="1260 1377 1412 1444">NA</td> </tr> <tr> <td colspan="2" data-bbox="279 1444 1412 1467"></td> </tr> </table>	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		
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3.9	Human Resources <table border="1"> <tr> <td data-bbox="279 1545 1260 1612">Have any significant HR implications been identified and managed appropriately, having taken advice from the HR Lead if appropriate?</td> <td data-bbox="1260 1545 1412 1612">NA</td> </tr> <tr> <td colspan="2" data-bbox="279 1612 1412 1646"></td> </tr> </table>	Have any significant HR implications been identified and managed appropriately, having taken advice from the HR Lead if appropriate?	NA						
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3.10	Environmental Sustainability <table border="1"> <tr> <td data-bbox="279 1713 1260 1780">Have any significant (positive or negative) impacts on the environment or the CCG's carbon footprint been identified?</td> <td data-bbox="1260 1713 1412 1780">NA</td> </tr> <tr> <td colspan="2" data-bbox="279 1780 1412 1814"></td> </tr> </table>	Have any significant (positive or negative) impacts on the environment or the CCG's carbon footprint been identified?	NA						
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2022/23 priorities and operational planning guidance

24 December 2021

Dear colleague

Thank you to you and your teams for your continued extraordinary efforts for all our patients.

At the end of January, we will mark two years since paramedics from Yorkshire Ambulance Service and hospital teams in Hull and Newcastle started to treat this country's first patients with COVID-19, and earlier this month we marked the anniversary of the first COVID-19 vaccine dose – and the milestone of 100 million doses – delivered in the biggest and fastest vaccination programme in NHS history.

The last two years have been the most challenging in the history of the NHS, and staff across the service – and many thousands of volunteers – have stepped up time and time again:

- expanding and flexing services to meet the changing demands of the pandemic
- developing and rolling out new treatments, new services and new pathways to respond to the needs of patients with COVID-19 and those without
- pulling out all the stops to recover services that have been disrupted.

At the time of writing, we are again operating within a [Level 4 National Incident](#) in response to the emergence of the Omicron variant. Teams from across the NHS and our partners are:

- significantly increasing vaccination capacity to provide the maximum level of immunity for the maximum number of people
- rolling out new antiviral and monoclonal antibody treatments through COVID medicines delivery units
- preparing for a potentially significant increase in those requiring life-saving care.

This concrete and rapid action in the face of uncertainty has characterised the NHS response to the pandemic. We face that uncertainty again now – in terms of the potential impact of Omicron over the coming weeks and months and the development of the pandemic as we look ahead to 2022/23. Despite this, the clear message I have had from colleagues across the NHS is that it is important to provide certainty and clarity where we can by now setting out the priorities and financial arrangements for the whole of 2022/23, recognising that they will have to be kept under review.

The objectives set out in this document are based on a scenario where COVID-19 returns to a low level and we are able to make significant progress in the first part of next year as we continue to rise to the challenge of restoring services and reducing the COVID backlogs.

Building on the excellent progress seen during 2021/22, this means significantly increasing the number of people we can diagnose, treat and care for in a timely way. This will depend on us doing things differently, accelerating partnership working through integrated care systems (ICSs) to make the most effective use of the resources available to us across health and social care, and ensure reducing inequalities in access is embedded in our approach. As part of this, and when the context allows it, we will need to find ways to eliminate the loss in non-COVID output caused by the pandemic.

Securing a sustainable recovery will depend on a continued focus on the health, wellbeing and safety of our staff. ICSs will also need to look beyond the immediate operational priorities and drive the shift to managing the health of populations by targeting interventions at those groups most at risk and focusing on prevention as well as treatment. Thank you for the significant progress that has been made in preparing for the proposed establishment of statutory Integrated Care Systems. To allow sufficient time for the remaining parliamentary stages, a new target date of 1 July 2022 has been agreed for statutory arrangements to take effect and ICBs to be legally and operationally established.

Our ability to fully realise the objectives set out in this document is linked to the ongoing level of healthcare demand from COVID-19. Given the immediate priorities and anticipated pressures, we are not expecting you or your teams to engage with specific planning asks now. The planning timetable will be extended to the end of April 2022, and we will keep this under review.

On behalf of myself and the whole NHS leadership team I want to thank you for the way you are continuing to support staff, put patients first and rise to the challenges we face.

With best wishes

Amanda Pritchard
NHS Chief Executive

Introduction

In 2022/23 we will continue to rise to the challenges of restoring services, meeting the new care demands and reducing the care backlogs that are a direct consequence of the pandemic. While the future pattern of COVID-19 transmission and the resulting demands on the NHS remain uncertain, we know we need to continue to increase our capacity and resilience to deliver safe, high quality services that meet the full range of people's health and care needs. We will:

- accelerate plans to grow the substantive workforce and work differently as we keep our focus on the health, wellbeing and safety of our staff
- use what we have learnt through the pandemic to rapidly and consistently adopt new models of care that exploit the full potential of digital technologies
- work in partnership as systems to make the most effective use of the resources available to us across acute, community, primary and social care settings, to get above pre-pandemic levels of productivity as the context allows
- use the additional funding government has made available to us to increase our capacity and invest in our buildings and equipment to support staff to deliver safe, effective and efficient care.

Our goal is that these actions will support a significant increase in the number of people we are able to treat and care for in a timely way. Our ability to fully realise this goal is linked to the ongoing level of healthcare demand from COVID-19. The new Omicron variant reminds us that we will need to remain ready to rise to new vaccination challenges and significant increases in COVID-19 cases. We are not able to predict the timing or impact of new variants and must develop ambitious plans for what we can achieve for patients and local populations in a more favourable context. The objectives for 2022/23 set out in this document are therefore based on COVID-19 returning to a low level. We will keep these objectives under review as the pandemic evolves.

Effective partnership is critical to achieving the priorities set out in this document. After several years of local development, we have established 42 integrated care systems (ICSs) across England with four strategic purposes:

- improving outcomes in population health and healthcare
- tackling inequalities in outcomes, experience and access

- enhancing productivity and value for money
- supporting broader social and economic development.

To underpin these arrangements, the Health and Care Bill, which intends to put ICSs on a statutory footing and create integrated care boards (ICBs) as new NHS bodies, is currently being considered by Parliament.

To allow sufficient time for the remaining parliamentary stages, a new target date of 1 July 2022 has been agreed for new statutory arrangements to take effect and ICBs to be legally and operationally established. This replaces the previously stated target date of 1 April 2022. This new target date will provide some extra flexibility for systems preparing for the new statutory arrangements and managing the immediate priorities in the pandemic response, while maintaining our momentum towards more effective system working.

The establishment of statutory ICSs, and timing of this, remains subject to the passage of the Bill through Parliament. An implementation date of 1 July would mean the current statutory arrangements would remain in place until then, with the first quarter of 2022/23 serving as a continued preparatory period.

Joint working arrangements have been in place at system level for some time, and there has already been significant progress in preparing for the proposed establishment of statutory ICSs, including recruitment of designate ICB chairs and chief executives. Designate ICB leaders should continue to develop system-level plans for 2022/23 and prepare for the formal establishment of ICBs in line with the guidance previously set out by NHS England and NHS Improvement and the updated transition timeline (this is set out more fully in section J).

The NHS's financial arrangements for 2022/23 will continue to support a system-based approach to planning and delivery and will align to the new ICS boundaries agreed during 2021/22. We will shortly issue one-year revenue allocations for 2022/23 and three-year capital allocations to 2024/25. We intend to publish the remaining two-year revenue allocations to 2024/25 in the first half of 2022/23. It is in this context that we are asking systems to focus on the following priorities for 2022/23:

- A. Invest in our workforce – with more people (for example, the additional roles in primary care, expansion of mental health and community services, and tackling

substantive gaps in acute care) and new ways of working, and by strengthening the compassionate and inclusive culture needed to deliver outstanding care.

- B. Respond to COVID-19 ever more effectively – delivering the NHS COVID-19 vaccination programme and meeting the needs of patients with COVID-19.
- C. Deliver significantly more elective care to tackle the elective backlog, reduce long waits and improve performance against cancer waiting times standards.
- D. Improve the responsiveness of urgent and emergency care (UEC) and build community care capacity– keeping patients safe and offering the right care, at the right time, in the right setting. This needs to be supported by creating the equivalent of 5,000 additional beds, in particular through expansion of virtual ward models, and includes eliminating 12-hour waits in emergency departments (EDs) and minimising ambulance handover delays.
- E. Improve timely access to primary care – maximising the impact of the investment in primary medical care and primary care networks (PCNs) to expand capacity, increase the number of appointments available and drive integrated working at neighbourhood and place level.
- F. Improve mental health services and services for people with a learning disability and/or autistic people – maintaining continued growth in mental health investment to transform and expand community health services and improve access.
- G. Continue to develop our approach to population health management, prevent ill-health and address health inequalities – using data and analytics to redesign care pathways and measure outcomes with a focus on improving access and health equity for underserved communities.
- H. Exploit the potential of digital technologies to transform the delivery of care and patient outcomes – achieving a core level of digitisation in every service across systems.
- I. Make the most effective use of our resources – moving back to and beyond pre-pandemic levels of productivity when the context allows this.
- J. Establish ICBs and collaborative system working – working together with local authorities and other partners across their ICS to develop a five-year strategic plan for their system and places.

Across all these areas we will maintain our focus on preventing ill-health and tackling health inequalities by redoubling our efforts on the five priority areas for tackling health

inequalities set out in [guidance](#) in March 2021. ICSs will take a lead role in tackling health inequalities, building on the [Core20PLUS5](#) approach introduced in 2021/22 to support the reduction of health inequalities experienced by adults, children and young people, at both the national and system level.

Improved data collection and reporting will drive a better understanding of local health inequalities in access to, experience of and outcomes from healthcare services, by informing the development of action plans to narrow the health inequalities gap. ICBs, once established, and trust board performance packs are therefore expected to be disaggregated by deprivation and ethnicity.

We will also continue to embed the response to climate change into core NHS business. Trusts and ICBs, once established, are expected to have a board-level Net Zero lead and a Green Plan, and are asked to deliver carbon reductions against this, throughout 2022/23.

ICS footprints represent the basis of strategic and operational plans for 2022/23 and beyond. Designate ICB leadership teams are asked to work with partners in their ICS to develop plans that reflect these priorities and are triangulated across activity, workforce and money. The immediate focus should remain on the priorities set out in [Preparing the NHS for the potential impact of the Omicron variant](#) and we have extended the planning timetable to reflect this.

A. Invest in our workforce – with more people and new ways of working, and by strengthening the compassionate and inclusive culture needed to deliver outstanding care

During the pandemic the focus has rightly been on the health, wellbeing and safety of our staff; this will continue. To support the restoration and recovery of services we need more people, working differently in a compassionate and inclusive culture where leaders at all levels inspire, empower and enable them to deliver high quality care in the most effective and efficient way.

We are therefore asking systems to accelerate work to transform and grow the substantive workforce and make the NHS a better place to work for all our staff. The actions to achieve this should be set out in whole system workforce plans that build on the progress made in delivering local people plans and reflect the ambitions to:

Look after our people:

- improve retention by delivering the NHS People Promise to improve the experience of our staff, through a focus on flexible working, early/mid/late career conversations and enabling staff to understand their pensions
- continue to support the health and wellbeing of our staff, including through effective health and wellbeing conversations and the mental health hubs
- improve attendance by addressing the root causes of non COVID-related sickness absence and, where appropriate, supporting staff to return to work.

Improve belonging in the NHS:

- improve the Black, Asian and minority ethnic disparity ratio, delivering the six high impact actions to overhaul recruitment and promotion practices
- implement plans to promote equality across all protected characteristics.

Work differently:

- accelerate the introduction of new roles, such as anaesthetic associates and first contact practitioners, and expanding advanced clinical practitioners
- develop the workforce required to deliver multidisciplinary care closer to home, including supporting the rollout of virtual wards and discharge to assess models
- ensure the highest level of attainment set out by the [‘meaningful use standards’](#) for e-job planning and e-rostering is met to optimise the capacity of the current workforce
- establish, or become part of, volunteer services such as the NHS cadets and NHS reservists.

Grow for the future:

- expand international recruitment through ongoing ethical recruitment of high quality nurses and midwives

- leverage the role of NHS organisations as anchor institutions/networks to widen participation and create training and employment opportunities, including through expanding apprenticeships as a route into working in health and care
- make the most effective use of temporary staffing, including by expanding collaborative system banks and reducing reliance on high-cost agency staff
- ensure training of postgraduate doctors continues, with adequate time in the job plans of supervisors to maintain education and training pipelines
- ensure sufficient clinical placement capacity to enable students to qualify and register as close to their initial expected date as possible.

Health Education England (HEE) and NHS England and NHS Improvement regional teams will support systems to develop and deliver their workforce plans. We will support systems to deliver through:

- investment to expand the national nursing international recruitment programme and support to recruit more allied health professionals
- the national healthcare support worker (HCSW) recruitment and retention programme
- continued funding of mental health hubs to enable staff access to enhanced occupational health and wellbeing and psychological support
- a suite of national GP recruitment and retention initiatives to enable systems to support their PCNs to expand the GP workforce and make full use of the digital locum pool
- the Additional Roles Reimbursement Scheme (ARRS) to deliver 26,000 roles in primary care, to support the creation of multidisciplinary teams.

B. Respond to COVID-19 ever more effectively – delivering the NHS COVID vaccination programme and meeting the needs of patients with COVID-19

The NHS has been asked to offer every eligible adult over the age of 18 a booster vaccination by 31 December 2021 and the immediate next steps for deployment were set out in the recent [letter](#) to services. Delivery of the vaccine programme is expected

to remain a key priority as we look ahead to 2022/23 and systems are asked to plan to maintain the infrastructure that underpins our ability to respond as needed. We will set out further details as future requirements become clearer.

A number of new treatment options, including neutralising monoclonal antibodies and oral antivirals, are now available for non-hospitalised NHS patients at greater risk from COVID-19. These treatments are in addition to COVID-19 vaccines, which remain the most important intervention for protecting people from COVID-19 infection.

These new treatments, which reduce the risk of hospitalisation and death, are being rolled out initially for a targeted cohort of highest-risk patients and should continue to be prioritised. In parallel, the government has also launched a study to assess the efficacy of antivirals in the UK's predominately vaccinated population. Dependent on the results of that study, we will develop plans for wider access to antivirals from the spring.

The Office for National Statistics (ONS) estimates around one million people are living with post-COVID syndrome (long COVID) in England. The NHS in England has responded by establishing 90 specialist post-COVID clinics to assess, diagnose and help people recover from long COVID, as well as 14 paediatric hubs to provide expert advice to local services treating children and young people.

While good progress has been made, there is still wide local variation in referral rates, waiting times and access to the clinics across diverse demographic groups. Systems are asked to:

- increase the number of patients referred to post-COVID services and seen within six weeks of referral
- decrease the number of patients waiting longer than 15 weeks, to enable their timely placement on the appropriate management or rehabilitation pathway.

£90 million is being made available to support this work in 2022/23.

C. Deliver significantly more elective care to tackle the elective backlog, reduce long waits and improve performance against cancer waiting times standards

C1: Maximise elective activity and reduce long waits, taking full advantage of opportunities to transform the delivery of services

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. Over the next three years, we will rise to the challenge of addressing the elective backlogs that have grown during the pandemic through a combination of expanding capacity, prioritising treatment and transforming delivery of services. Every system is required to develop an elective care recovery plan for 2022/23, setting out how the first full year of longer-term recovery plans will be achieved.

As in the COVID-19 wave last winter, it is crucial that we continue to deliver elective care and ensure that the highest clinical priority patients – including patients on cancer pathways and those with the longest waits – are prioritised. Once again, clinical leadership and judgement about prioritisation and risk will be essential. Wherever possible over winter, we need systems and providers to continue to separate services and to maintain maximum possible levels of inpatient, day case, outpatient and diagnostic activity, recognising the requirement to release staff to support the vaccination programme and respond to the potential increase in COVID-19 cases. This should include the independent sector as separate green pathway capacity.

The ongoing uncertainties and challenges of COVID-19 and demand make it particularly hard to predict how quickly we will be able to recover elective services, but we have set an ambitious goal to deliver around 30% more elective activity by 2024/25 than before the pandemic, after accounting for the impact of an improved care offer through system transformation, and specialist advice, including advice and guidance. We will continue to work to return to pre-pandemic performance as soon as possible with an ambition in 2022/23 for systems to deliver over 10% more elective activity than before the pandemic and reduce long waits. Treatment should continue to be prioritised based on clinical urgency and steps should be taken to address health

inequalities. Systems should make use of alternative providers if people have been waiting a long time for treatment. Systems are asked to:

- eliminate waits of over 104 weeks as a priority and maintain this position through 2022/23 (except where patients choose to wait longer)
- reduce waits of over 78 weeks and conduct three-monthly reviews for this cohort of patients, extending the three-monthly reviews to patients waiting over 52 weeks from 1 July 2022
- develop plans that support an overall reduction in 52-week waits where possible
- accelerate the progress we have already made towards a more personalised approach to follow-up care in hospitals or clinics, reducing outpatient follow-ups by a minimum of 25% against 2019/20 activity levels by March 2023 and going further where possible. We will agree specific targets with systems through the planning process.

Our ability to fully deliver on the objectives is linked to the ongoing level of healthcare demand from COVID-19 and will depend on:

- holding elective activity through the winter
- systems eliminating the loss in productivity caused by the operating constraints resulting from the pandemic.

A more personalised approach to outpatient follow-up appointments will ensure people who require a follow-up appointment receive one in a timely manner – protecting clinical time for the most value adding activity. The opportunity to reduce outpatient follow-ups will differ by trust and specialty and local planning should inform how the ambition will be delivered across the system, supported through a combination of:

- patient initiated follow-up (PIFU) – expanding the uptake of PIFU to all major outpatient specialties, moving or discharging 5% of outpatient attendances to PIFU pathways by March 2023
- effective discharge, particularly of those patients for whom clinical interventions have been exhausted
- more streamlined diagnostic pathways
- referral optimisation, including through use of specialist advice services to enhance patient pathways – delivering 16 specialist advice requests, including

advice and guidance (A&G), per 100 outpatient first attendances by March 2023.

Systems are asked to plan how the redeployment of the released capacity (including staff) is used to increase elective clock-stops or reduce clock-starts proactively.

£2.3 billion of elective recovery funding has been allocated to systems to support the recovery of elective services in 2022/23. We will set out further details in additional guidance.

£1.5 billion of capital above that funded within core envelopes has been made available to the NHS over three years to support new surgical hubs, increased bed capacity and equipment to help elective services recover. Systems are asked to demonstrate how their capital proposals support a material quantified increase in elective activity, eg through schemes that enable the separation of elective and non-elective activity, the setting up or expansion of elective hub sites, day case units or increased bed capacity. Further detail on these requirements and the process will be set out in additional guidance.

Systems are asked to rapidly draw up delivery plans across elective inpatient, outpatient and diagnostic services for adults and children (including specialised services) for April 2022 to March 2023. These plans should set out how:

- systems will meet the ambitions set out above, reflecting the additional revenue and capital funding being made available. We will set out further details in additional guidance
- services will be organised and delivered to maximise productivity opportunities and secure the best possible outcomes for patients
- local independent sector capacity is incorporated as a core element to deliver improved outcomes for patients and reduce waiting times sustainably
- the updated UK Health Security Agency (UKHSA) guidance will be implemented, ensuring safety concerns are appropriately balanced.
- systems will ensure inclusive recovery and reduce health inequalities where they are identified
- elective care, UEC, social care and mental health will be managed in a way that ensures elective recovery can be protected and any disruptions minimised.

C2: Complete recovery and improve performance against cancer waiting times standards

The number of patients seen following an urgent suspected cancer referral has remained at a record high since March 2021. However, backlogs remain for those who have been referred for treatment, and we would have expected at least 36,000 more patients to have come forward to start treatment during the pandemic than have done so. Systems should therefore, as a priority, complete any outstanding work on the post-pandemic cancer recovery objectives set out in the 2021/22 H2 planning guidance, to:

- return the number of people waiting for longer than 62 days to the level in February 2020 (based on the national average in February 2020)
- meet the increased level of referrals and treatment required to reduce the shortfall in number of first treatments.

Priority actions should centre on ensuring there is sufficient diagnostic and treatment capacity to meet recovering levels of demand, with a particular focus on the three cancers making up two-thirds of the national backlog (lower GI, prostate and skin), including:

- provision of sufficient commissioned capacity so that every urgent suspected lower GI cancer referral is accompanied by a faecal immunochemical test (FIT) result
- delivery of the optimal timed pathway for prostate cancer, including ensuring mpMRI prior to biopsy to eliminate the need for biopsy wherever possible
- making teledermatology available as an option for clinicians in all providers receiving urgent cancer referrals.

Systems are asked to work with Cancer Alliances to develop and implement a plan to:

- improve performance against all cancer standards, with a focus on the 62-day urgent referral to first treatment standard, the 28-day faster diagnosis standard and the 31-day decision-to-treat to first treatment standard
- make progress against the ambition in the NHS Long Term Plan to diagnose more people with cancer at an earlier stage, with a particular focus on disadvantaged areas where rates of early diagnosis are lower.

Delivery of these plans is expected to support:

- Timely presentation and effective primary care pathways including:
 - working with PCNs to support implementation of cancer early diagnosis as set out in the Network Contract Directed Enhanced Service (DES)
 - running local campaigns to complement national advertising to raise public awareness of cancer symptoms and encourage timely presentation.
- Faster diagnosis, including:
 - extending coverage of non-specific symptom pathways – with at least 75% population coverage by March 2023
 - ensuring at least 65% of urgent cancer referrals for suspected prostate, colorectal, lung, oesophago-gastric, gynaecology and head and neck cancer meet timed pathway milestones.
- Targeted case finding and surveillance, including:
 - maximising the uptake of targeted lung health checks (TLHC) and the effective delivery of follow-up low dose CT scans, to meet trajectories agreed with the national team. From 2022/23, all Cancer Alliances will have at least one TLHC project
 - ensuring that every person diagnosed with colorectal and endometrial cancer is tested for Lynch syndrome (with cascade testing offered to family members), and patients who qualify for liver surveillance under National Institute for Health and Care Excellence (NICE) guidance are identified and invited to surveillance.

The national cancer team will provide data and guidance to Cancer Alliances to support the development of their plans. Plans will form the basis of Cancer Alliance funding agreements.

ICBs and Cancer Alliances are also asked to work with trusts to:

- ensure they have fully operational and sustainable patient stratified follow-up (PSFU) pathways for breast, prostate, colorectal and one other cancer by the end of the first quarter of 2022/23; and for two further cancers (one of which should be endometrial cancer) by March 2023
- for systems participating in colon capsule endoscopy and cytosponge projects, deliver agreed levels of activity

- increase the recruitment and retention of clinical nurse specialists, cancer support workers and pathway navigators, and promote take up of clinical training opportunities for the cancer workforce.

Maintaining and restoring cancer screening programmes is critical to our efforts to fully restore cancer services. For breast cancer screening in particular, any systems that have not restored compliance with the three-year cycle by the end of March 2022 are expected to have done so by the end of June 2022.

C3: Diagnostics

Recovery of the highest possible diagnostic activity volumes is critical to providing responsive, high quality services and supporting elective recovery and early cancer diagnosis. This will be supported by the timely implementation of new community diagnostic centres (CDCs). Systems are asked to:

- increase diagnostic activity to a minimum of 120% of pre-pandemic levels across 2022/23 to support these ambitions and meet local need
- develop investment plans that lay the foundations for further expansion of capacity through CDCs in 2023/24 and 2024/25.

Three-year capital funding allocations will be included in system envelopes for this purpose. National investment through HEE is planned to facilitate training and supply of the workforce to support these goals. Systems will be able to access dedicated revenue funding to support set up and running of CDCs, subject to the necessary business case approvals. Revenue will be allocated to align with the programmes of work or agreed capital business cases.

Systems are asked to utilise targeted capital allocations to:

- increase the number of endoscopy rooms, levelling up to a guide level of 3.5 rooms per 100,000 population over 50 years of age. Systems should consider using this funding to locate endoscopy services in CDCs and supplement available CDC funding allocations, seeking to co-locate endoscopy and imaging services where possible. Funding will also be available to units that have yet to meet Joint Advisory Group (JAG) on Gastrointestinal Endoscopy Endoscopy accreditation to upgrade their services

- invest in CT capacity to support expansion the Target Lung Health Checks programme from 2023/24, with target coverage to be agreed between Cancer Alliances and the National Cancer Programme team. Cancer Alliances will receive this targeted funding on the basis of their remaining unscreened population and existing CT capacity and should coordinate with ICSs.
- develop additional digitally connected imaging capacity and ensure that acute sites have a minimum of two CT scanners
- procure new breast screening units to deliver the 36-month cycle.

Operational capital resources should continue to be used to reduce the backlog of diagnostic equipment replacement over 10 years old.

Pathology and imaging networks are asked to complete the delivery of their diagnostic digital roadmaps as part of their digital investment plans. National funding will be provided that is broadly consistent with these roadmaps, taking account of progress to date. Refreshed roadmaps need to include specific plans setting out how pathology and imaging networks and CDCs will with their systems support artificial intelligence (AI) research and innovation, and the scalable and sustainable integration of AI-driven diagnostics. The implementation of digital diagnostic investments is expected to deliver at least a 10% improvement in productivity by 2024/25, in line with the best early adopters.

Systems should ensure that pathology networks reach, as a minimum, the ‘maturing’ status for delivery of pathology services on the pathology network maturity framework by 2024/25. They should also meet the requirements of all national data collections for diagnostic services and support the work to scope creation of endoscopy and clinical physiology networks.

Programme funding of £21 million is available to support pathology and imaging networks to deliver on these priorities in 2022/23 alongside the implementation of CDCs.

C4 Deliver improvements in maternity care

Systems working through local maternity systems (LMSs) are asked to continue to work towards delivering a range of transformation objectives to make maternity and neonatal care safer, more personalised and more equitable. ICSs should undertake

formal, structured and systematic oversight of how their LMS delivers its functions and there should be a direct line of sight to the LMS board.

Providers are asked to continue to embed and deliver the seven immediate and essential actions identified in the interim Ockenden report, along with any future learning shared in the second Ockenden report and East Kent review (when published). LMSs should continue to oversee quality in line with [Implementing a revised perinatal quality surveillance model](#).

LMSs are asked to support providers to prioritise reopening any services suspended due to the pandemic, ensuring women can take somebody with them to all maternity appointments and supporting work to increase vaccination against COVID-19 in pregnancy. LMSs should implement local maternity equity and equality action plans in line with [Equity and equality: Guidance for local maternity systems](#).

LMSs are also asked to continue to work with providers to implement local plans to deliver Better Births, the report of the national maternity review, including:

- delivering local plans for midwifery continuity of carer (MCoC) in line with [Delivering midwifery continuity of carer at full scale](#), prioritising MCoC so that most Black, Asian and mixed ethnicity women and most women from the most deprived areas receive it once the building blocks are in place
- offering every woman a personalised care and support plan in line with the [Personalised care and support planning guidance](#)
- fully implement Saving Babies' Lives. Providers should have a preterm birth clinic and act so that at least 85% of women who are expected to give birth at less than 27 weeks' gestation are able to do so in a hospital with appropriate on-site neonatal care.

Funding of c£93 million to support the implementation of Ockenden actions through investment in workforce will go into baselines from 2022/23. Programme funding will also be made available to support the delivery of the Better Births priorities.

D. Improve the responsiveness of urgent and emergency care and build community care capacity– keeping patients safe and offering the right care, at the right time, in the right setting

Sustaining UEC performance has been very challenging due to the pandemic. We need to continue reforms to community and urgent and emergency care to deliver safe, high quality care by preventing inappropriate attendance at EDs, improving timely admission to hospital for ED patients, reducing length of stay and restoring ambulance response times. An essential requirement is to increase the capacity of the NHS by the equivalent of at least 5,000 G&A beds and return, as a minimum, to pre-pandemic levels of bed availability through a combination of:

- national funding for the further development of virtual wards (including hospital at home)
- system capital plans to increase physical bed capacity as part of elective recovery plans
- re-establishing bed capacity consistent with latest UKHSA IPC guidance.

D1: Urgent and emergency care

The urgent and emergency care system continues to be under significant pressure ahead of what is expected to be an extremely challenging winter. These pressures are exacerbated by delayed ambulance handovers and ambulance response times. A longer term improvement approach is required for the full recovery of urgent and emergency care services. Expected performance levels in 2022/23 therefore represent a first step towards recovery.

Systems are therefore asked to:

- reduce 12-hour waits in EDs towards zero and no more than 2%
- improve against all Ambulance Response Standards, with plans to achieve Category 1 and Category 2 mean and 90th percentile standards

- minimise handover delays between ambulance and hospital, allowing crews to get back on the road and contribute to achieving the ambulance response standards. This includes:
 - eliminating handover delays of over 60 minutes
 - ensuring 95% of handovers take place within 30 minutes
 - ensuring 65% of handovers take place within 15 minutes
- ensure stability of services and have planned contingency in advance of next winter.

Systems are asked to build on the work already commenced, as indicated in the UEC 10 Point Action Recovery Plan. This should incorporate:

- Increasing capacity within NHS 111 to ensure the service is the credible first option for patients, enabling their referral to the most appropriate care setting, including:
 - call handling capacity to meet growing demand
 - clinical capacity within the clinical assessment service to support decision-making, with >15% of calls received having clinical input
 - ensuring there is a full range of available options in the Directory of Services to meet local need
 - adopting the new regional/national route calling technology.
- Expanding urgent treatment centre (UTC) provision and increasingly moving to a model where UTCs act as the front door of ED, to enable emergency medicine specialists to focus on higher acuity need within the ED.

Systems are asked to put in place integrated health and care plans for children and young people's services that include a focus on urgent care; building on learning from pilots placing paediatric staff within NHS 111 services; better connections between paediatric health services; joining up children's services across the NHS and local authorities; improving transitions to adult services; and supporting young people with physical and mental health needs within acute and urgent care settings.

Systems are asked to consistently submit timely Emergency Care Data Set (ECDS) data, now seven days a week.

D2: Transform and build community services capacity to deliver more care at home and improve hospital discharge

The transformation of out-of-hospital services is a key element of the NHS recovery. National funding, alongside additional growth within core allocations for community services funding, will support systems to increase overall capacity of community services to provide care for more patients at home and address waiting lists, develop and expand new models of community care and support timely hospital discharge.

Community care models

Virtual wards

The NHS has already had considerable success in implementing virtual wards, including Hospital at Home services. Over 53 virtual wards are already providing over 2,500 'beds' nationwide, enabled by technology. In addition to managing patients with COVID, they also support patients with acute respiratory infections, urinary tract infections (UTIs), chronic obstructive pulmonary disease (COPD) and complex presentations, such as those who are frail as well as having a specific medical need.

The scope for virtual wards is far greater. Given the significant pressure on acute beds we must now aim for their full implementation as rapidly as possible. We are therefore asking systems to develop detailed plans to maximise the rollout of virtual wards to deliver care for patients who would otherwise have to be treated in hospital, by enabling earlier supported discharge and providing alternatives to admission. These plans should be developed across systems and provider collaboratives, rather than individual institutions, based on partnership between secondary, community, primary and mental health services. Systems should also consider partnerships with the independent sector where this will help grow capacity.

By December 2023, we expect systems to have completed the comprehensive development of virtual wards towards a national ambition of 40–50 virtual wards per 100,000 population. Successful implementation will require systems to:

- maximise their overall bed capacity to include virtual wards
- prevent virtual wards becoming a new community-based safety netting service; they should only be used for patients who would otherwise be admitted to an NHS acute hospital bed or to facilitate early discharge
- maintain the most efficient safe staffing and caseload model

- manage length of stay in virtual wards through establishing clear criteria to admit and reside for services
- fully exploit remote monitoring technology and wider digital platforms to deliver effective and efficient care.

Up to £200 million will be available in 2022/23 and up to £250 million in 2023/24 (subject to progress of systems) to support the implementation of these plans. We expect plans to cover two years. The scale of funding awarded in 2022/23 will depend on credible ambition for delivery of virtual wards by December 2022 to provide capacity for next winter. Systems will want to consider approaches that address patients with lower intensity and higher intensity needs (ie Hospital at Home services). We will set out further guidance on the virtual ward model, the support available and the funding criteria.

Urgent community response

By April 2022 all parts of England will be covered by 2 hour urgent community response services and over 2022-23 providers and systems will be required to:

- Maintain full geographic rollout and continue to grow services to reach more people extending operating hours where demand necessitates and at a minimum operating 8am to 8pm, 7 days a week in line with national guidance
- Improve outcomes through reaching patients in crisis in under 2 hours where clinically appropriate. Providers will be required to achieve, and ideally exceed in the majority of cases, the minimum threshold of reaching 70% of 2 hour crisis response demand within 2 hours from the end of Q3.
- Increase the number of referrals from all key routes, with a focus on UEC, 111 and 999, and increase care contacts
- Improve capacity in post urgent community response services to support flow and patient outcomes including avoiding deterioration into crisis again or unnecessary admission
- Ensure workforce plans support increasing capacity and development of skills and competencies in line with service development
- Improve data quality and completeness in the Community Services Dataset (CSDS) as this will be the key method to monitor outcomes, system performance and capacity growth

Anticipatory care

Anticipatory care (AC) is a Long-Term Plan commitment focused on provision of proactive care in the community for multimorbid and frail individuals who would benefit most from integrated evidence-based care. ICSs should design, plan for and commission AC for their system. Systems need to work with health and care providers to develop a plan for delivering AC from 2023/24 by Q3 2022, in line with forthcoming national operating model for AC.

Enhanced Health in Care Homes

Ensure consistent and comprehensive coverage of Enhanced Health in Care Homes in line with the national framework.

Community service waiting lists

Systems must develop and agree a plan for reduction of community service waiting lists and ensure compliance of national sitrep reporting. Specifically, systems are asked to:

- develop a trajectory for reducing their community service waiting lists
- significantly reduce the number of patients waiting for community services
- prioritise patients on waiting lists
- consider transforming service pathways and models to improve effectiveness and productivity.

Hospital discharge

As outlined in the H2 2021/22 planning guidance, the additional funding for the Hospital Discharge Programme will end in March 2022. As part of [preparing the NHS for the potential impact of the Omicron variant and other winter pressures](#), we have asked systems to work together with local authorities and partners, including hospices and care homes, to release the maximum number of beds, as a minimum this should be equivalent to half of current delayed discharges. Systems should seek to sustain the improvement in delayed discharges in 2022/23 working with local authority partners and supported by the Better Care Fund and the investment in virtual wards.

Digital

Digital tools and timely, accurate information are key to delivering on these aims and systems are asked to:

- identify digital priorities to support the delivery of out-of-hospital models of care through the development of system digital investment plans, ensuring community health services providers are supported to develop robust digital strategies to support improvements in care delivery
- ensure providers of community health services, including ICS-commissioned independent providers, can access the Local Care Shared Record as a priority in 2022/23, to enable urgent care response and virtual wards
- deliver radical improvements in quality and availability against national data requirements and clinical standards, including the priority areas of urgent care response and musculoskeletal (MSK).

E. Improve timely access to primary care – expanding capacity and increasing the number of appointments available

The NHS Long Term Plan commits to increasing investment in primary medical and community services (PMCS) by £4.5 billion real terms investment growth by 2023/24. We expect systems to maximise the impact of their investment in primary medical care and PCNs with the aim of driving and supporting integrated working at neighbourhood and place level. Systems are asked to look for opportunities to support integration between community services and PCNs, given they are an integral part of solutions to key system challenges that require a whole system response, including elective recovery and supporting more people in their own homes and local communities. Systems should also consider how community pharmacy can play a greater role in local plans as part of these integrated approaches.

Expanding the primary care workforce remains a top priority to increase capacity. Systems are expected to:

- support their PCNs to have in place their share of the 20,500 FTE PCN roles by the end of 2022/23 (in line with the target of 26,000 by the end of 2023/24) and

to work to implement shared employment models, drawing on more than £1 billion of Additional Roles Reimbursement Scheme (ARRS) funding across system development funding (SDF) and allocations

- expand the number of GPs towards the 6,000 FTE target, with consistent local delivery of national GP recruitment and retention initiatives, thereby continuing to make progress towards delivering 50 million more appointments in general practice by 2024.

In line with the principles outlined in the October 2021 [plan](#), systems are asked to support the continued delivery of good quality access to general practice through increasing and optimising capacity, addressing variation and spreading good practice. Every opportunity to secure universal participation in the Community Pharmacist Consultation Service should be taken. Systems should drive the transfer of lower acuity care from both general practice and NHS 111 under this scheme, supported by a new investment and impact fund indicator for PCNs which incentivises contributions to a minimum of two million appointments in 2022/23. Performance at the rate of the best early implementers of 50 referrals a week would move more than 15 million appointments out of general practice. Systems will need to implement revised arrangements for enhanced access delivered through PCNs from October 2022.

Systems are asked to support practices and PCNs to ensure the commitment that every patient has the right to be offered digital-first primary care by 2023/24 is delivered. By 'digital-first primary care' we mean a full primary care service that patients can access easily and consistently online, that enables them to quickly reach the right service for their needs (whether in person or remotely), that is integrated with the wider health system, and that enables clinicians to provide efficient and appropriate care.

2022/23 will see the implementation of GP contract changes, including those to the DES. In addition to the five services already being delivered by PCNs, from April 2022 there will be a phased introduction of two new services – anticipatory care and personalised care – and an expanded focus on cardiovascular disease (CVD) diagnosis and prevention.

Systems are asked to support their PCNs to work closely with local communities to address health inequalities. Practices should continue the critical job of catching up on the backlog of care for their registered patients who have ongoing conditions, to

ensure the best outcomes for them and to avoid acute episodes or exacerbations that may otherwise result in avoidable hospital admissions or even premature mortality.

Systems are asked to take every opportunity to use community pharmacy to support this; for example, in the delivery of care processes such as blood pressure measurement under new contract arrangements. This will drive detection of hypertension across our communities, address backlogs in care and deliver longer-term transformation in integrated local primary care approaches. Systems should also optimise use of pharmacy services around smoking cessation on hospital discharge, the expanded new medicines service and the discharge medicines service.

For dental services, the focus is on maximising clinically appropriate activity in the face of ongoing IPC measures, and targeting capacity to meet urgent care demand, minimise deterioration in oral health and reduce health inequalities.

Subject to the passage of the Health and Care Bill, ICBs will become the delegated commissioners for primary medical services and, in some cases, also dental, community pharmacy and optometry services, during 2022/23 – the target date now being 1 July 2022. Once established, ICBs should develop plans, working with NHS England regional commissioning teams to take on effective delegated dental, community pharmacy and optometry commissioning functions from 2023/24.

F. Grow and improve mental health services and services for people with a learning disability and/or autistic people

F1: Expand and improve mental health services

The complexity of needs for those requiring mental health services has risen because of the pandemic. In addition to a pre-existing treatment gap within mental health, this is increasing pressures within community services, mental health UEC and inpatient pathways across all ages. To address these pressures and continue to make progress against the NHS Long Term Plan ambitions, systems are asked to:

- Continue to expand and improve their mental health crisis care provision for all ages. This includes improving the operation of all age 24/7 crisis lines, crisis resolution home treatment teams and mental health liaison services in acute

hospitals. Systems are also asked to increase the provision of alternatives to A&E and admission, and improve the ambulance mental health response. Over the next three years £150 million targeted national capital funding will be made available to support improvements in mental health UEC, including mental health ambulances, extending Section 136 suites, safe spaces in or near A&E.

- Ensure admissions are intervention-focused, therapeutic and supported by a multidisciplinary team, utilising the expansion of mental health provider collaboratives across the whole mental health pathway where systems plan such developments. These collaboratives will support systems to transform services and reduce reliance on hospital-based care delivered away from people's local area.
- Continue the expansion and transformation of mental health services, as set out in the NHS Mental Health Implementation Plan 2019/20–2023/24, to improve the quality of mental healthcare across all ages. The [mental health LTP ambitions tool](#) will support systems to understand their delivery requirements for expanding access, as well as the Mental Health Delivery Plan 2022/23.
- Continue to grow and expand specialist care and treatment for infants, children and young people by increasing the support provided through specialist perinatal teams for infants and their parents up to 24 months and through continuing to expand access to children and young people's mental health services.
- Subject to confirmation, encourage participation in the first phase of the national Quality Improvement programme to support implementation of the Mental Health Act reforms.

We ask that systems maintain a focus on improving equalities across all programmes, noting the actions and resources identified in the Advancing Mental Health Equalities Strategy.

Delivery of the Mental Health Investment Standard (MHIS) remains a mandatory minimum requirement, ensuring appropriate investment of baseline funding and SDF to deliver the mental health NHS Long Term Plan objectives by 2023/24. Where SDF funding supports ongoing services, these will continue to be funded beyond 2023/24. This will support the continued expansion and transformation of the mental health workforce. For this:

- systems are asked to develop a mental health workforce plan to 2023/24 in collaboration with mental health providers, HEE and partners in the voluntary, community and social enterprise (VCSE) and education sectors
- PCNs and mental health trusts are asked to continue to use the mental health practitioner ARRS roles to improve the care and treatment for adults, children and young people in line with NHS Long Term Plan ambitions.

Capital funding made available through system allocations is expected to support urgent patient safety projects for mental health trusts, such as those that address ligature points and other infrastructure concerns that pose immediate risks to patients. Funding to eradicate mental health dormitories will continue in 2022/23 and 2023/24.

Systems are asked to work with the Mental Health Provider Collaboratives to produce a clear plan of requirements for CYPMH general adolescent and psychiatric intensive care in-patient beds to meet the health needs of their population, strengthen local services and eliminate out of area placements for the most vulnerable young people. These bed plans should be an integral part of the overall plan for CYP mental health services to ensure a local, whole patient pathway for patients with mental health, learning disability and/or autism needs. The plans should be complete by the end of Q1 2022/23 and should be funded through system operational capital. Investing in this way is expected to reduce operating costs as a direct result of improving access to local services and reducing out of area patient flows. Further guidance on the development of these plans will be issued before the start of 2022/23.

All NHS commissioned services must flow data to the national datasets and relevant bespoke collections. Provision for this must be included and agreed in commissioning arrangements planned for 2021/22, as part of this process.

F2: Meeting the needs of people with a learning disability and autistic people

The pandemic has highlighted and exacerbated the significant health inequalities experienced by people with a learning disability and autistic people. As we recover from the pandemic, we must ensure that people with a learning disability and autistic people are not further disadvantaged in fair access to healthcare. As digital healthcare develops, this means making sure there are reasonable adjustments and tailored responses, including consideration of the ongoing need for face-to-face appointments. Systems are asked to:

- Increase the rate of annual health checks for people aged 14 and over on a GP learning disability register towards the 75% ambition in 2023/24. Every annual health check should be accompanied by a health action plan to identify actions to improve the person's health.
- Continue to improve the accuracy of GP learning disability registers so that the identification and coding of patients is complete, and particularly for under-represented groups such as children and young people and people from ethnic minority groups.
- Maintain a strong commitment to reducing reliance on inpatient care for both adults and children with a learning disability and/or who are autistic, consistent with the ambition set out in the NHS Long Term Plan, and to develop community services to support admission avoidance and timely discharge.
- Build on the investment made in 2021/22 to develop a range of care and diagnostic services for autistic people delivered by multidisciplinary teams. This includes access to community mental health services; support for autistic children and young people and their families; and access to the right support and housing. Systems should adopt best practice to improve local diagnostic pathways to minimise waiting times for diagnosis, improve patient experience and ensure that there is accurate and complete reporting of diagnostic data.
- Implement the actions coming out of Learning Disability Mortality Reviews (LeDeRs), including following deaths of people who are autistic, to tackle the inequalities experienced by people with a learning disability; these have been exacerbated by the pandemic.

Service development funding support of £75 million is being made available in 2022/23 to achieve the above ambitions.

G. Continue to develop our approach to population health management, prevent ill-health and address health inequalities

Working alongside local authorities and other partners we will continue to develop our approach to population health management and prevention so that people can play a more proactive role in promoting good health. ICSs will drive the shift to population

health, targeting interventions at those groups most at risk, supporting health prevention as well as treatment. ICSs will take a lead role in tackling health inequalities by building on the [Core20PLUS5](#) approach introduced in 2021/22.

The safe and effective use of patient data is key to this. Systems are asked to develop plans by June 2022 to put in place the systems, skills and data safeguards that will act as the foundation for this. By April 2023, every system should have in place the technical capability required for population health management, with longitudinal linked data available to enable population segmentation and risk stratification, using data and analytics to redesign care pathways and measure outcomes with a focus on improving access and health equity for underserved communities. Systems are encouraged to work together to share data and analytic capabilities.

To support this, we will:

- continue to operate national data platforms for key, individually identified clinical data driven national programmes (eg the COVID pass, vaccine registries)
- provide a clear set of technical requirements and standards.

We are asking systems to develop robust plans for the prevention of ill-health, led by a nominated senior responsible officer (SRO). These plans should reflect the primary and secondary prevention deliverables as outlined in the NHS Long Term Plan, and the key local priorities agreed by the ICS. Plans should set out how system allocations will be deployed to:

- Support the rollout of tobacco dependence treatment services in all inpatient and maternity settings, in line with agreed trajectories and utilising £42 million of SDF funding.
- Improve uptake of lifestyle services, the Diabetes Prevention Programme, Low Calorie Diets, the new Digital Weight Management Programme and digitally supported self-management services.
- Restore diagnosis, monitoring and management of hypertension, atrial fibrillation and high cholesterol and diabetes, as well as asthma and COPD registers and spirometry checks for adults and children, to pre-pandemic levels in 2022/23, as per the Quality and Outcomes Framework (QOF), Integrated Investment Fund and Direct Enhanced Service targets.

- Progress against the NHS Long Term Plan high impact actions to support respiratory, stroke and cardiac care, implementing new models of care and rehabilitation, including remote and digital models, and increasing respiratory, hypertension, atrial fibrillation and high cholesterol detection and monitoring/control to pre-pandemic levels. This should include how systems plan to implement national procurements and population health agreements such as those in place for inclisiran and direct oral anticoagulants (DOACs). NHS England's new DOAC framework agreement will make treatment more affordable, allowing the NHS to provide DOACs to 610,000 additional patients. Uptake of DOAC treatment at this level will help prevent an estimated 21,700 strokes and save 5,400 lives over the next three years
- Reduce antibiotic use in primary and secondary care through early identification and treatment of bacterial infections, and support reduced lengths of hospital stays by ensuring that intravenous antibiotics are only used for as long as clinically necessary, with a switch to oral antibiotics as soon as appropriate.

There is strong evidence that people from socio-economically deprived populations and certain ethnic minority groups experience poorer health than the rest of the population, so it is particularly important to focus preventative services on these groups. Smoking is the single largest driver of health disparities between the most and least affluent quintiles. Obesity is the next biggest preventable risk factor and obesity in children has seen a major increase during the pandemic, especially in the least well off.

Systems are also asked to:

- renew their focus on reducing inequalities in access to and outcomes from NHS public health screening and immunisation services
- continue to adopt culturally competent approaches to increasing vaccination uptake in groups that have a lower than overall average uptake as of March 2022
- continue to deliver on the personalised care commitments set out in the NHS Long Term Plan – social prescribing referrals, personal health budgets, and personalised care and support plans are key enablers of population health and prevention.

H. Exploit the potential of digital technologies to transform the delivery of care and patient outcomes

During the pandemic digital technologies transformed the delivery of care. The opportunity now is for the health and care sector to build on this and use the potential of digital to help the NHS address both its long-term challenges and the immediate task of recovering from the pandemic. In practice this means better outcomes for patients, better experience for staff and more effective population health management.

We will support health and care systems to 'level-up' their digital maturity, and ensure they have a core level of infrastructure, digitisation and skills.

A core level of digitisation in every service within a system is essential. Acute, community, mental health and ambulance providers are required to meet a core level of digitisation by March 2025, in line with the NHS Long Term Plan commitment. By March 2022, systems should develop plans that set out their first year's priorities for achieving a core level of digitisation across all these settings (as set out by the Frontline Digitisation minimum viable product, which will be published by 31 December).

Costed three-year digital investment plans should be finalised by June 2022 in line with What Good Looks Like (WGLL). We will fund systems to establish dedicated teams to support the development and delivery of their plans, which should:

- include provisions for robust cyber security across the system. We will continue to provide and further enhance centralised cyber security capabilities systems; however, local organisations are responsible for managing their own cyber risk
- reflect ambitions to consolidate purchasing and deployment of digital capabilities, such as electronic patient records and workforce management systems, at system level where possible
- set out the steps being taken locally to support digital inclusion
- consider how digital services can support the [NHS Net Zero Agenda](#).

Capital will be available to systems for three years from 2022/23, to support digitisation of acute, mental health, ambulance and community services. £250 million will initially

be allocated to systems for 2022/23 while they develop their digital investment plans. This funding will be directed towards those services and settings that are the least digitally mature.

A digitised, interoperable and connected health and care system is a key enabler of delivering more effective, integrated care. Systems are asked to ensure that:

- by March 2023, all systems within a Shared Care Record collaborative can exchange information across the whole collaborative, with a view to national exchange by March 2024. Standards will be published to support this
- local authorities with social service responsibilities within their footprint are connected to their local Shared Care Record solution by March 2023, and that all social care providers can connect within six months of them having an operational digital social care record system
- suppliers comply with interoperability standards as these are finalised by April 2022
- general practice promotes the NHS App and NHS.UK to reach 60% adult registration by March 2023
- plans are developed to support skilling up the workforce to maximise the opportunities of digital solutions.

The ambition is for the NHS e-Referral Service (e-RS) to become an any-to-any health sector triage, referral and booking system by 2025. This will support two-way digital advice and guidance between clinical teams, ensuring patients are managed safely, and the referral is triaged and processed according to clinical priority. We will support systems with adoption as this functionality is made available to support triage, bookings and referrals. Mental health and other additional services are being evaluated for inclusion in 2022/23.

I. Make the most effective use of our resources

The 2021 Spending Review (SR21) provided the NHS with a three-year revenue and capital settlement covering 2022/23 to 2024/25. The government committed to spend an additional £8 billion to support tackling the elective backlog over the next three

years, from 2022/23 to 2024/25. This allows us to prioritise £2.3 billion in 2022/23 to support elective recovery.

SR21 also confirmed that the NHS will receive total capital resources of £23.8 billion over the next three years, including £4.2 billion of funding to support the building of 40 new hospitals and to upgrade more than 70 hospitals; £2.3 billion to transform diagnostic services; £2.1 billion for innovative use of digital technology; and £1.5 billion to support elective recovery.

We will shortly issue one-year revenue allocations to 2022/23 and three-year capital allocations to 2024/25. We intend to publish the remaining two-year revenue allocations to 2024/25 in the first half of 2022/23.

I1: Use of resources

With this funding, the NHS is expected to fully restore core services and make significant in-roads into the elective backlog and NHS Long Term Plan commitments. The SR21 settlement assumes the NHS takes out cost and delivers significant additional efficiencies, on top of the NHS Long Term Plan requirements, to address the excess costs driven by the pandemic response, moving back to and beyond pre-pandemic levels of productivity when the context allows this.

The scale of the efficiency requirement will be sustained throughout the SR21 period and systems should ensure they develop plans that deliver the necessary exit run-rate position to support delivery of future requirements.

We will continue to provide tools, information and support to help systems work together to deliver cost improvement plans that maximise efficiency and productivity opportunities, and reduce unwarranted variation. We will set out additional information on the support programmes available in additional guidance.

I2: Financial framework

The COVID-19 pandemic necessitated simplified finance and contracting arrangements that supported systems to dedicate maximum focus to responding to immediate operational challenges. To support the next phase of service restoration, the financial and contracting frameworks need to evolve to enable systems to take the appropriate funding decisions for their populations.

The future financial framework will continue to support system collaboration with a focus on financial discipline and management of NHS resources within system financial balance. Partner organisations should work together to deliver the new duties on ICBs and trusts.

Advice and guidance on the establishment of ICB financial management and governance arrangements is available as part of the ongoing support offer for ICB establishment. Regional teams are working with clinical commissioning groups (CCGs) and designate ICB board appointees to ensure that ICBs are ready to operate as statutory bodies from 1 July 2022, subject to the passage of legislation. ICBs and the boards of their constituent partners must be clear on the lines of financial accountability in managing NHS resources. This includes meeting core principles for managing public money, statutory responsibilities and other national expectations.

The 2022/23 financial and contracting arrangements are summarised as:

- A glidepath from current system revenue envelopes to fair share allocations. ICB revenue allocations will be based on current system funding envelopes, which continue to include the funding previously provided to support financial sustainability. In addition to a general efficiency requirement, we will apply a convergence adjustment to bring systems gradually towards their fair share of NHS resources. This will mean a tougher ask for systems consuming more than their relative need.
- Increased clarity and certainty over capital allocations, with multi-year operational capital allocations set at ICB level, building on the approach taken in the last two years, and greater transparency over the allocation of national capital programmes.
- A collective local accountability and responsibility for delivering system and ICB financial balance. The Health and Care Bill includes provisions which are designed to ensure that ICBs and trusts are collectively held responsible for their use of revenue and capital resources. Each ICB and its partner trusts will have a financial objective to deliver a financially balanced system, namely a duty on breakeven.
- A return to signed contracts and local ownership for payment flows under simplified rules. To restore the link between commissioning and funding flows, commissioners and trusts will have local ownership for setting payment values on simplified terms, supported by additional guidance from NHS England and

NHS Improvement. While written contracts between commissioners and all providers (NHS and non-NHS) will be needed to cover the whole of the 2022/23 financial year, systems and organisations should continue to take a partnership approach to establishing payment terms and contract management such that focus on delivery of operational and financial priorities can be maximised. We are separately publishing an updated draft of the NHS Standard Contract for 2022/23 for consultation; the final version of the contract, to be used in practice, will be published in February 2022.

- A commitment to support systems to tackle the elective backlog and deliver the NHS Long Term Plan. Additional revenue and capital funding will be provided to systems to support elective recovery, with access to additional revenue where systems exceed target levels. Provider elective activity plans will be funded as per the aligned payment and incentive approach, with payment linked to the actual level of activity delivered. ICBs will continue to be required to deliver the MHIS, as well as to meet other national investment expectations. We will set these out in additional guidance.
- A continued focus on integration of services to support the transition for future delegations. For those services that continue to be commissioned by NHS England in 2022/23, mechanisms to strengthen joint working with ICBs will be established.

J. Establish ICBs and collaborative system working

The establishment of ICBs, and everything that follows regarding the process and timing for this, remains subject to the passage of the Health and Care Bill through Parliament.

The continued development of ICSs during 2022/23 will help to accelerate local health and care service transformation and improve patient outcomes. As stated in the introduction to this document, a new target date of 1 July 2022 has been agreed for new statutory arrangements for ICSs to take effect and ICBs to be legally and operationally established. National and local plans for ICS implementation will now be adjusted to reflect this timescale, with an extended preparatory phase from 1 April 2022 up to the point of commencement of the new statutory arrangements. During this period:

- CCGs will remain in place as statutory organisations. They will retain all existing duties and functions and will conduct their business (collaboratively in cases where there are multiple CCGs within an ICS footprint) through existing governing bodies.
- CCG leaders will work closely with designate ICB leaders in key decisions that will affect the future ICB, notably commissioning and contracting.
- NHS England and NHS Improvement will retain all direct commissioning responsibilities not already delegated to CCGs.

During Q4 2021/22, NHS England and NHS Improvement will consult a small number of CCGs on changes to their boundaries, to align with the ICS boundary changes decided by the Secretary of State in July 2021. Those CCG boundary changes coming into effect from 1 April 2022 would support the smooth transition from CCGs to ICBs at the implementation date. Arrangements for people affected will be discussed directly with the relevant CCG and designate ICB leaders.

We do not plan to implement any further CCG mergers before the establishment of ICBs.

Next steps

CCG leaders and designate ICB leaders should continue with preparations for the closure of CCGs and the establishment of ICBs, working toward the new target date. NHS England and NHS Improvement will support CCG and designate ICB leaders to reset their implementation plans, to ensure the safe transfer of people, property (in its widest sense) and liabilities from CCGs to ICBs from their establishment. The national programme team will work closely with colleagues in systems and in regional teams to identify what support is needed to manage the new timetable.

We will work with national partners, including trade unions, to communicate the changed target date and any implications for the transfer process. Systems should also ensure they have clear and effective plans for local communications and engagement with the public, staff, trade unions and other stakeholders.

ICB designate chairs and chief executives should continue to progress recruitment to their designate leadership teams, adjusting their timelines as necessary while managing immediate operational demands. Current/planned recruitment activities for designate leadership roles should continue where this is the local preference, but

formal transition to the future leadership arrangements should now be planned for the new target date of 1 July 2022.

Regional teams will work with CCG leaders to agree arrangements that ensure that:

- CCGs remains legally constituted and able to operate effectively, working in partnership with the designate ICB leadership
- individuals' roles and circumstances are clear during the extended preparatory phase.

The employment commitment arrangements for other affected staff and the talent-based approach to people transition [previously set out](#) will be extended to reflect the new target date.

The requirements for ICB Readiness to Operate and System Development Plan submissions currently due in mid-February 2022 will be revised to reflect the extended preparatory period. Further details of these plans along with specific implications for financial, people or legal arrangements during the extended preparatory period will be developed with systems and set out in January 2022.

Designate ICB leaders, CCG accountable officers and NHS England and NHS Improvement regional teams will be asked to agree ways of working for 2022/23 before the end of March 2022. This will include agreeing how they will work together to support ongoing system development during Q1, including the establishment of statutory ICSs and the oversight and quality governance arrangements in their system.

Planning during 2022/23

The Health and Care Bill before Parliament will require each ICB to publish a five-year system plan before April each year. This plan must take account of the strategy produced by the integrated care partnership (ICP), and the joint strategic needs assessments and joint health and wellbeing strategies produced by the relevant health and wellbeing board(s).

We expect to require ICBs' refreshed five-year system plans in March 2023. This will give each ICB and its local authority partners sufficient time to agree a strategy for the ICP that has broad support, and to develop a plan to support its implementation, including the development of place based integration. ICBs will undertake preparatory work through 2022/23 to ensure that their five-year system plans:

- match the ambition for their ICS, including delivering specific objectives under the four purposes to:
 - improve outcomes in population health and healthcare
 - tackle inequalities in outcomes, experience and access
 - enhance productivity and value for money
 - support broader social and economic development
- reflect the national priorities and ambitions for the NHS
- take account of the responsibilities that they will be taking on for commissioning services that are currently directly commissioned by NHS England, such as primary care and some specialised services.

Plan submission

The planning timetable will be extended to the end of April 2022, with draft plans due in mid-March. We will keep this under review and publish further guidance setting out the requirements for plan submission.

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This publication can be made available in a number of other formats on request.

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To: *(by email)*
Cllr James Andrews, Chair, Barnsley Health and
Wellbeing Board
Chris Edwards, Clinical Commissioning Group
Accountable Officer(s)
Sarah Norman, Chief Executive, Barnsley
Council

12 January 2022

Dear Colleagues

BETTER CARE FUND 2021-22

Thank you for submitting your Better Care Fund (BCF) plan for regional assurance and approval. We recognise that the BCF has again presented challenges in preparing plans at a late stage and at pace and we are grateful for your commitment in providing your agreed plan.

I am pleased to let you know that, following the assurance process, your plan has been classified as '**Approved**'. The Clinical Commissioning Group (CCG) BCF funding can therefore now be formally released subject to the funding being used in accordance with your final approved plan, and the conditions set out in the BCF policy framework for 2021-22 and the BCF planning guidance for 2021-22, including transfer of funds into a pooling arrangement governed by a Section 75 agreement. Your Section 75 agreement should aim to be confirmed by the end of January 2022.

These conditions have been imposed through the NHS Act 2006 (as amended by the Care Act 2014). If the conditions are not complied with and NHS England considers that the CCG(s) is failing, has failed or it at significant risk of failing to discharge its functions, then NHS England is able to direct the CCG(s) in your Health and Wellbeing Board area as to the use of the funding.

The Disabled Facilities Grant (DFG) and the improved Better Care Fund (iBCF) grant are also pooled along-side the CCG allocations. The DFG and iBCF grants are paid directly to local authorities via a grant by the Department of Levelling Up, Housing and Communities. These grants are subject to grant conditions set out in their respective grant determinations, as specified in the BCF Planning Requirements.

Ongoing support and oversight will continue to be led by your local Better Care Manager (BCM). Please note that we will be regularly monitoring the performance of all areas against their length of stay ambitions and offering support as appropriate. Following the assurance process, we are asking all BCMs to feedback identified areas for improvement in your plan and share where systems may benefit from conversations with other areas.

Local systems must remain compliant for the financial year. Where an area is not compliant with one or more conditions of the BCF, or if the funds are not being spent in accordance with the agreed plan and risking the national conditions not being met, then the BCF team, in consultation with national partners, may make a recommendation to initiate an escalation process. Any intervention will be proportionate to the risk or issue identified. The intervention and escalation process (outlined in the BCF Planning Requirements 2021-22) could lead to NHS England exercising its powers of intervention provided by the NHS Act 2006, in consultation with DHSC and DLUHC, as the last resort.

As you will be aware, since the BCF planning and assurance process, NHS England and Improvement has written to the NHS¹ to declare a level 4 National Incident and the Department for Health and Social Care has written to local government in similar terms. In light of this, I am asking all local areas to review and revise BCF discharge ambitions and activity plans in order to support the aim of maximising capacity across acute and community settings – enabling the maximum number of people to be discharged safely and quickly, home wherever possible, and supporting people in their own homes. Revised plans are for local discussion and agreement and do not need to be re-submitted.

Reporting for 2021-22 will be limited to an End of Year return. Reporting arrangements will be confirmed in future guidance. HWBs will be required to provide an end of year reconciliation to Departments and NHS England, confirming that the national conditions have been met, total spend from the mandatory funding sources and a breakdown of agreed spending on social care from the CCG minimum contribution. A reporting template and associated guidance will be published in due course.

¹ [Coronavirus » Preparing the NHS for the potential impact of the Omicron variant and other winter pressures \(england.nhs.uk\)](https://www.england.nhs.uk/coronavirus/preparing-the-nhs-for-the-potential-impact-of-the-omicron-variant-and-other-winter-pressures/)

Once again, thank you for your work and best wishes with implementation and ongoing delivery.

Yours sincerely,



Matthew Winn

Director of Community Health - NHS England and Improvement
and Senior Responsible Officer for the Better Care Fund

Copy (by email) to:

Richard Barker, Regional Director, NHS England and NHS Improvement
Rosie Seymour, Programme Director, Better Care Fund Team, Better Care Fund
Programme, NHS England and NHS Improvement
Jenny Sleight, Better Care Manager, Better Care Fund Programme, NHS England and
NHS Improvement

GOVERNING BODY

20 January 2022

Covid-19 update

1.	THIS PAPER IS FOR											
	<input type="checkbox"/> <i>Decision</i>	<input type="checkbox"/> <i>Approval</i>	<input checked="" type="checkbox"/> <i>Assurance</i>									
	<input checked="" type="checkbox"/> <i>Information</i>											
2.	PURPOSE											
	<p>To provide Governing Body with an update in relation to the current situation, national guidance and the CCG response to the Coronavirus Disease (COVID19) pandemic.</p> <p>At the Governing Body meeting on 11 November, 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 and provides Governing Body Members with details of recent guidance.</p>											
3.	REPORT OF											
	<table border="1"> <thead> <tr> <th></th> <th>Name</th> <th>Designation</th> </tr> </thead> <tbody> <tr> <td>Executive / Clinical Lead</td> <td>Nick Balac</td> <td>Chair</td> </tr> <tr> <td>Author</td> <td>Jamie Wike</td> <td>Chief Operating Officer</td> </tr> </tbody> </table>				Name	Designation	Executive / Clinical Lead	Nick Balac	Chair	Author	Jamie Wike	Chief Operating Officer
	Name	Designation										
Executive / Clinical Lead	Nick Balac	Chair										
Author	Jamie Wike	Chief Operating Officer										
4.	SUMMARY OF PREVIOUS GOVERNANCE											
	<p>The matters raised in this paper have been subject to prior consideration in the following forums:</p> <table border="1"> <thead> <tr> <th>Group / Committee</th> <th>Date</th> <th>Outcome</th> </tr> </thead> <tbody> <tr> <td>Management Team</td> <td>Weekly</td> <td>Updates and COVID related decisions</td> </tr> </tbody> </table>			Group / Committee	Date	Outcome	Management Team	Weekly	Updates and COVID related decisions			
Group / Committee	Date	Outcome										
Management Team	Weekly	Updates and COVID related decisions										
5.	EXECUTIVE SUMMARY											
5.1	<p>Introduction</p> <p>Following the declaration by the World Health Organisation (WHO) on 11 March 2020 that the COVID19 outbreak be classified as a pandemic and the</p>											

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 the pandemic the UK Chief Medical Officers have advised ministers on the UK COVID-19 alert level. The alert levels were originally defined in the UK government's COVID-19 recovery strategy 'Our Plan to Rebuild' in May 2020 (revised in August 2021) and communicate the current risk at a UK-wide level.

The alert levels are:

- level 1: COVID-19 is not known to be present in the UK
- level 2: COVID-19 is present in UK, but the number of cases and transmission is low
- level 3: a COVID-19 epidemic is in general circulation
- level 4: a COVID-19 epidemic is in general circulation; transmission is high and direct COVID-19 pressure on healthcare services is widespread and substantial or rising
- level 5: as level 4 and there is a material risk of healthcare services being directly overwhelmed by COVID-19

Following a steep increase in infection rates and increased transmissibility of the Omicron variant the alert level was increased to level 4 on 12 December.

Monitoring of Covid levels continues to be monitored to inform planning and future response. The latest summary position for the reporting period 28 December to 3 January 2022 showed that the 7-day all-age incidence rate was 2125 per 100,000 for the period ending 3rd January 2022. This was a 130% increase compared to the previous non-overlapping 7-days. There are also increase in rates in vulnerable groups including over 60's – latest rate 1200 per 100,000.

Following a very steep rise in transmission, just over 7,000 new cases were recorded in the week (compared to ~1,000 weekly cases early Dec 2021). Barnsley's all-age case rate is 5x what it was two weeks previous and 3x higher than previously recorded. For over 60s, case rates are double the previous highest peak and nine times higher than two weeks ago.

Hospital cases have risen rapidly since Christmas, with over 80 positive inpatients and rising admissions. Most are over 50, vaccinated and in hospital for reasons other than covid, and there are proportionally less requiring ITU or HDU. Staffing and general demand is affecting all parts of health and care, and SWYFT and primary care have reported the highest Operational Pressures Escalation Level due mainly to workforce issues.

Following significantly increased capacity for vaccination including the establishment of a large pop-up walk-in facility at Barnsley Metrodome there was a high uptake pre-Christmas, booster coverage is now 90% for over 70s, 85% for 60-69s, and 72% for 50-59s. The level of demand has since reduced and there are still around 50,000 eligible people who haven't received a booster, and

	<p>36,000 people remain unvaccinated. Work therefore continue to increase uptake and encourage and support those who have not yet received the vaccine to do so.</p> <p>In response to the increased alert level and also JCVI Guidance published on 3 December in response to the emergence of the Omicron variant (see appendix 1), during December NHE England published a range of letters and guidance to support the covid vaccination programme, prepare for the potential impact of the Omicron variant and other winter pressures and release capacity to manage the pandemic. These were:</p> <ul style="list-style-type: none"> • C1475 – Temporary GP contract changes to support Covid-19 vaccination programme (Appendix 2) • C1487 – Preparing the NHS for the potential impact of the Omicron variant and other winter pressures (Appendix 3) • C1488 - National call: Next steps for the NHS COVID-19 vaccine deployment (Appendix 4) • C1518 – Reducing the burden of reporting and releasing capacity to manage the Covid19 pandemic (Appendix 5) 		
6.	THE GOVERNING BODY / COMMITTEE IS ASKED TO:		
	<ul style="list-style-type: none"> • Note the update provided in this paper and the related appendices including the current position in Barnsley in relation to covid and the vaccination programme. 		
7.	APPENDICES / LINKS TO FURTHER INFORMATION		
	<ul style="list-style-type: none"> • C1468 - JCVI advice in response to the emergence of the B. 1. 1.529 (Omicron) variant: next steps for deployment (Appendix 1) • C1475 – Temporary GP contract changes to support Covid-19 vaccination programme (Appendix 2) • C1487 – Preparing the NHS for the potential impact of the Omicron variant and other winter pressures (Appendix 3) • C1488 - National call: Next steps for the NHS COVID-19 vaccine deployment (Appendix 4) • C1518 – Reducing the burden of reporting and releasing capacity to manage the Covid19 pandemic (Appendix 5) 		
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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 (<i>place ✓ beside all that apply</i>):			
	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	✓
	3.2 Maximising Elective Activity	✓	9.1 Digital and Technology	✓
	4.1 Mental Health	✓	10.1 Compliance with statutory duties	✓
	5.1 Integrated Care @ System	✓	11.1 Delivery of Enhanced Health in Care Homes	✓
	5.2 Integrated Care @ Place	✓	12.1 Delivering The Covid Vaccination Programme & Meeting The Needs of Patients with Covid-19	✓
	5.3 Implementing Population Health Management And Personalised Care	✓		
	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 (<i>place ✓ beside all that are relevant</i>):			
	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 (<i>these will be especially relevant where a proposal or policy is brought for decision or approval</i>)			
3.1	Clinical Leadership			
	Have GB GPs and / or other appropriate clinicians provided input and leadership?			Y
	COVID Response has input from Governing Body and the Vaccination Programme is delivered by the Barnsley Primary Care Network, supported by Barnsley Healthcare Federation.			
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

Official
Publication approval reference: C1468

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To: ICS and STP Leaders

Copy to:

- CCG Accountable Officers
- GP practices
- PCN-led local vaccination services
- Community pharmacy-led local vaccination services
- Vaccination centres
- Chief Executives of all NHS trusts and foundation trusts
- NHS Regional Directors
- NHS Regional Directors of Commissioning
- Directors of Public Health
- All Local Government Chief Executives

3 December 2021

Dear Colleague

JCVI advice in response to the emergence of the B. 1. 1.529 (Omicron) variant: next steps for deployment

On Monday the government accepted updated advice from the Joint Committee on Vaccination and Immunisation (JCVI) following the emergence of the Omicron variant.

The JCVI advise an acceleration of COVID-19 vaccination to increase protection ahead of any wave of infection and to help reduce the impact of the Omicron variant of COVID-19. The JCVI recommend that:

“Booster vaccination eligibility should be expanded to include all adults aged 18 years to 39 years.

“Booster vaccination should now be offered in order of descending age groups, with priority given to the vaccination of older adults and those in a COVID-19 at-risk group. Booster vaccination should not be given within three months of completion of the primary course.

“Severely immunosuppressed individuals who have completed their primary course (three doses) should be offered a booster dose with a minimum of three months between the third primary and booster dose. Those who have not yet received their third dose may be given the third dose now to avoid further delay. A further booster dose can be given in three months, in line with the clinical advice on optimal timing.

“Both the Moderna (50 microgram) and Pfizer-BioNTech (30 microgram) vaccines should be used with equal preference in the COVID-19 booster programme.”

The JCVI also advise that children and young people aged 12 to 15 years should be offered a second dose of the Pfizer-BioNTech COVID-19 vaccine at a minimum of 12 weeks from the first dose. No immediate action is required, and we will write separately on implementation of this advice.

A full copy of the JCVI's advice can be found [here](#).

NEXT STEPS FOR DEPLOYMENT

The JCVI are clear that those at greatest risk must be prioritised, including those who are housebound, and those severely immunosuppressed. Therefore, the NHS will offer vaccination in descending age groups, with priority given to the vaccination of older adults and those in a COVID-19 at-risk group first.

IMPLEMENTING THE NEW DOSING INTERVAL

The National Booking Service (NBS) is now being updated to reflect the three-month (91 days) interval from second dose to booster. Our intention is to go live as soon as possible and no later than 13 December. As these changes are being made, existing booking arrangements will remain in place: individuals in cohorts 1-10 can book their booster from five months (152 days) post second dose, for slots from six months (182 days) after their second dose.

UKHSA is now updating the Patient Group Directive (PGD), the National Protocol and Green Book Guidance to reflect the three-month interval. We expect these to be updated no later than 13 December. We will ensure the NBS opening and PGD publication are aligned.

INCREASING CAPACITY

We recognise the pressure all local services are under, however as the Secretary of State for Health and Social Care has said, the 'new national mission' is to increase vaccine capacity. There are no supply challenges with either the Moderna or Pfizer booster stocks, therefore all vaccination sites are now asked to load their NBS calendars to the end of January, where possible.

For PCN-led Local Vaccination Services: Given the invaluable contribution and scale of effort required in primary care, several measures will now be put in place to support all PCN-led local vaccination services. These include creating capacity and financial support. These will allow wherever possible practices and PCNs to continue to pursue the clinical ambitions underlying QOF and IIF while releasing capacity to support the increased vaccine effort:

- a) **Creating capacity:** Creating capacity within primary care will be enabled by the following: If participating in the vaccination programme, income protection for the Minor Surgery DES will apply from 1 December 2021 until 31 March 2022. Local commissioners should make the monthly payments to practices for the Minor Surgery DES that they made for the corresponding period from 1 December 2018 to 31 March 2019. No contract enforcement will be taken where no activity is done under the Minor Surgery Additional Service from 1 December 2021 to 31 March 2022. Capacity released must be redeployed to vaccination.

- b) From 1 December 2021 to 31 March 2022, where contractors consider it clinically appropriate, routine health checks for those over 75 and for new patients may be deferred.
- c) The evidence-based care provided via QOF continues to be important in minimising health inequalities, securing the best outcomes for those with long term conditions and preventing wider system impacts. In order to support the ongoing response to COVID-19 and the increase in vaccination capacity, combined with the need to target proactively and support our most vulnerable patients during this period, we will introduce the following changes for 2021/22:
- Some QOF indicators will continue to be paid on the basis of practice performance. These include vaccination, cervical screening, register indicators and those related to optimal prescribing.
 - Others will be subject to income protection based upon historical practice performance, in a similar way to arrangements in 2020/21.
 - To be eligible for income protection, practices will need to agree with their commissioner a plan that will set out how QOF care will be delivered wherever possible but with priority according to clinical risk, and accounting for inequalities.
 - QOF will recommence in April 2022.
- d) For the IIF, the indicators introduced in April 2021 covering flu immunisation and the completed work on appointment recording and categorisation will be paid as normal. The remaining indicators will be suspended and the funding repurposed. The majority of the funding allocated to these suspended indicators will instead be allocated to PCNs via a PCN Support Payment, on a weighted patient basis, subject to confirmation from the PCN that it will be reinvested into services or workforce. The remaining funding will instead be allocated to a new IIF incentive to support PCNs whose practices are fully participating in the vaccination programme. Further details will follow. IIF will recommence in April 2022.
- e) The Dispensing Services Quality Scheme will be amended to reduce the requirement for medication reviews from a minimum of 10% of dispensing patients to a minimum of 7.5% for 2021/22. Practices are asked to prioritise patients who they consider to be higher-risk or would benefit most from a review.

Financial support: Enhanced financial support for PCN-led local vaccination services, to help sites attract and retain staff, including during unsociable parts of the week, is now available. This comprises:

- an increase to the Item of Service (IoS) fee to £15 per jab administered on weekdays and Saturdays from 1 December 2021 to 31 January 2022 (exclusive of days designated as a Bank Holiday) and an increase to the IoS fee to £20 per jab administered on Sundays or Bank Holidays over the same period
- an increase in the supplement for third dose and booster vaccination of house-bound patients to £30 from £20 until 31 December, backdated for those already carried out

- a temporary supplement of £10 for the administration of COVID-19 vaccinations to severely immunosuppressed people from 1 December 2021 to 31 January 2022. From 1 December, LVS sites are advised to select the 'other residential settings' field within the Point of Care systems to ensure an additional supplementary payment of £10 can be applied to the Item of Service fee for any doses administered to patients identified as severely immunosuppressed. Point of Care system suppliers have been requested to amend the text within their system to reflect this change and this will be introduced imminently but should not prevent any site from recording this information and claiming the additional payment. Please note this payment will not apply to any vaccinations administered prior to 1 December 2021
- an enhanced payment to support Clinical Director and management leadership of PCN sites to 1 WTE for the period 1 December 2021 to the end of March 2022.

Regulatory activity: The CQC have confirmed that routine inspections of practices will continue to be paused, and only risk-based assessment will be undertaken, where deemed critical to safety and quality.

We recognise this additional support may now enable additional PCNs to participate in the vaccination programme, therefore the sign-up window for the Phase Three GP COVID-19 Vaccination Enhanced Service (ES) has now been reopened. Practices who wish to sign up should liaise with their local commissioner as soon as possible to discuss next steps.

PCNs that have opted in to deliver boosters to Cohort 10 will be able to deliver boosters to Cohorts 11 and 12 once these cohorts are opened. In addition, PCNs should prepare for further delivery of vaccination cohorts if announced.

There is some opportunity for PCN-led local vaccination services to be onboarded to the NBS where there is a strategic need. Please liaise with your local commissioner so that regions can prioritise available licences. Any sites onboarded onto the NBS should use the system for the majority of their bookings.

For Community Pharmacy-Led Local Vaccination Services: Recognising the critical role community pharmacy LVS plays in local communities, we will provide the enhanced financial support to CP-led LVS to help sites attract and retain staff, including during unsociable parts of the week. This comprises:

- an increase to the IoS fee to £15 per jab administered on weekdays and Saturdays from 1 December 2021 to 31 January 2022 and an increase to the IoS to £20 per jab administered on Sundays or Bank Holidays over the same period
- an increase in the supplement for third dose and booster vaccination of house-bound patients to £30 from £20 until 31 December, backdated for those already carried out
- a temporary supplement of £10 for the administration of COVID-19 vaccinations to severely immunosuppressed people from 1 December 2021 to 31 January 2022. From 1 December, LVS sites are advised to select the 'other residential settings' field within the Point of Care systems to ensure an additional supplementary payment of £10 can be applied to the Item of Service fee for any doses administered to patients identified as severely immunosuppressed. Point of Care system suppliers have been requested to amend the text within their

system to reflect this change and this will be introduced imminently but should not prevent any site from recording this information and claiming the additional payment. Please note this payment will not apply to any vaccinations administered prior to 1 December 2021.

In addition, we are discussing with the Pharmaceutical Service Negotiating Committee any further measures that may be required to support community pharmacy in delivering vaccinations.

For Hospital hubs: Hospital hubs continue to play a critical role in the vaccination of health and care staff. Given the scale of the challenge, we are now asking hospital hubs to work with their system partners to review their capacity and extend their booster offer.

As a priority, hospital hubs should continue to offer vaccinations to their staff and extend their offer to patients who are immunosuppressed, as well as opportunistic vaccination of inpatients and outpatients, as a minimum. If they did so in the first phase of the vaccination programme, hospital hubs should again implement local booking solutions to vaccinate other health and social care workers and unpaid carers in their area. Where this is required locally, hospital hubs should also provide an offer to the general public by becoming a hospital hub plus and utilising the NBS or local booking systems.

WORKFORCE

Systems have highlighted workforce as a rate limiting factor for increasing capacity, particularly in rural areas. Therefore, the following steps to improve access to additional workforce are now being put in place:

- A request to the Ministry of Defence to secure military personnel to provide rapid deployment vaccination teams across England.
- All national NHS organisations have now been asked to deploy their registered healthcare professionals into vaccination services.
- Clinical students are being invited to work bank shifts when not engaged in educational activities or on placement. Students will be contacted directly and asked to rapidly register.
- NHS Professionals have committed to recruiting staff including registrants, unregistered vaccinators, healthcare support workers and administrators.
- Contingency staff pools offered through NHS Professionals (vaccine operational support teams) will be expanded, increasing coverage across the country.
- St John Ambulance are re-engaging existing volunteers and recruiting additional vaccinator volunteers, patient advocates and post vaccination observers.
- A new campaign to recruit more stewards and volunteers has been launched by the Royal Voluntary Service. All vaccination services can book these volunteers directly through the GoodSam app.

Your system lead employer can provide assistance and access to all of the resources listed above. Their contact details [are set out here on FutureNHS](#), and have been provided alongside the cascade of this letter.

Finally, in their December [update](#), the UKHSA estimate that, as of 24 September, 127,500 deaths and 24,144,000 infections have been prevented as a result of the COVID-19 vaccination programme. As we approach the anniversary of offering the first vaccination in the world outside of a clinical trial, we want to thank you for your continued commitment to saving lives and protecting communities.

Yours sincerely



Amanda Pritchard

NHS Chief Executive



Dr Emily Lawson

NHS SRO Vaccine
Deployment



Dr Nikki Kanani

Deputy SRO,
COVID-19
Vaccination
Deployment
Programme,
Medical Director
for Primary Care



Ed Waller

Director of Primary
Care

- To:
- GP practices
 - Primary care networks
 - NHS England and NHS Improvement regions:
 - directors
 - directors of commissioning
 - Clinical commissioning groups:
 - clinical leads
 - accountable officers

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

8 December 2021

Dear Colleagues

Temporary GP contract changes to support COVID-19 vaccination programme

1. In our letter of 3 December, NHS England and NHS Improvement set out plans for an acceleration of COVID-19 vaccination following the emergence of the Omicron variant. This letter sets out further details of the actions we are taking to support GPs, primary care networks (PCNs) and their teams to progress this expansion of the vaccination programme alongside prioritisation of timely patient access to general practice services this winter.
2. We recognise that balancing your resources this winter between the urgent needs of your patients, the management of long term conditions, and the vital task of vaccination and public health is a daily challenge. The measures in this letter seek to support your professional clinical judgement in balancing these considerations.

The Quality and Outcomes Framework (QOF)

3. The evidence-based care provided via QOF continues to be important in minimising health inequalities and securing the best outcomes for those with long term conditions. However, to support the ongoing response to COVID-19 and the increase in vaccination capacity, combined with the need to target proactively and support our most vulnerable patients during this period, we are making the following changes to QOF in 2021/22 – applying to all practices – which will be reflected in an amended statement of financial entitlement (SFE):
 - a. Practices should focus on the four vaccination and immunisation indicators, the two cervical screening indicators, the register indicators and the eight prescribing

indicators (see Appendix 1). These will continue to operate on the basis of practice performance in 2021/22.

- b. Forty-six QOF points for new indicators where there is no historic performance to use as the basis for income protection (the eight points associated with the new for 2021/22 cancer indicators, 20 points from the new for 2021/22 mental health indicators and 18 points from the non-diabetic hyperglycaemia indicator that was introduced for 2020/21) will be reallocated. These will increase the total points available for the eight prescribing indicators, reflecting the continued importance of effective prescribing in the management of long term conditions. We appreciate the work you will have undertaken in these domains to date and that you will continue to clinically prioritise care.
 - c. The remaining indicators will be income protected using a methodology very similar to the one applied in 2020/21: most income-protected indicators for 2021/22 will be paid based on achievement in 2018/19, while the income-protected indicators relating to diabetes and hypertension will be based on 2019/20 achievement, given some indicators in those domains were new for the 2019/20 year (see Appendix 2). Points will be subject to a list size and prevalence adjustment calculated in the usual way at year end. Practices are expected to continue to apply their clinical judgement and deliver as much patient care in these areas as they can, with a focus on the highest risk patients, but their income will not be dependent on recorded QOF achievement this year for the income-protected indicators.
 - d. The quality improvement (QI) domain will be paid to practices in full.
 - e. To be eligible for income protection, practices will need to agree with their commissioner a plan that will set out how QOF care will be delivered wherever possible, but with priority according to clinical risk and accounting for inequalities. We will be working with the Royal College of GPs (RCGP) and the British Medical Association (BMA) to provide some guidance to systems and practices.
4. All activity undertaken should continue to be coded. The Calculating Quality Report Service (CQRS) will continue to operate in 2021/22 and achievement data will be collected and reported for all indicators. Aspiration payments will continue as at present. Payment for QOF may be made later than usual for 2021/22, given that the proposed changes to the scheme are being made towards the end of the year.
5. QOF will recommence in full from April 2022.

Investment and Impact Fund (IIF)

6. The following changes will apply to IIF for 2021/22, implemented via a forthcoming Variation to the Network Contract Directed Enhanced Service (DES):
 - a. The three flu immunisation indicators, and the appointment categorisation indicator (as the work is complete), will continue to operate on the basis of PCN performance in 2021/22 (see Appendix 3).
 - b. The remaining indicators will be suspended and the funding allocated (worth £112.1m) repurposed (see Appendix 4).
 - c. £62.4m of the funding allocated to these suspended indicators will instead be allocated to PCNs via a PCN support payment, to be paid on a weighted patient basis, subject to a simple confirmation from the PCN that it will be reinvested into services or workforce.
 - d. £49.7m will be allocated to a new binary IIF indicator, paid on the basis of all practices within a PCN being signed up to phase 3 of the COVID-19 Vaccination Enhanced Service as at 31 December 2021, remaining signed up until 31 March 2022, and actively delivering the programme. Given the opt-in deadline of **10 December 2021**, practices not signed up to the phase 3 Enhanced Service would need to opt in by 10 December 2021, be assured to go live in early January, and continue to participate in the enhanced service until 31 March 2022 to be eligible for this indicator. Payment for this indicator will be made on a registered list size basis after the end of the financial year. Where, in exceptional circumstances, the commissioner agrees with one or more practices that they should not participate in the COVID-19 Vaccination Enhanced Service (as a result of wider access, performance or patient safety issues) then the PCN may still receive payment with those practices excluded from consideration. The payment will not apply if any practice in the PCN otherwise declines to participate in the programme.
7. As with QOF, CQRS will continue to operate in 2021/22 and achievement data will be collected and reported for all indicators. Recording of activity should continue. Payment for IIF may be made later than usual for 2021/22, given that the proposed changes to the scheme are being made towards the end of the year.
8. IIF will recommence in full from April 2022.

Wider measures

9. If participating in the vaccine programme, income protection for the Minor Surgery DES will apply from 1 December 2021 until 31 March 2022. Local commissioners

should make the monthly payments to practices for the Minor Surgery DES that they made for the corresponding period from 1 December 2018 to 31 March 2019. No contract enforcement will be taken where no activity is done under the Minor Surgery Additional Service from 1 December 2021 to 31 March 2022. Capacity released must be redeployed to vaccination.

10. From 1 December 2021 to 31 March 2022, where contractors consider it clinically appropriate and they are participating in the vaccine programme, routine health checks on request for those over 75 who have not had a consultation in the last 12 months, and for new patients may be deferred.
11. The Dispensary Services Quality Scheme will be amended to reduce the requirement for medication reviews from a minimum of 10% of dispensing patients to a minimum of 7.5% for 2021/22. Practices are asked to prioritise patients who they consider to be higher-risk or would benefit most from a review.

Additional telephony support

12. As a component of the NHS England and NHS Improvement Winter Access programme, NHSX have agreed a time-limited offer with Microsoft for general practice to utilise MS Teams telephony functionality. This solution will enable staff to use MS teams to make outbound only calls independently of the existing telephone solutions. This will free up the existing lines for incoming calls. Practices will keep their current telephony supplier and associated number in place to support the receiving of calls. This national offer is an additional component to the Microsoft Teams application currently provided and will increase telephone capacity at no additional cost to the practice. The additional outbound only call functionality will expire on 30 April 2023.
13. If you have already responded to the baselining questionnaire indicating interest, this functionality will be enabled for all Teams users in your practice. Further communications will follow from the NHSmail Team confirming the date of availability and providing links to the support site which contains details of how to access including training and support.
14. Contact the team on scwcsu.nhsei.winterpressures.advancedtelephony@nhs.net if you no longer wish to progress with this offer, or if you did not complete the original questionnaire, but wish to take up this offer.

Next steps

15. The sign-up window for the phase 3 GP COVID-19 Vaccination Enhanced Service has therefore been reopened. Practices who wish to sign up should liaise with their local commissioner as soon as possible to discuss next steps.

Yours sincerely,

A handwritten signature in blue ink, appearing to read 'Ed Waller', on a light blue background.

Ed Waller

Director of Primary Care
NHS England and NHS Improvement

A handwritten signature in blue ink, appearing to read 'N. Kanani', on a light blue background.

Dr Nikita Kanani MBE

Medical Director for Primary Care
NHS England and NHS Improvement

Appendix 1: QOF performance-based indicators 2021/22

Table 1: Performance-based public health indicators with unchanged points values 2021/22

Indicator ID	Indicator wording	Points	Payment thresholds	Points at the lower threshold
VI001	The percentage of babies who reached 8 months old in the preceding 12 months, who have received at least 3 doses of a diphtheria, tetanus and pertussis containing vaccine before the age of 8 months	18	90-95%	3
VI002	The percentage of children who reached 18 months old in the preceding 12 months, who have received at least 1 dose of MMR between the ages of 12 and 18 months	18	90-95%	7
VI003	The percentage of children who reached 5 years old in the preceding 12 months, who have received a reinforcing dose of DTaP/IPV and at least 2 doses of MMR between the ages of 1 and 5 years	18	87-95%	7
VI004	The percentage of patients who reached 80 years old in the preceding 12 months, who have received a shingles vaccine between the ages of 70 and 79 years	10	50-60%	-
CS005	The proportion of women eligible for screening aged 25-49 years at end of period reported whose notes record that an adequate cervical screening test has been performed in the previous 3 years and 6 months	7	45-80%	-
CS006	The proportion of women eligible for screening and aged 50-64 years at end of period reported whose notes record that an adequate cervical screening test has been performed in the previous 5 years and 6 months	4	45-80%	-
Total				75

Table 2: Performance-based prescribing indicators with changed points values 2021/22

Indicator ID	Indicator wording	Original points	Updated points	Payment thresholds
AF007	In those patients with atrial fibrillation with a record of a CHA2DS2-VASc score of 2 or more, the percentage of patients who are currently treated with anti-coagulation drug therapy	12	25	40-70%
CHD005	The percentage of patients with coronary heart disease with a record in the preceding 12 months that aspirin, an alternative anti-platelet therapy, or an anti-coagulant is being taken	7	15	56-96%
HF003	In those patients with a current diagnosis of heart failure due to left ventricular systolic dysfunction, the percentage of patients who are currently treated with an ACE-I or ARB	6	12	60-92%
HF006	The percentage of patients with a current diagnosis of heart failure due to left ventricular systolic dysfunction, who are currently treated with a beta-blocker licensed for heart failure	6	12	60-92%
STIA007	The percentage of patients with a stroke shown to be non-haemorrhagic, or a history of TIA, who have a record in the preceding 12 months that an anti-platelet agent, or an anti-coagulant is being taken	4	8	57-97%
DM006	The percentage of patients with diabetes, on the register, with a diagnosis of nephropathy (clinical proteinuria) or micro-albuminuria who are currently treated with an ACE-I (or ARBs)	3	8	57-97%
DM022	The percentage of patients with diabetes aged 40 years and over, with no history of cardiovascular disease and without moderate or severe frailty, who are currently treated with a statin (excluding patients with type 2 diabetes and a CVD risk score of <10% recorded in the preceding 3 years)	4	7	50-90%
DM023	The percentage of patients with diabetes and a history of cardiovascular disease (excluding haemorrhagic stroke) who are currently treated with a statin	2	4	50-90%
			Total	90

Table 3: Disease register indicators

Indicator ID	Indicator	Points
AF001	The contractor establishes and maintains a register of patients with atrial fibrillation	5
CHD001	The contractor establishes and maintains a register of patients with coronary heart disease	4
HF001	The contractor establishes and maintains a register of patients with heart failure	4
HYP001	The contractor establishes and maintains a register of patients with established hypertension	6
PAD001	The contractor establishes and maintains a register of patients with peripheral arterial disease	2
STIA001	The contractor establishes and maintains a register of patients with stroke or TIA	2
DM017	The contractor establishes and maintains a register of all patients aged 17 or over with diabetes mellitus, which specifies the type of diabetes where a diagnosis has been confirmed	6
AST005	The contractor establishes and maintains a register of patients with asthma aged 6 years or over, excluding patients with asthma who have been prescribed no asthma related drugs in the preceding 12 months	4
COPD009	The contractor establishes and maintains a register of: 1. Patients with a clinical diagnosis of COPD before 1 April 2021 and 2. Patients with a clinical diagnosis of COPD on or after 1 April 2021 whose diagnosis has been confirmed by a quality assured post bronchodilator spirometry FEV1/FVC ratio below 0.7 between 3 months before or 6 months after diagnosis (or if newly registered in the preceding 12 months a record of an FEV1/FVC ratio below 0.7 recorded within 6 months of registration); and 3. Patients with a clinical diagnosis of COPD on or after 1 April 2021 who are unable to undertake spirometry	8
DEM001	The contractor establishes and maintains a register of patients diagnosed with dementia	5
MH001	The contractor establishes and maintains a register of patients with schizophrenia, bipolar affective disorder and other psychoses and other patients on lithium therapy	4
CAN001	The contractor establishes and maintains a register of all cancer patients defined as a 'register of patients with a diagnosis of cancer excluding non-melanotic skin cancers diagnosed on or after 1 April 2003'	5
CKD005	The contractor establishes and maintains a register of patients aged 18 or over with CKD with classification of categories G3a to G5 (previously stage 3 to 5)	6

Indicator ID	Indicator	Points
EP001	The contractor establishes and maintains a register of patients aged 18 or over receiving drug treatment for epilepsy	1
LD004	The contractor establishes and maintains a register of patients with learning disabilities	4
OST004	The contractor establishes and maintains a register of patients: 1. Aged 50 or over and who have not attained the age of 75 with a record of a fragility fracture on or after 1 April 2012 and a diagnosis of osteoporosis confirmed on DXA scan, and 2. Aged 75 or over with a record of a fragility fracture on or after 1 April 2014 and a diagnosis of osteoporosis	3
RA001	The contractor establishes and maintains a register of patients aged 16 or over with rheumatoid arthritis	1
PC001	The contractor establishes and maintains a register of all patients in need of palliative care/support irrespective of age	3
OB002	The contractor establishes and maintains a register of patients aged 18 years or over with a BMI ≥ 30 in the preceding 12 months	8
Total		81

The points allocated to these indicators in Table 4 are reallocated to the prescribing indicators in Table 2.

Table 4: Indicators without historic performance

Indicator ID	Indicator wording	Points	Payment thresholds
MH007	The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of alcohol consumption in the preceding 12 months	4	50-90%
MH011	The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of a lipid profile in the preceding 12 months (in those patients currently prescribed antipsychotics, and/or who have pre-existing cardiovascular conditions, and/or smoke, and/or are overweight [BMI of ≥ 23 kg/m ² or ≥ 25 kg/m ² if ethnicity is recorded as White]) or preceding 24 months for all other patients	8	50-90%
MH012	The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of blood glucose or HbA1c in the preceding 12 months	8	50-90%
CAN004	The percentage of patients with cancer, diagnosed within the preceding 24 months, who have a patient Cancer Care Review using a structured template recorded as occurring within 12 months of the date of diagnosis	6	50-90%
CAN005	The percentage of patients with cancer, diagnosed within the preceding 12 months, who have had the opportunity for a discussion and been informed of the support available from primary care, within 3 months of diagnosis	2	70-90%
NDH001	The percentage of patients with non-diabetic hyperglycaemia who have had an HbA1c or fasting blood glucose performed in the preceding 12 months	18	50-90%
Total points to be reallocated			46

Appendix 2: QOF income-protected indicators 2021/22

Table 5: Indicators to be paid based on performance in 2018/19 (with indicator dates amended as appropriate)

Indicator ID	Indicator description	Points
AF006	The percentage of patients with atrial fibrillation in whom stroke risk has been assessed using the CHA2DS2-VASc score risk stratification scoring system in the preceding 12 months (excluding those patients with a previous CHADS2 or CHA2DS2-VASc score of 2 or more)	12
CHD008	The percentage of patients aged 79 years or under with coronary heart disease in whom the last blood pressure reading (measured in the preceding 12 months) is 140/90 mmHg or less	12
CHD009	The percentage of patients aged 80 years or over with coronary heart disease in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less	5
HF005	The percentage of patients with a diagnosis of heart failure on or after 1 April 2021 which: 1. Has been confirmed by an echocardiogram or by specialist assessment between 3 months before or 6 months after entering on to the register; or 2. If newly registered in the preceding 12 months, with no record of the diagnosis originally being confirmed by echocardiogram or specialist assessment, a record of an echocardiogram or a specialist assessment within 6 months of the date of registration.	6
HF007	The percentage of patients with a diagnosis of heart failure on the register, who have had a review in the preceding 12 months, including an assessment of functional capacity and a review of medication to ensure medicines optimisation at maximal tolerated doses	7
STIA010	The percentage of patients aged 79 years or under with a history of stroke or TIA in whom the least blood pressure reading (measured in the preceding 12 months) is 140/90 mmHg or less	3
STIA011	The percentage of patients aged 80 years and over with a history of stroke or TIA in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less	2
AST006	The percentage of patients with a diagnosis of asthma on or from 1 April 2021 with either: 1. a record of spirometry and one other objective test (FeNO or reversibility or variability) between 3 months before or 6 months after diagnosis; or 2. If newly registered in the preceding 12 months with a diagnosis of asthma recorded on or after April 2021 but no record of objective tests being performed at the date of registration, with a record of spirometry and one other objective test (FeNO or reversibility or variability) recorded within 6 months of registration	15

Indicator ID	Indicator description	Points
AST007	The percentage of patients with asthma on the register, who have had an asthma review in the preceding 12 months that includes an assessment of asthma control using a validated asthma control questionnaire, a recording of the number of exacerbations, an assessment of inhaler technique and a written personalised action plan	20
AST008	The percentage of patients with asthma on the register aged 19 or under, in whom there is a record of either personal smoking status or exposure to second-hand smoke in the preceding 12 months	6
COPD010	The percentage of patients with COPD on the register, who have had a review in the preceding 12 months, including a record of the number of exacerbations and an assessment of breathlessness using the Medical Research Council dyspnoea scale	9
COPD008	The percentage of patients with COPD and Medical Research Council (MRC) dyspnoea scale ≥ 3 at any time in the preceding 12 months, with a subsequent record of an offer of referral to a pulmonary rehabilitation programme (excluding those who have previously attended a pulmonary rehabilitation programme)	2
DEM004	The percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months	39
DEP003	The percentage of patients aged 18 or over with a new diagnosis of depression in the preceding 1 April to 31 March, who have been reviewed not earlier than 10 days after and not later than 56 days after the date of diagnosis	10
MH002	The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive care plan documented in the record, in the preceding 12 months, agreed between individuals, their family and/or carers as appropriate	6
MH003	The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of blood pressure in the preceding 12 months	4
MH006	The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of BMI in the preceding 12 months	4
RA002	The percentage of patients with rheumatoid arthritis, on the register, who have had a face-to-face review in the preceding 12 months	5
BP002	The percentage of patients aged 45 or over who have a record of blood pressure in the preceding 5 years	15
SMOK002	The percentage of patients with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses whose notes record smoking status in the preceding 12 months	25

Indicator ID	Indicator description	Points
SMOK004	The percentage of patients aged 15 or over who are recorded as current smokers who have a record of an offer of support and treatment within the preceding 24 months	12
SMOK005	The percentage of patients with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses who are recorded as current smokers who have a record of an offer of support and treatment within the preceding 12 months	25
Total		244

Table 6: Indicators to be paid based on 2019/20 performance (with indicator dates amended as appropriate)

Indicator ID	Indicator description	Points
DM0012	The percentage of patients with diabetes, on the register, with a record of a foot examination and risk classification: 1) low risk (normal sensation, palpable pulses), 2) increased risk (neuropathy or absent pulses), 3) high risk (neuropathy or absent pulses plus deformity or skin changes in previous ulcer) or 4) ulcerated foot within the preceding 12 months	4
DM014	The percentage of patients newly diagnosed with diabetes, on the register, in the preceding 1 April to 31 March who have a record of being referred to a structured education programme within 9 months after entry on to the diabetes register	11
DM019	The percentage of patients with diabetes, on the register, without moderate or severe frailty in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less	10
DM020	The percentage of patients with diabetes, on the registers, without moderate or severe frailty in whom the last IFCC-HbA1c is 58 mmol/mol or less in the preceding 12 months	17
DM021	The percentage of patients with diabetes, on the register, with moderate or severe frailty in whom the last IFCC-HbA1c is 75 mmol/mol or less in the preceding 12 months	10
HYP003	The percentage of patients aged 79 years or under with hypertension in whom the last blood pressure reading (measured in the preceding 12 months) is 140/90 mmHg or less	14
HYP007	The percentage of patients aged 80 years and over with hypertension in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less	5
Total		71

Table 7: Indicators awarded in full for 2021/22

Indicator ID	Indicator description	Points
QIECD005	The contractor can demonstrate continuous quality improvement activity focused upon early cancer diagnosis as specified in the QOF guidance.	27
QIECD006	The contractor has participated in network activity to regularly share and discuss learning from quality improvement activity focused on early cancer diagnosis as specified in the QOF guidance. This would usually include participating in a minimum of two peer review meetings	10
QILD007	The contractor can demonstrate continuous quality improvement activity focused on care of patients with a learning disability as specified in the QOF guidance	27
QILD008	The contractor has participated in network activity to regularly share and discuss learning from quality improvement activity focused on the care of patients with a learning disability as specified in the QOF guidance. This would usually include participating in a minimum of two network peer review meetings	10
Total		74

Appendix 3: Existing IIF indicators paid on a performance basis 2021/22

Indicator	Thresholds	Valuation
VI-01: Percentage of patients aged 65 years or over who received a seasonal influenza vaccination between 1 September and 31 March	80% (LT), 86% (UT)	£9.0m / 40 pts
VI-02: Percentage of at-risk patients aged 18 to 64 years who received a seasonal influenza vaccination between 1 September and 31 March	57% (LT), 90% (UT)	£19.8m / 88 pts
VI-03: Percentage of patients aged two or three years on 31 August of the relevant financial year who received a seasonal influenza vaccination between 1 September and 31 March	45% (LT), 82% (UT)	£3.2m / 14 pts
ACC-01: Confirmation that all practices in the PCN have mapped all active appointment slot types to the new set of national appointment categories, and are complying with the August 2020 guidance on recording of appointments	n/a - Binary indicator	£6.1m / 27 pts

Appendix 4: Suspended IIF indicators 2021/22

Indicator	Thresholds	Valuation
HI-01: Percentage of patients on the Learning Disability register aged 14 years or over, who received an annual Learning Disability Health Check and have a completed Health Action Plan	49% (LT), 80% (UT)	£8.1m / 36 pts
HI-02: Percentage of registered patients with a recording of ethnicity	81% (LT), 95% (UT)	£10.1m / 45 pts
CVD-01: Percentage of patients aged 18 years or over, not on the QOF hypertension register as of 30 September 2021, and who have (i) a last recorded blood pressure reading in the two years prior to 1 October 2021 \geq 140/90mmHg or (ii) a blood pressure reading \geq 140/90mmHg on or after 1 October 2021, for whom there is evidence of clinically appropriate follow-up to confirm or exclude a diagnosis of hypertension by 31 March 2022	20% (LT), 25% (UT)	£12.0m / 53 pts
CVD-02: Percentage of registered patients on the QOF hypertension register	Increase 0.2pp (LT), Increase 0.3pp (UT)	£6.1m / 27 pts
PC-01: Percentage of registered patients referred to social prescribing	0.8% (LT), 1.2% (UT)	£4.5m / 20 pts
EHCH-01: Number of Patients recorded as living in a care home, as a percentage of care home beds eligible to receive the Network Contract DES Enhanced Health in Care Homes service	30% (LT), 85% (UT)	£4.1m / 18 pts
EHCH-02: Percentage of care home residents aged 18 years or over, who had a Personalised Care and Support Plan (PCSP) agreed or reviewed	80% (LT), 98% (UT)	£4.1m / 18 pts
EHCH-03: Percentage of permanent care home residents aged 18 years or over who received a Structured Medication Review	80% (LT), 98% (UT)	£4.1m / 18 pts
EHCH-04: Mean number of patient contacts as part of weekly care home round on or after 1 October per care home resident	3 (LT), 4 (UT)	£2.9m / 13 pts
ACC-02: Number of online consultations on or after 1 October per 1000 registered patients	130 over 6 months (5 per 1000 per week) (single threshold)	£6.1m / 27 pts
ACC-03: By 31 March 2022, analyse and discuss the implications of data on Type 1 A&E attendance rates for minor conditions with the local ICS, making a plan to reduce unnecessary attendances and admissions.	n/a Binary indicator	£12.6m / 56 pts

Indicator	Thresholds	Valuation
ACC-04: Work collaboratively with local community pharmacy colleagues to develop and commence delivery of a plan to increase referrals to the Community Pharmacist Consultation Service, with referral levels increasing by no later than 31 March 2022.	n/a Binary indicator	£12.6m / 56 pts
ACC-05: By 31 March 2022, make use of GP Patient Survey results for practices in the PCN to identify patient groups experiencing inequalities in their experience of access to general practice, and develop and implement a plan to improve access for these patient groups.	n/a Binary indicator	£12.6m / 56 pts
ES-01: Metered Dose Inhaler (MDI) prescriptions as a percentage of all non-salbutamol inhaler prescriptions issued on or after 1 October	53% (LT), 44% (UT)	£6.1m / 27 pts
ES-02: Mean carbon emissions per salbutamol inhaler prescribed on or after 1 October (kg CO ₂ e)	22.5kg (LT), 19.4kg (UT)	£6.1m / 27 pts

- To: • Chief executives of all NHS trusts and foundation trusts
- CCG accountable officers
 - GP practices and PCNs
 - Providers of community health services
 - NHS111 providers
 - PCN-led local vaccination sites
 - Vaccinations centres
 - Community pharmacy vaccination sites
 - ICS and STP leads

NHS England and NHS Improvement
Skipton House
80 London Road
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13 December 2021

- cc. • NHS regional directors
- NHS regional directors of commissioning
 - Regional incident directors
 - Regional heads of EPRR
 - Chairs of ICSs and STPs
 - Chairs of NHS trusts, foundation trusts and CCG governing bodies
 - Local authority chief executives and directors of public health

Dear Colleagues,

Preparing the NHS for the potential impact of the Omicron variant and other winter pressures

Thank you for everything you and your teams have done since the COVID-19 pandemic began to treat those with the virus, including over half a million people who have needed specialist hospital care, as well as delivering the largest and fastest vaccination programme in our history. This is while maintaining urgent non-COVID-19 services and now working to recover the backlogs that have inevitably built up, providing around 90% of pre-pandemic levels of activity this year, despite continuing to care for thousands of hospital inpatients with COVID-19 over that period.

The discovery of the Omicron variant once again requires an extraordinary response from the NHS. Last night, the Prime Minister announced the new vaccination challenge which will see the NHS deliver more vaccines over the coming weeks than ever before, and will require us to prioritise activities to deliver this.

However, even with the additional protection that vaccine boosters will give, the threat from Omicron remains serious. The UK chief medical officers on 12 December increased their assessment of the COVID-19 threat level to 4, and advice from SAGE is that the number of people requiring specialist hospital and community care could be significant over the coming period.

In light of this, we are again **declaring a Level 4 National Incident**, in recognition of the impact on the NHS of both supporting the vital increase in the vaccination programme and preparing for a potentially significant increase in COVID-19 cases.

This letter therefore sets out important actions we are now asking every part of the NHS to put in place to prepare for and respond to the Omicron threat.

These will:

- Ensure the successful ramp up of the vital COVID-19 vaccine programme.
- Maximise the availability of COVID-19 treatments for patients at highest risk of severe disease and hospitalisation.
- Maximise capacity across acute and community settings, enabling the maximum number of people to be discharged safely and quickly and supporting people in their own homes.
- Support patient safety in urgent care pathways across all services and manage elective care.
- Support staff, and maximise their availability.
- Ensure surge plans and processes are ready to be implemented if needed.

1. Ensure the successful ramp-up of the vital COVID-19 vaccine programme

You will be aware of the Prime Minister's announcement yesterday outlining the latest situation with regards to the Omicron and other variants. The Prime Minister launched an urgent national appeal calling for people to get vaccinated and set out the commitment that all adults in England would be offered a booster jab by the end of the year.

In just over a year since the vaccination programme was launched, more than 100 million jabs have been given. In their December update, the UKHSA estimated that, as of 24 September, 127,500 deaths and 24,144,000 infections had been prevented as a result of the COVID-19 vaccination programme. This is a remarkable achievement, but the urgency of this new national mission requires the NHS to once again step up to support an immediate, all out drive to protect the health of the nation.

A separate letter will set out the immediate next steps for the vaccination programme, describing the ask of systems including:

- Clinically prioritising services in primary care and across the NHS to free up maximum capacity to support the COVID-19 vaccination programme over the next few weeks, alongside delivering urgent or emergency care and other priority services. As the Prime Minister said, this means some other appointments will need to be postponed.
- Delivering at scale whilst also retaining the focus on vaccination of those at greatest risk, including those who are housebound. Continuing to maximise uptake of first and second doses including through identifying dedicated resources to work alongside directors of public health locally.
- Creating capacity, both by maximising throughput, efficiency and opening times of existing sites to operate 12 hours per day as standard, seven days per week as well as running 24 hours where relevant for the local community, and through opening additional pop-up and new sites.
- Increasing training capacity with immediate effect to support lead employers with rapid onboarding and deployment of new vaccinators.

The letter also describes support available including a removal of the current cap on spend against the budget for programme costs, additional vaccine supply and significant expansion of volunteering and recruitment activity.

The NHS has been clear that staff should get the life-saving COVID-19 vaccination – and that is even more important now – to protect themselves their loved ones and their patients, and the overwhelming majority have already done so.

Working with NHS organisations, we will continue to support staff who have not yet received the vaccine to take up the evergreen offer of COVID-19 vaccination. NHS England has released [resources](#) on how to help engage and communicate with staff to encourage vaccine uptake within your organisations. We also recommend that CQC regulated services review the new [Planning and Preparation guidance](#) which will help organisations prepare for when the regulations (which are subject to parliamentary passage) are introduced.

Flu can be a serious illness for some people and the flu vaccine provides vital extra protection as well as minimising transmission. NHS staff should take every opportunity to encourage patients, [including pregnant women](#), to receive their COVID-19 and flu

vaccines if they are eligible. Healthcare colleagues are asked to make every contact count this winter with pregnant women – and those planning pregnancy – to advise them of the benefits of COVID-19 and flu vaccination.

2. Maximise the availability of COVID-19 treatments for patients at highest risk of severe disease and hospitalisation

Having discovered the efficacy of dexamethasone as a treatment for COVID-19 and begun rolling it out just hours after trial results were announced, saving thousands of lives both here and across the world, the NHS is again at the forefront of new treatments for COVID-19.

The UK was the first country in the world to approve an antiviral (monupiravir) able to be taken at home. It will be available for use by patients at highest risk in the community from 16 December alongside other treatments including monoclonal antibodies. Arrangements for deployment of these treatments was set out in a [letter](#) on 9 December alongside the UK [policy](#) for use.

Local ICS teams should finalise preparations for COVID-19 Medicine Delivery Unit service implementation, working with regions on final assurance of delivery models.

Separately, the Government also announced the [PANORAMIC](#) national study for oral antivirals treatment for at-risk patients. The study will allow medical experts to gather further data on the potential benefits of oral antivirals for the UK's predominately vaccinated population. General practices can refer patients into this study as per the [GP and community pharmacy letter](#).

3. Maximise capacity across acute and community settings, enabling the maximum number of people to be discharged safely and quickly and supporting people in their own homes

The operational imperative is to create the maximum possible capacity within acute care settings to support patient safety in the urgent care pathway, which is currently under significant pressure as the data on ambulance response times and 12 hour waits in A&E shows, to maintain priority access for elective care, particularly P1, P2 and cancer assessment, diagnostics and treatment, and to create capacity to respond to a potential increase in COVID-19 demand.

To that end, you are asked now to work together with local authorities, and partners across your local system including hospices and care homes to release the maximum number of beds (and a minimum of at least half of current delayed discharges) through:

- A) An immediate focus to support people to be home for Christmas. Throughout the period between Christmas and New Year, ensure there is support in place to discharge medically fit patients across all seven days of the week.
- B) Those patients who do not need an NHS bed, because they do not meet the reasons to reside criteria, must be discharged as soon as practically possible. Working with local authorities, every system will need to put in place sufficient measures in order to reduce by half their own number of patients not meeting the reasons-to-reside criteria. This will necessitate senior system leaders across the NHS and local authorities meeting daily to ensure sufficient progress is made.
- C) A significant proportion of discharge delays are within the gift of hospitals to solve. Hospitals should work to eliminate avoidable delays on pathway zero, ie straight home without the need for social care support. Where necessary, this could include using personal health budgets, which has been successfully piloted in Cornwall and Lancashire; or use of hotel beds.
- D) Making full use of non-acute beds in the local health and care system. NHS England has today switched back on the full use of spare hospice capacity – both beds and community contacts, through the same [national arrangement](#) with Hospice UK that was in place earlier in the year. As well as making use of personal health budgets, [hotel beds](#), and hospices, systems can also make use of independent sector capacity in the community using the following [framework](#). We encourage systems to explore surging community rehabilitation capacity and securing spare capacity from care homes. To support safe discharge of COVID-19 patients, DHSC will be expanding the number of designated beds from CQC accredited providers.
- E) Expanding the use of [virtual wards and hospital at home models](#) with the full confidence of knowing these models will be supported in forthcoming planning guidance with significant additional funding, to enable a major expansion over the next two years.

Systems already have access to resources within core funding, COVID-19 allocations and through the Hospital Discharge Programme to fund these measures. Where systems can show further funding is necessary in addition to existing budgets then, to facilitate this drive, NHS England will fund additional costs incurred. Commissioners and providers

should notify regional teams of the estimated additional cost and bed benefit as plans are firmed up and claim the actual cost through the existing quarterly claims process.

The NHS will need to increase its effective capacity next year and we are planning on ring-fencing significant national funding for the further development of virtual wards (including hospital at home). Therefore, where steps taken now on virtual wards can have an enduring benefit to overall capacity and have recurrent costs those should be notified at the same time so that we can allow for them on top of core system allocations for 2022/23.

To facilitate this drive, and maintain it thereafter through winter and into next year:

- the Government has announced a further additional £300 million support for domiciliary care workforce, to boost capacity, on top of the existing £162 million workforce scheme.
- A new national discharge taskforce including the NHS, ADASS, national and local government, led by Sarah-Jane Marsh, has been established. Working to both DHSC and NHS England, it will focus on the local authority and NHS actions required to drive progress. This will dock with enhanced regional and local system arrangements that need to be put in place.

4. Support patient safety in urgent care pathways across all services, and manage elective care

Ambulance response: Systems must focus on eliminating ambulance handover delays in order to ensure vehicles and paramedic crews are available to respond to urgent 999 calls as set out in the letter of 26 October, and take action to see patients quickly and avoid 12 hour waits in emergency departments. Working with health, social care, voluntary sector partners and CQC, systems should take a balanced view of risk and safety across all parts of the health system, recognising that the greatest risk may be the patient waiting for an ambulance response.

Prioritising the recruitment of 999 and 111 call handling capacity will be crucial to ensure patients have rapid access into urgent and emergency care services when required. It is therefore important that Regions work closely with Ambulance Trusts and 111 providers to monitor progress on a weekly basis.

Community crisis response: Local systems should take immediate steps to maximise referrals from 999 to the two-hour Urgent Community Response services. Good progress has been made in developing and rolling out UCR services across England faster than

planned trajectories, with 27 ICSs now providing UCR services 8-8pm seven days a week.

Further expansion and join-up with other services is needed now, as part of a wider drive to reduce ambulance response times and support people in their own homes. Systems should:

- Where possible, accelerate coverage and capacity of UCR services in line with the [2 hour guidance](#), to make an impact in January. This includes supporting equipment purchases such as lifting chairs and point of care testing equipment.
- Maximise the number of patients being referred and transferred to UCR from ambulance services.
- Work together with local councils and providers of local pendant alarm/Technology Enabled Care (TEC) providers and reduce the demand on 999 ambulance services through the re-direction of appropriate patients.
- Refresh your local [Directory of Services \(DoS\)](#) so that NHS Service Finder profiles are accurate, up to date and are updated to show that UCR teams will accept referrals from health & social care colleagues including TEC providers.
- Ensure accurate and complete data to via the Community Services Data Set for UCR, so you can track how much the services are being used and helping reduce pressures.

Further information, webinar recordings and tools, such as legal advice, information governance documents and case studies, are available on the [Urgent Community Response FutureNHS platform](#).

Mental health, learning disability and autism: The pandemic has had an impact on the nation's mental health, disrupting daily routines. In response, the NHS has extended mental health support, including introducing 24/7 all-age mental health crisis support lines earlier than planned, and continued to expand services to meet growing need in line with the Long-Term Plan.

Systems are asked to ensure that access to community-based mental health services and learning disability and autism services are retained throughout the COVID-19 surge to ensure that people at risk of escalating mental health problems and those who are most vulnerable can access treatment and care and avoid escalation to crisis point, with face-to-face care retained as far as possible.

Healthcare colleagues are asked to make every contact count this winter with people with SMI and LD – to ensure promotion of health checks and interventions as well as

access to COVID-19 and flu vaccination, in the context of stark health inequalities for these patients.

Managing critical care: Over the course of the pandemic, the NHS showed its determination and flexibility time and time again, not least in rapidly expanding critical care capacity. Indeed, the Health and Social Care Select Committee wrote in their recent report on lessons learned to date that it was ‘a remarkable achievement for the NHS to expand ventilator and intensive care capacity’.

We do not know what the demand from Omicron will be on critical care facilities, but it is essential that trusts familiarise themselves with existing plans for managing a surge in patients being admitted with COVID-19, with particular focus on the management of oxygen supplies, including optimising use at ward level. This work should also include a review of how critical care capacity can be expanded and of surge arrangements in critical care networks – acknowledging these will already have been activated in some parts of the country. Further guidance on surge planning will be published based on good practice from the early phases of the pandemic.

Managing elective care: As in the COVID-19 wave last winter, it is crucial that we continue to deliver elective care and ensure that the highest clinical priority patients – including patients on cancer pathways and those with the longest waits – continue to be prioritised. Once again, clinical leadership and judgement about prioritisation and risk will be essential.

There are now 6 million patients waiting for elective care, of whom 16 thousand have been waiting over 104 weeks, as a result of the inevitable disruption caused by the COVID-19 pandemic. It is therefore even more important that diagnostic, first outpatient, elective inpatient and day case capacity should be maintained as far as possible, recognising the requirement to release staff to support the vaccination programme and respond to the potential increase in COVID-19 cases. Systems and NHS trusts should work collaboratively, particularly using the provider collaborative arrangements you have in place to prepare elective contingency plans against different COVID-19 scenarios for discussion and agreement with Regions.

A key feature of plans should be the separation of elective and non-elective capacity where possible, and the use of mutual aid between trusts and across systems and regions where necessary to maintain access to urgent elective care. You should maintain your focus on eliminating waits longer than two years, as set out in H2 planning guidance as far as possible.

Independent sector (IS): Local systems need to significantly step up use of available capacity in the independent sector to help maintain services. IS capacity should be one of the main protected 'green' pathways for treating elective patients during the final quarter of this year. Systems should take action now to agree plans with your local IS providers, building on existing H2 plans, to maximise use of local IS capacity so that as many patients can be treated as possible through the IS route. This should include, where clinically appropriate, additional pathways including cancer.

Any work will be funded consistent with original H2 planning guidance.

Primary care: The vaccination ramp up is the current priority for primary care, supported by the additional funding already announced and changes to GP contract arrangements. Continued access to general practice remains essential for those who need care and the £250 million Winter Access Fund remains available through systems to support general practice capacity more generally, including through the use of locums and support from other health professionals.

Cancer: local systems should stress test their plans to confirm that the elements that helped to sustain cancer services in previous waves are in place, and to ensure that:

- rapid access, including tests and checks for patients with suspected cancer, as well as screening services, are maintained
- provision for P1 and P2 cancer surgery is prioritised
- cancer surgical hubs have been established with cancer surgery consolidated on COVID-19-protected sites, and that centralised triage is in place across local systems to prioritise patients based on clinical need
- arrangements are in place to centralise high volume or high complexity work such as upper GI or head and neck surgery
- local systems have adapted cancer pathways in line with the advice on streamlining cancer diagnostic pathways and keeping them COVID-19-protected
- local systems are maximising the use they make of IS capacity for cancer services, where clinically appropriate
- effective communications with patients and safety netting is in place, and patients are involved in decisions around their care, including when they chose to reschedule
- anyone with concerning symptoms is encouraged to come forward, in line with our 'Help us, Help You' messages.

5. Support staff, and maximise their availability

The experience of the pandemic has shown, once more, that the NHS is nothing without its exceptional staff. NHS staff have been severely tested by the challenges of dealing with the pandemic and it is of vital importance that we collectively support them over the months ahead.

Support for staff to stay well and at work: We also ask you to revisit your staff wellbeing offer to ensure it has kept pace with the changing nature of the pandemic, with a continued focus on ongoing health and wellbeing conversations taking place for staff. Health and wellbeing conversations are the best route for exploring the many drivers and root causes of sickness absence and for offering individualised support to staff where it is needed, including with work pressures, worries and relationships.

Employers should be ready to communicate any changes in testing and isolation guidance associated with Omicron as we learn more, as these may well evolve, and to offer staff options wherever possible to continue to contribute when they are unable to come into work, if they are able to do so. In addition, organisations should consider contingency options for significant staff absences to ensure essential services can be maintained.

The pandemic has had a disproportionate impact on our staff from ethnic minority communities. It is therefore vital that as we prepare for this next phase, we take action to address systemic inequality that is experienced by some of our staff including by allowing staff network leads the dedicated time they need to carry out this role effectively. We will continue to collect and publish data on the experiences of our ethnic minority colleagues via the Workforce Race Equality Standard (WRES).

Mental health and wellbeing support: We have strengthened the mental health [support offer for health and social care staff](#) to ensure they can get rapid access to assessment and evidence-based mental health services and support as required.

This includes your own occupational health services as well as the 40 local staff mental health and wellbeing hubs across the country which provide proactive outreach and clinical assessment, and access to evidence-based mental health services and support where needed.

Please continue to promote the mental health hubs and the confidential helplines that are available for all staff, and in particular the bereavement helpline (0300 303 4434, 8am-8pm) to support staff who may have been affected by the death of patients and colleagues.

Workforce planning, flexibility and training: System leaders and NHS organisations should review workforce plans for the next three months to ensure that, as per your surge plan testing, you have the appropriate workforce in place to deal with an increase in the number of COVID-19 patients and are able to support the ramp up of the COVID-19 vaccination programme. Organisations should continue to use their staff flexibly to manage the most urgent priorities, working across systems as appropriate.

Where staff require particular support or training to enable their potential redeployment, including for vaccination or to support critical care services, please use the next few weeks to provide this.

Recruitment: Trusts should seek to accelerate recruitment plans where possible, [including for healthcare support workers](#), and where possible bringing forward the arrival of internationally recruited nurses, ensuring they are well supported as they start work in the NHS.

Volunteers: Volunteers play an important part in supporting patients, carers and staff over winter months. In particular, there are a number of high-impact volunteer roles which free up clinical time for clinical tasks, improve communication with families and assist with discharge, and support staff wellbeing. Although volunteers have been active in many NHS trusts, many more experienced volunteers are willing to help yet remain inactive. Trusts are encouraged to take advantage of the available support to restore volunteering and strengthen volunteer management in ways which can contribute significantly to reducing service pressures, including NHS Reserves.

6. Ensure surge plans and processes are ready to be implemented if needed

Incident Co-ordination: In light of the move to a Level 4 national incident, systems and NHS organisations will need to review incident coordination centre arrangements, and should ensure that these are now stood up, including to receive communication and act as the single point of contact.

Surge Plans: As we have done previously, we are asking all systems and NHS organisations to review and test their incident management and surge plans to assess their number of beds (G&A, community and critical care), supplies and staffing, learning the lessons from previous waves of COVID-19, and making preparations to have the capacity in place to meet a potentially similar challenge this winter.

Systems should ensure that preparedness includes making plans to deliver the services needed to vulnerable groups within systems as well as maintaining essential services in primary, community, mental health and learning disability and autism services.

To support regional and national planning, we will ask you to submit your identified maximum capacity, including your plans for critical care capacity, by 17 December.

These plans should detail the incident coordination arrangements, including leadership roles and responsibilities, hours of operation of the incident coordination centre, including out-of-hours contact arrangements. The plans should also detail how organisations will deal with timely information/SitRep reporting.

We will keep under review the timing and scope of the regular sitrep returns and we ask for your cooperation in continuing to make timely returns as requested.

Supplies: As a result of the work undertaken over the past 18 months, nationally held stock levels are more than adequate to respond to any additional increases in demand caused by a new variant. You should maintain normal ordering patterns and behaviours. In advance of the Christmas period, you may wish to review your local current stock levels particularly oxygen supplies, medical equipment and relevant consumables and it is key that you connect into the regional incident arrangements as and when needed.

Oxygen: In addition, through the testing of your surge plans, trusts must ensure that their oxygen delivery systems and infrastructure are able to bear at least the same level of demand when COVID-19 inpatients were at their highest point, and that any improvements or adaptations identified as necessary have been put in place.

Infection prevention and control: Staff and organisations should continue to follow the recommendations in the [UK Infection Prevention and Control \(IPC\) guidance](#). According to research, [IPC measures prevented 760 in-hospital COVID-19 infections each day in wave 1](#). Organisations must ensure that application of IPC practices is monitored using the IPC Board Assurance Framework and that resources are in place to implement and measure adherence to good IPC practice.

The past two years have arguably been the most challenging in the history of the NHS, but staff across the NHS have stepped up time and time again to do the very best for the nation – expanding and flexing services to meet the changing demands of the pandemic; introducing new treatments, new services and new pathways to respond to the needs of patients with COVID-19 and those without; pulling out all the stops to recover services that have been disrupted, whilst rolling out the largest and fastest vaccination programme in our history. The Omicron variant presents a new and significant threat, and the NHS must once again rise to the national mission to protect as many people as possible through the vaccination programme whilst also now taking steps to prepare for and respond to this threat.

Thank you for everything you have done and continue to do – as we have said before, this is a time when the NHS will benefit from pulling together again in a nationally co-ordinated effort, but please be assured that within the national framework you have our backing to do the right thing in your particular circumstances.

We look forward to speaking to you at the virtual regional events later this week and will keep in regular contact over the coming weeks and months.

Yours sincerely,

A handwritten signature in black ink, appearing to read 'A. Pritchard'.

Amanda Pritchard
NHS Chief Executive

A handwritten signature in black ink, appearing to read 'Stephen Powis'.

Professor Stephen Powis
Chief Executive of NHS Improvement

To: • ICS and STP leads

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- cc. • CCG accountable officers
- PCN-led local vaccination sites
 - Community pharmacy-led LVS
 - All NHS trust and foundation trust chief executives
 - NHS regional directors
 - NHS regional directors of commissioning
 - All directors of public health
 - All local government chief executives
 - All GP practices

13 December 2021

Dear Colleagues,

National call: Next steps for the NHS COVID-19 vaccine deployment

You will have seen the Prime Minister's address to the nation last night on the latest situation with regards to the Omicron and other variants. Yesterday, the chief medical officers also recommended that the alert level is raised from three to four.

We are writing to you now to ask you once again to support an immediate, all out drive to protect the health of the nation.

Immediate next steps for deployment

The NHS has been asked to offer every eligible adult over the age of 18 a booster vaccination by 31 December. To respond to this national mission, all systems are now asked to work with system partners, including local authorities, other public sector organisations and the voluntary and community sector, to prioritise delivery.

All NHS and local government organisations need to prepare to redeploy their administrative and clinical staff to support delivery of the vaccination programme between now and the new year. CCGs, should do all they can to offer immediate additional administrative support to all PCN and CP sites, to support the organisation and delivery of community outreach vaccination through the use of mobile and pop up clinics.

All General practice teams (not just LVS sites) are now asked to clinically prioritise your services to free up maximum capacity to support the COVID-19 vaccination programme alongside delivering urgent or emergency care and other critical services such as cancer. That could include pausing routine and non-urgent care and redeploying staff to support delivery of COVID-19 vaccinations. Further guidance will follow in an operational note and from RCGP and BMA. **All community pharmacy sites** will be supported to extend their opening hours and ensure they can deliver at their maximum capacity. Further detail will follow in an operational note. **All NHS trusts, including secondary, community and mental health providers**, will need to make alternative arrangements for prescription and sick note requests that are usually sent to primary care. As the Prime Minister said last night, this means that some other appointments will need to be postponed to the new year. If we don't do this now, the wave of Omicron could be so big that cancellations and disruptions would be even greater. We will work with you to ensure consistent messaging to the public to reflect this.

To support the rollout, the Care Quality Commission has confirmed it will postpone on-site inspections in mainstream NHS services for three weeks (ie hospitals, ambulances, GPs, 111), **except** in cases where we have reason to believe serious failings in safety pose a risk to life, or serious harm.

Prioritisation of vaccination

Scientists are very concerned about the spread of Omicron due to the speed with which it spreads and because two doses do not appear to provide much protection, threatening a new wave of infections, hospitalisations and deaths greater even than those seen in previous waves. Thankfully, a booster dramatically improves protection which is why we need to do all in our power to deliver top up jabs and reduce the impact of Omicron.

The JCVI are clear that those at greatest risk must be prioritised, including those residing and working in care homes, health and care staff, those who are housebound, and those severely immunosuppressed.

As the NHS opens bookings to all adults over 18 for a booster by Wednesday 15 December, all systems are asked to ensure that they are both able to deliver at scale and retain their focus on reaching the most vulnerable and ensuring access for all communities. Therefore, all systems are asked to ensure GP-led and community pharmacy-led teams are supported to complete care home and housebound vaccination as soon as possible, preferably by the end of week commencing 13 December as previously advised.

Now is the time to pull out all of the stops to ensure maximum uptake, including first and second doses. Every system, working with their directors of public health and local authority leads, should continue to offer mobile and pop up clinics, community engagement and to support access (eg providing community transport). To do this, all systems are now asked to identify dedicated resource (vaccine, vaccinators and any further resource) work side by side with directors of public health to reach those still yet to have a first or second dose. Funding is available to support this through ICSs, and requests will be processed speedily.

Creating capacity

The immediate priority for all sites is to stand up additional capacity to support this major acceleration. This will need to include maximising throughput and efficiency at existing sites, opening additional pods and extending opening times. Sites should request resources to enable them to operate 12 hours a day as standard, seven days a week. In every community there should be slots available at least 16 hours a day. This should extend to 24 hour operations where relevant for the local community. In earlier phases this was particularly helpful for those working shifts.

Do Not Attend rates are currently running nationally at around 10 per cent so all sites are now asked to review their DNA rates and adjust capacity uploaded to the National Booking Service accordingly. From today, the NBS will automatically cancel appointments where an individual has already received a booster dose and we will continue to encourage the public to remember to cancel if they receive a vaccine at a walk in or at their local GP-led site.

All vaccination sites, including hospital hubs, should be utilising the national protocol as the default legal mechanism to deliver the vaccine programme as it gives the greatest opportunity to utilise the unregistered workforce and create additional vaccinating capacity.

As well as creating capacity for those aged 18 years and over, all systems must ensure that eligible children are able to access vaccination. Guidance for systems on vaccination for 12-15s, including delivery of second doses, will be issued shortly.

Workforce

Lead employers will continue to co-ordinate the workforce, and will now implement a push of workforce out to systems, rather than a traditional demand-led approach. Each lead employer will have up to three military personal deployed to further support co-

ordination and delivery. A full list of lead providers and their contact details are [set out here](#) on NHS Futures, and have been provided alongside the cascade of this letter.

All NHS providers need to be prepared to redeploy staff to support the vaccination effort. All NHS providers are now asked to share their workforce availability, and a dedicated point of contact, with their lead employer.

Systems will need to release additional workforce beyond those currently working on the vaccination programme. Wider public sector organisations, including local authorities, fire and rescue and police forces are also asked to identify and release any staff members who are trained vaccinators.

NHS Professionals and St John Ambulance continue to accelerate recruitment and re-engagement. Details of the workforce will be shared with lead employers as it becomes available including offers to support housebound and care home vaccination from St John Ambulance.

All national health bodies are working at pace to share expressions of interest from their employees with lead employers. The civil service has also started a push of people to register with St John Ambulance, NHS Professionals and the Royal Voluntary Service as appropriate.

To ensure we have a safe and competent workforce, additional training capacity will be required. Systems are therefore asked to increase their training capacity with immediate effect to support lead employers with rapid onboarding and deployment.

Vaccine supply, equipment and estates

There are no supply challenges with either the Moderna or Pfizer booster stocks and vaccine supply will be pushed manually from Tuesday to enable you to increase capacity as quickly as possible.

This approach will ensure more than 8.9m doses of Pfizer and Moderna will be available across the network (3.2m already on site; 2.1m in immform; 3.6m planned (minimum additional supply). For VCs and HHs, additional vaccine supply has now been made available on immform.

For PCN and CP-led LVS, regional teams have been asked to provide details for sites that require additional deliveries on Thursday and Friday this week. All sites expecting a delivery on Tuesday can expect their volume doubled, for some sites this will arrive on

Tuesday for others an additional delivery day will be allocated later this week. Further detail will be communicated in an operational note.

For unexpected levels of demand, for example for pop up and mobile clinics, mutual aid policies can be found [here](#). These existing policies allow movement of sufficient vaccines between end users, in quantities sufficient to meet demand and permits movement under NHS England and NHS Improvement direction; NHS regions should therefore feel empowered in the current circumstances to direct supplies to those areas where they are required.

This guidance is there to support good professional decision making to ensure that patients are vaccinated safely and effectively as well as promptly and therefore, it is for pharmacy professionals at a local level to determine what's best to do. If you require additional vaccine supply, please follow the usual processes.

Local authorities are asked to identify opportunities to use existing estate to offer vaccination centres and mobile clinics, drawing on their knowledge and understanding of their local communities. As the school term comes to an end, schools and school halls should be considered.

We recognise that smaller sites are limited by estate, especially in the colder months. Therefore, if you require temporary buildings such as Portakabins, tents, outdoor weather-protective cover to support queues or extended estate, please flag your requirements as soon as possible to your SVOC.

Finance

Recognising this sprint into the New Year will require additional support, additional funding has been requested from HMT, and this framework allows for the current cap on spend against the budget for programme costs to be removed. This means programme resources can be sourced and deployed to support delivery with immediate effect.

The support of local authorities in delivering facilities and resources has been critical to success. To ensure local authorities can continue to support, funding can be made available to support enhancement of the vaccination programme. Where costs are agreed between the local authority and ICS, local authorities should invoice the lead CCG for their ICS system and continue to report costs incurred to the Department for Levelling Up, Housing and Communities to support appropriate accounting and analysis.

Further details including details on contracting, estates and consumables, will shortly be shared with regional directors of finance and directors of finance for local authorities.

Thank you in advance for everything you are doing to continue to deliver the vaccination programme.

Yours sincerely,



Amanda Pritchard
Chief Executive Officer
NHS England and NHS Improvement



Emily Lawson
NHS Senior Responsible Officer, Vaccine
Deployment



Eleanor Kelly
LA CEO Advisor



Dr Nikita Kanani
Medical Director for Primary Care
NHS England and NHS Improvement

- To:
- Chief executives of all NHS trusts and foundation trusts
 - CCG accountable officers
 - GP practices and PCNs
 - Providers of community health services
 - NHS 111 providers
 - PCN-led local vaccination sites
 - Vaccinations centres
 - Community pharmacy vaccination sites
 - ICS and STP leads

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

24 December 2021

- cc.
- NHS regional directors
 - NHS regional directors of commissioning
 - Regional incident directors
 - Regional heads of EPRR
 - Chairs of ICSs and STPs
 - Chairs of NHS trusts, foundation trusts and CCG governing bodies
 - Local authority chief executives and directors of public health

Dear Colleague

Reducing the burden of reporting and releasing capacity to manage the COVID-19 pandemic

Once again, the NHS is facing a significant challenge from COVID-19. As we continue to manage infections from the Delta variant, the Omicron variant is growing substantially and once again there is a risk of significant levels of COVID-19 hospitalisations with the challenges these place across the whole NHS. At the same time, the NHS is delivering a national COVID booster vaccination programme and continuing to provide essential non-COVID care.

This letter should be read in conjunction with [‘Preparing the NHS for the potential impact of the Omicron variant and other winter pressures’](#), which declared a Level 4 National Incident.

Following our letters in [March](#) and [July](#) last year and [January](#), this letter updates our position on regulatory and reporting requirements for NHS trusts and foundation trusts, including:

- streamlining oversight meetings
- streamlining assurance and reporting requirements
- providing greater flexibility on various year-end submissions
- focusing our improvement resources on COVID-19, vaccination, discharge, UEC and elective recovery priorities
- only maintaining development workstreams that support recovery and safety.

Our intention is that the measures here will collectively help you free up resource to address the priorities we have set out.

We will keep this under close review, making further changes where necessary to support you and remaining mindful of the balance between timely information and not flooding the service with requests. We will review and update the measures set out in this letter in Q1 2022/23.

Once again, we appreciate the incredible level of commitment and hard work from you and your teams that has helped the NHS rise to meet the challenge of COVID-19 since March 2020.



Sir David Sloman

Chief Operating Officer

NHS England and NHS Improvement

A) Governance and meetings

No.	Areas of activity	Detail	Actions
1.	Board and sub-board meetings	<p>Trusts and CCGs should continue to hold board meetings but streamline papers and focus agendas. No sanctions for technical quorum breaches (eg because of self-isolation).</p> <p>For board committee meetings, trusts should continue quality committees, but consider streamlining other committees.</p> <p>While under normal circumstances the public can attend at least part of provider board meetings, government social isolation requirements constitute 'special reasons' to avoid face-to-face gatherings as permitted by legislation.</p> <p>All system meetings to be virtual unless there is a specific business reason to meet face to face.</p>	Organisations to inform audit firms where necessary
2.	FT governor meetings	Face-to-face meetings should be stopped wherever possible at the current time ¹ – virtual meetings can be held for essential matters e.g. transaction decisions. FTs must ensure that governors are (i) informed of the reasons for stopping meetings and (ii) included in regular communications on response to COVID-19, eg via webinars/emails.	FTs to inform lead governor
3.	FT governor and membership processes	<p>FTs free to stop/delay governor elections where necessary.</p> <p>Annual members' meetings should be deferred.</p> <p>Membership engagement should be limited to COVID-19 purposes.</p>	FTs to inform lead governor
4.	Annual accounts and audit	Wherever possible the NHS England and NHS Improvement accounts team will reduce the administrative burden of year-end accounts as far as is possible, but the current intention is to stick with the published timetable. We will, as ever, remain responsive to challenges as they emerge.	Organisations to continue with year-end planning in light of updated guidance
5.	Quality accounts – preparation	The deadline for quality accounts preparation of 30 June is specified in Regulations. As in previous years, we intend to write to all providers concerning the requirements for 2021/22 Quality Accounts.	No action for organisations at the current time

¹ This may be a technical breach of foundation trusts' constitution but acceptable given government guidance on social isolation.

No.	Areas of activity	Detail	Actions
6.	Quality accounts and quality reports – assurance	We are removing requirements for FTs to include quality reports within their 2021/22 annual report and removing the need for assurance of quality reports and quality accounts from all trusts.	Organisations to inform external auditors where necessary
7.	Annual report	We wrote to the sector on 15 January 2021 confirming that the options available to simplify parts of the annual report that were introduced in 2019/20 and kept for 2020/21 are available for 2021/22.	Organisations to continue with year-end planning in light of updated guidance
8.	Decision-making processes	While having regard to their constitutions and agreed internal processes, organisations need to be capable of timely and effective decision-making. This will include using specific emergency decision-making arrangements.	

B) Reporting and assurance

No.	Areas of activity	Detail
1.	Constitutional standards (eg A&E, RTT, cancer, ambulance waits, mental health and learning disability measures)	See Annex A
2.	Friends and Family Test	Reporting requirement to NHS England and NHS Improvement has been resumed. Note that trusts have flexibility to change their arrangements under the new guidance, and published case studies show how trusts can continue to hear from patients while adapting to pressures and needs. We emphasise local discretion.
3.	Long Term Plan: mental health	NHS England and NHS Improvement will maintain the Mental Health Investment Guarantee. As a foundation of our COVID-19 response, systems should continue to expand services in line with the LTP.
4.	Long Term Plan: learning disability and autism	Systems should continue learning disability and autism investment and transformation to support the LTP.
5.	Long Term Plan: cancer	NHS England and NHS improvement will maintain their commitment and investment through the Cancer Alliances and regions to improve survival rates for cancer. We will work with Cancer Alliances to prioritise delivery of commitments that free up capacity and slow or stop those that do not, in a way that will release necessary resource to support the COVID-19 response

No.	Areas of activity	Detail
		and restoration and maintenance of cancer screening programmes (including bowel and targeted lung checks) and symptomatic pathways.
6.	Long Term Plan: maternity and neonatal	<p>Systems should ensure that maternity services can operate safely in the pandemic context and continue to implement initiatives which support this, such as Saving Babies' Lives and the seven Immediate and Essential Actions from the Ockenden report.</p> <p>We will work with local maternity systems to prioritise delivery of commitments that free up capacity and slow or stop those that do not, in a way that will help them to maintain safe services. This will include reviewing planning milestones, such as submission of plans to roll out continuity of carer and improve equity.</p>
7.	GIRFT and transformation programmes	<p>Routine GIRFT visits to trusts have been stood down with resources concentrated on supporting hospital discharge co-ordination and HVLC work.</p> <p>National transformation programmes (outpatients, diagnostics and pathways) now focus on activity that directly supports the COVID response or recovery, eg video consultation, personalised outpatients and patient-initiated follow-up, maximising diagnostics and clinical service capacity, supporting discharge priorities, etc.</p>
8.	NHS England and NHS Improvement oversight meetings	Oversight meetings will continue to be held by phone or video conference unless it is agreed that there is a compelling business reason to hold them face-to-face, and they will focus on critical issues. Teams will also review the frequency of these meetings on a case-by-case basis to ensure it is appropriate, streamlining agendas to focus on COVID-19 issues/discharge/recovery/ winter and support needs.
9.	ICS development activity	System working is essential in managing the response to COVID-19 and delivering the NHS's priorities in 2022/23. Work to establish ICSs – and ICBs as statutory NHS bodies – continues, with a revised target date of July 2022. This will allow sufficient time for the remaining parliamentary stages of the Health and Care Bill and provide some extra flexibility for systems in preparing for the new statutory arrangements and managing the immediate priorities in the pandemic response.
10.	Corporate data collections (eg licence self-certs, annual governance statement, mandatory NHS Digital submissions)	<p>Look to streamline and/or waive certain elements.</p> <p>Delay the forward plan documents FTs are required to submit.</p> <p>We will work with analytical teams and NHS Digital to suspend agreed non-essential data collections.</p>

No.	Areas of activity	Detail
11.	CQC routine assessments, Use of Resources assessments, HSIB investigations	With CQC, we continue to prioritise our Recovery Support Programme work to give the appropriate support to the most challenged systems to help them manage COVID-19 pressures. CQC has suspended routine assessments and currently uses a risk-based transitional monitoring approach. NHS England and NHS improvement continue to suspend the Use of Resources assessments in line with this approach. Visits and inspections in connection with HSIB investigations will also be reduced.
12.	Provider transaction appraisals – mergers and subsidiaries Service reconfigurations	Potential for NHS England and NHS Improvement to deprioritise or delay transactions assurance if in the local interest given COVID-19 factors. Urgent temporary service changes on safety grounds in response to COVID-19 or other pressures can still be made with agreement from system partners. Should systems look to make these permanent, normal reconfiguration assurance processes will apply at a later stage.
13.	7-day services assurance	No changes – self-cert statements to continue.
14.	Clinical audit	Given the importance of clinical audit in COVID and non-COVID care, clinical audit platforms will remain open for data collection. It should be noted clinical teams should always prioritise clinical care over data collection and submission.
15.	Pathology services	We need support from providers to manage pathology supplies which are crucial to COVID-19 testing. Trusts should not penalise those suppliers who are flexing their capacity to allow the NHS to focus on COVID-19 testing equipment, reagent, and consumables. Trusts must also continue to support the prioritisation of covid testing and genotyping services within their own laboratories.

C) Other areas including primary care, HR and staff-related activities

No.	Areas of activity	Detail
1.	Mandatory training	With staff absences likely to rise, new training activities – eg refresher training for staff and new training to expand the number of ICU staff – are likely to continue to be necessary. Reduce other mandatory training as appropriate.
2.	Appraisals and revalidation	Professional standards activities may need to be reprioritised: eg appraisals can be postponed or cancelled. Appraisal is a support for many doctors, so it is helpful to keep the option available, but if going ahead, please use the shortened Appraisal 2020 model. Medical directors may also use discretion to decide which concerns require urgent action and which can be deferred.

		The Nursing and Midwifery Council (NMC) has also extended the revalidation period for current registered nurses and midwives by an additional three months for those due to revalidate between December 2021 and March 2022.
3.	Primary care	We have already announced a series of changes to GP contract arrangements and some changes for community pharmacy .
4.	CCG clinical staff deployment	Review internal needs to retain a skeleton staff for critical needs and redeploy the remainder to the frontline. CCG governing body GPs to focus on primary care provision and booster campaign.
5.	Repurposing non-clinical staff from CCGs	Non-clinical staff to focus on supporting primary care and providers to maintain and restore services and the vaccine booster programme.
6.	Enact business critical roles at CCGs	To include support and hospital discharge, EPRR etc.

Annex A – constitutional standards and reporting requirements

While existing performance standards remain in place, we continue to acknowledge and appreciate the challenges in maintaining them during the continuing COVID-19 response. Our approach to tracking those standards most directly impacted by the COVID-19 situation is set out below.

A&E and ambulance performance – Monitoring and management against the four-hour standard and ambulance performance continues nationally and locally, to support system resilience.

RTT – Monitoring and management of RTT and waiting lists will continue, to ensure consistency and continuity of reporting and to understand the impact of the suspension of non-urgent elective activity and the subsequent recovery of the waiting list position that will be required. Application of financial sanctions for breaches of 52+ week waiting patients occurring during 2020/21 continue to be suspended. Recording of clock starts and stops should continue in line with current practice for people who are self-isolating, people in vulnerable groups, patients who cancel or do not attend due to fears around entering a hospital setting, and patients who have their appointments cancelled by the hospital.

Discharge – Monitoring and management of delayed discharge for patients who no longer meet the reasons to reside will continue, and from Tuesday 21 December daily calls will take place in every region with every ICS discharge SRO to discuss performance and actions to decrease the number of people with a delayed discharge.

Cancer: referrals and treatments – Cancer treatment remains a priority and should be protected. We will continue to track cancer referral and treatment volumes to provide oversight of the delivery of timely identification, diagnosis and treatment for cancer patients. The Cancer PTL data collection will continue and we expect it to continue to be used locally to ensure that patients continue to be tracked and treated in accordance with their clinical priority.

Screening: cancer (breast, bowel and cervical) and non-cancer (abdominal aortic aneurysm, diabetic eye and antenatal, newborn screening and targeted lung checks) – Screening remains a priority and should be protected.

Immunisations – All routine invitations should continue to be monitored via the NHS England and NHS Improvement regional teams.

The Weekly Activity Return (WAR) will continue to be a key source of national data, and through the urgent and emergency care daily SitRep return we now capture data on the clinical priority ('P code') of elective cancellations and patients who have not yet been booked for treatment. This is vital management information to support our operational response to the pandemic, and we require 100% completion of this data with immediate effect. Guidance can be found [here](#).

Note: it has been necessary to institute a number of additional central data collections to support management of COVID – for example, the daily Covid SitRep and the Critical Care Directory of Service (DoS) collections. These collections continue to be essential during the pandemic response, but to offset some of the additional reporting burden that this has created, the following collections will be suspended:

Title	Designation	Frequency
Critical care bed capacity and urgent operations cancelled	Official Statistics	Monthly
Delayed transfers of care	Official Statistics	Monthly
Cancelled elective operations	Official Statistics	Quarterly
Audiology	Official Statistics	Monthly
Mixed-sex accommodation	Official Statistics	Monthly
Venous thromboembolism (VTE)	Official Statistics	Quarterly
Mental health community teams activity	Official Statistics	Quarterly
Dementia assessment and referral return	Official Statistics	Monthly
Diagnostics weekly PTL	Management Information	Monthly
26-week patient choice offer	n.a. - trial	weekly

(This has already been communicated to data submission leads via NHS Digital.)

Integrated Care: Barnsley Health & Care Plan - Delivery Update (Jan 22)



Introduction

Work continues on mobilisation and delivery of the Barnsley health and care plan, which sets out 25 strategic deliverables partners will work collaboratively to deliver (see slide 3).

In October 2021 the health and care partnership, due to operational pressures re COVID, agreement that programme leads should prioritise work plans for implementation over the Winter period.

Working with programme managers a draft milestone plan has been developed, which sets out the key programme deliverables through 21/22.

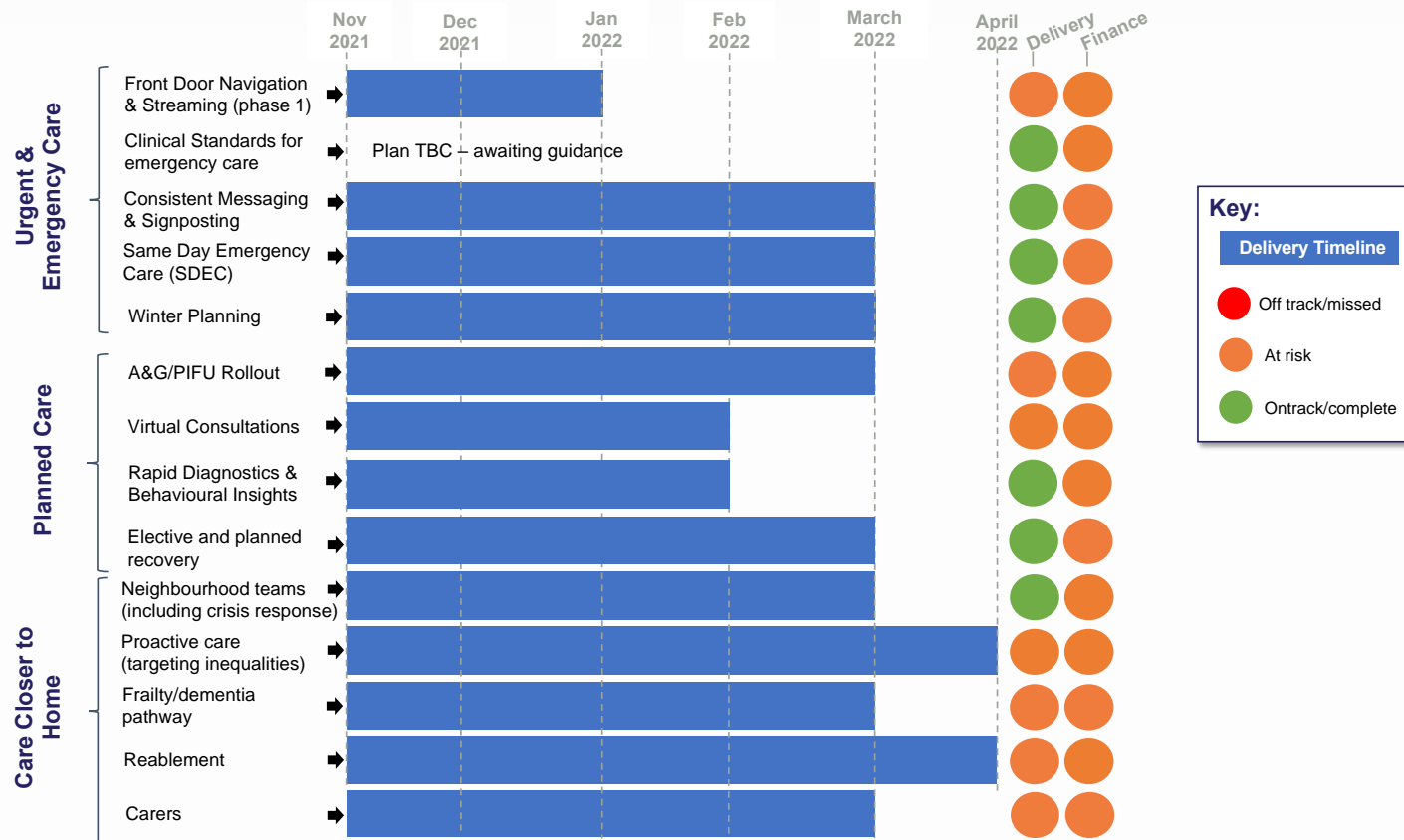
Notwithstanding pressures within the system, progress continues to be made across a number of areas.

The programme priorities and status of these in terms of delivery & finance are summarised overleaf. The focus for the plan in 21/22 is on operational delivery, rather than efficiency. This will be a key focus for the 22/23 plan – see next steps on slide 7.

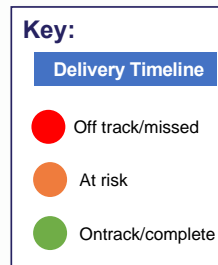
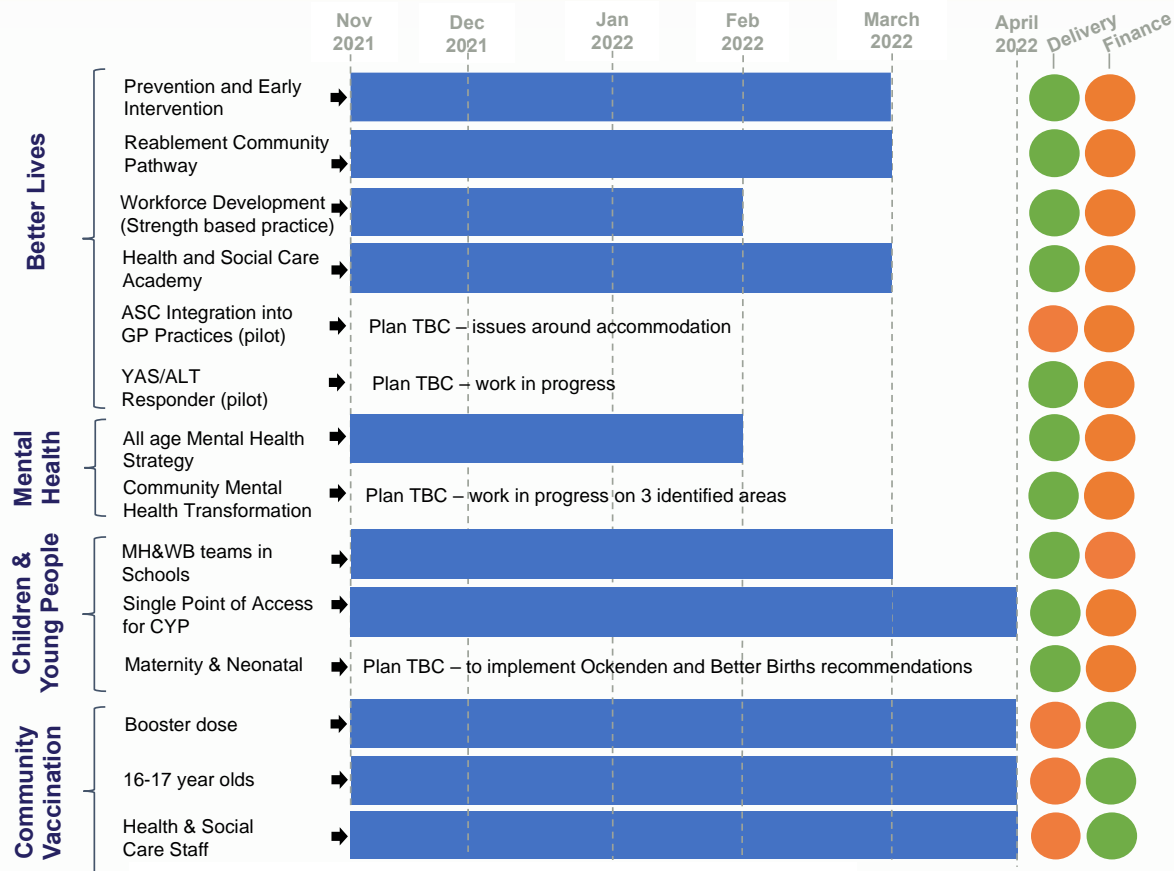
Health & Care Plan - Strategic Deliverables



Programme Summary (1)



Programme Summary (2)



PMO Mobilisation

First integrated PMO meeting has taken place, well received from all attendees (programme managers & enabler leads) and over the coming months with a focus on implementation through a busy Winter period, it is envisaged this group will be an integral part of the place-based delivery arrangements feeding into ICDG/ICPG respectively.

Each programme asked to consider any further support requirements eg. resources to optimise delivery. Limited response to this request to this point, other than for facilitation support.

Further work required with Enablers to ensure work aligned with agreed delivery priorities
Further work required through the Efficiency Executive to assess system efficiencies through delivery of the programmes

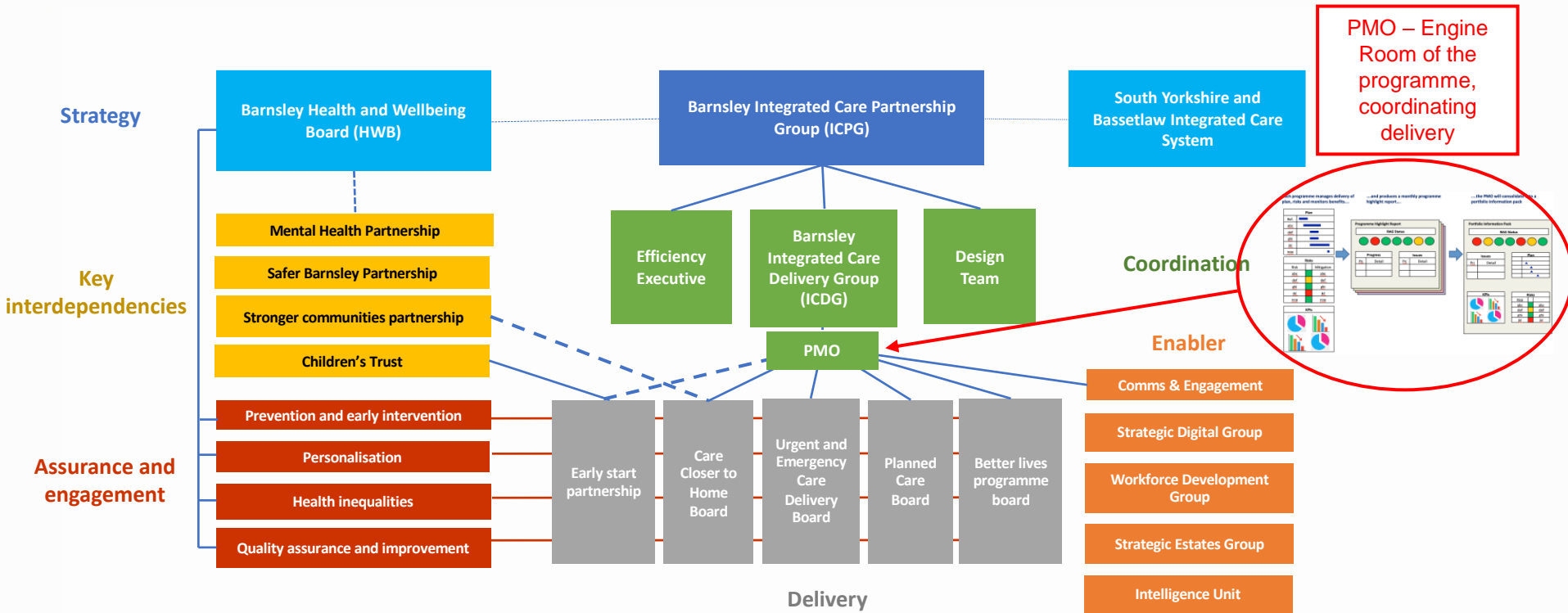
NOTE: This programme is still operating under C19 principles, recognizing operational pressures at place. All should note that some PMO BAU activities, such as PIDs, Business cases, benefits analysis, EIA, QIA processes are not being produced. **This will need to change for 22/23.**

Next Steps

- The health and care partnership will commence planning for 22/23 and beyond (5 year plan refresh) from February 2020; operational situation permitting at that point
- CCG Governing Body will continue to be proactively engaged in this process
- The CCG and partners are committed to continuing to engage with citizens and patients in the development of our 5 year plan – which will be undertaken in alignment with our ICS as well
- Most 21/22 priorities are expected to continue into 22/23, with the partnership committed to delivery
- 22/23 will see a return to a focus on efficiency and effectiveness and this will be a key element of our 22/23 planning.

Appendix

Governance - Reporting



PMO Meeting – Outline Terms of Reference

Function	Members	Input	Frequency
<ul style="list-style-type: none"> Monitor and manage progress of projects and programmes milestones and any cost savings identified. Identify slippage in the progress of schemes and agree plans to bring back into line with projected timescales. For Opportunity Assessment/PIDs and Draft Business Cases to be discussed at PMO and approved before being taken through the HHCP governance process. Agree proposed mitigating schemes to address such slippage, and to provide leadership for contingency planning. Manage the HCP Risk and Issue Log and Interdependencies Log. Map benefits realisation and KPI delivery. Coordinate implementation of the recovery and cost savings plans A forum to provide support for colleagues and to share learning and best practice. 	<ul style="list-style-type: none"> PMO Lead (Interim) Programme Managers/Project Managers Finance Lead BI Lead Comms and Engagement Lead Digital Lead Workforce Lead 	<ul style="list-style-type: none"> Logic Models Business Cases Programme Highlight reports Implementation plans Risk Register Interdependencies Log Transformation Dashboard/KPIs Deep dive reports as required Other reports to support project discussions 	Monthly 2 hours
			Accountable to:
			Integrated Care Delivery Group (ICDG)
			Other: <ul style="list-style-type: none"> Action and decision logs Deputies are “in attendance” only

GOVERNING BODY

20 January 2022

Cancer Programme Assurance and Community Diagnostic Centre

PART 1A – SUMMARY REPORT

1.	THIS PAPER IS FOR															
	<i>Decision</i>	<input type="checkbox"/>	<i>Approval</i>	<input type="checkbox"/>	<i>Assurance</i>	<input checked="" type="checkbox"/>	<i>Information</i>	<input checked="" type="checkbox"/>								
2.	PURPOSE															
	<p>The purpose of this report is:</p> <ol style="list-style-type: none"> 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 and delivering the recovery priorities. 															
	<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 50%;">Priority</th> <th style="width: 50%;">Progress /assurance</th> </tr> </thead> <tbody> <tr> <td>Preventing cancer incidence</td> <td>Refer to the section Minimising harm due to COVID on the cancer pathways</td> </tr> <tr> <td>Reduced Inequalities especially those diagnosed at emergency admission</td> <td>Refer to the section Minimising harm due to COVID on the cancer pathways</td> </tr> <tr> <td>Better cancer survival to be diagnosed at stage 1 or 2</td> <td>Refer to the section on restoring the 28 days cancer referrals to diagnosis pathway service improvements and cancer waiting times</td> </tr> <tr> <td>Implement rapid assessment and diagnosis pathways for all tumour sites</td> <td>Refer to the section on restoring the 28 days cancer referrals to diagnosis pathway service improvements and cancer waiting times</td> </tr> <tr> <td>Improve care and treatment - embed new cancer waiting times system</td> <td>Refer to the section on restoring the 28 days cancer referrals to diagnosis pathway service improvements and cancer waiting times</td> </tr> </tbody> </table>				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
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	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)	This is embedded within the cancer programme													
	Deliver Survivorship Program (LWABC) including recovery package Stratified follow up pathways breast, prostate and urology rolled out	This is embedded within the cancer programme													
	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 65% (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 76 % at November 2021.													
3.	REPORT OF														
	<table><tr><td></td><td>Name</td><td>Designation</td></tr><tr><td>Executive</td><td>Jamie Wike</td><td>Chief Operating Officer</td></tr><tr><td>Clinical Leads</td><td>Dr Kadarsha Mr M Simms</td><td>Cancer Governing Body Clinical Lead Secondary Care- Governing Body Member</td></tr><tr><td>Author</td><td>Siobhan Lenzionowski</td><td>Lead Commissioning and Transformation Manager</td></tr></table>				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 Lenzionowski	Lead Commissioning and Transformation Manager
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Clinical Leads	Dr Kadarsha Mr M Simms	Cancer Governing Body Clinical Lead Secondary Care- Governing Body Member													
Author	Siobhan Lenzionowski	Lead Commissioning and Transformation Manager													
4.	SUMMARY OF PREVIOUS GOVERNANCE														
	<p>The matters raised in this paper have been subject to prior consideration in the following forums:</p> <table><tr><td>Group / Committee</td><td>Date</td><td>Outcome</td></tr><tr><td>Barnsley Cancer Steering group</td><td>4/11/2021</td><td>Noted issues and ongoing actions being delivered</td></tr><tr><td>Quality and Patient Safety Committee</td><td>15/12/2021</td><td>Noted issues and ongoing actions being delivered</td></tr></table>			Group / Committee	Date	Outcome	Barnsley Cancer Steering group	4/11/2021	Noted issues and ongoing actions being delivered	Quality and Patient Safety Committee	15/12/2021	Noted issues and ongoing actions being delivered			
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Barnsley Cancer Steering group	4/11/2021	Noted issues and ongoing actions being delivered													
Quality and Patient Safety Committee	15/12/2021	Noted issues and ongoing actions being delivered													
5.	EXECUTIVE SUMMARY														

	<p>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.</p> <p>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 December 2021.</p> <p>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.</p> <p>This paper focuses on providing assurance about the main priorities for the cancer programme. The areas are:</p> <ol style="list-style-type: none"> 1. Restoring the 28 Days Cancer Referrals to Diagnosis Pathway service improvements and cancer waiting times 2. Minimising harm to patient due to Covid pressures on the cancer pathways delivery. 3. Responding to the increase in referral and diagnostic capacity to meet demand 4. Screening recovery and ongoing improvements 5. Community Diagnostic Centre Update and Lung Health Check Programmes <p>The main risks to the CCG of the cancer programme delivery are:</p> <ul style="list-style-type: none"> • 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:
	<ul style="list-style-type: none"> • Note the information that is providing assurance for the cancer programme delivery and approve this assurance paper.

Agenda time allocation for report:	10 minutes
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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:			<i>Cancer delivery</i>
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 (<i>these will be especially relevant where a proposal or policy is brought for decision or approval</i>)			
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
	<p>This paper focuses on providing assurance about four areas that are the priorities for the cancer programme.</p> <p>These four areas are outlined in more detail within the sections below:</p> <p>1. Restoring the 28 Days Cancer Referrals to Diagnosis Pathway Service Improvements and Cancer Waiting Times</p>

Cancer services have been fully staffed throughout this period and continue to be prioritised by BHNFT. This has ensured that Cancer services have been running throughout the whole last 6 months of this reporting period. There is also robust patient safety netting procedures in place at BHNFT and in primary care to ensure patients are prioritised and seen is based on clinical need and prioritisation. This includes for treatment/surgery and chemotherapy/radiology slots.

BHNFT's Cancer validated position for November 2021 is:

- **Breast 14-day Access Standard** – this was non-compliant at 86% - (target 93%) this is due to the ongoing challenge within the Breast service specifically around Radiology workforce. BHNFT continue to explore options for in source and cross working opportunities with other hospitals and is working on ensuring staff capacity in line with capacity by February 2022. The Trust during this period did ensure all women were seen within 21 days from referral.
- **28 Day Faster Diagnosis Standard** – this is non compliant at 65% (75% target). This does continue to improve month on month due to key focused work. The Trust is working on reducing the first Outpatient appointment to support quicker access to diagnostic test and ensuring patients are prepared and ready to attend appointments within the timescale that is needed to support 28-day performance. This is key in the GI pathway delivery which has the highest amount weekly referrals.
- BHNFT is also working on exploring if a results clinic for all patients with a 'good news' referral outcome would be an improvement and enable this part of the pathway to be delivered in a different way. This will help patient outcome and experience and also improve compliance against the standard.
- The use of Primary Care Co-Ordinator type role and three new BHNFT Cancer Navigator roles is being used to maximise joined up communication between the patient, the GP practice and the Hospital to ensure the patient is fully prepared and ready for the journey to come over the next few weeks. It was also developed in response to patient feedback which identified having one point of contact would be very beneficial.
- **31-day Straight to test Treatment Standard** – remains high and compliant with a 100% achievement. This is an area that has been maintained over a long period of time, with the Trust continuing to locally deliver treatment timescales to a high standard for all diagnosed patients.
- **62-day Treatment Standard** – currently this is not compliant at 76% (target 85%) but Barnsley continues to remain in the upper performance range both regional and nationally. The sustained work in reducing long waiter patients and recovery over the next 3 months will improve this performance. But before this occurs it will continue to fluctuate around the 65 to 80% mark during this period.

2. Minimising Harm due to COVID on the Cancer Pathway Delivery

The focus of this work has been about minimising the harm to four Patient

Cohorts. These are:

1. People referred via the 2 weeks 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 who are not presenting to services

At this time 65% of patients who are referred are being diagnosed within 28 days. Patient who are not diagnosed within this timeframe have been clinically triaged and appointments prioritised accordingly and within 62 days. Additional appointments slots continue to run at BHNFT to increase the diagnostic capacity and treatment times required to meet the 50% increase demand in referrals compared to pre-COVID.

The CCG is tracking the referral rates versus pre-COVID levels and this data is indicating that there is evidence that some neighbourhoods are recovering as referrals have increased into BHNFT, however some are not at their 2019 baseline level. This data indicates that some people will have unfortunately by passed this route and come another way (e.g. via urgent and emergency care) or are being managed in primary care. This is because referrals into BHNFT have increased in this period and cancer diagnosis rates have been reduced proportionally. In addition, there is no clinic type that is polarising in a negative direction against baseline, as the data indicates that the pathways are retaining their associated backlog.

The greatest impact for the CCG is to focus during the next 6 months on the emerging priorities especially female bladder and head and neck; patients whom are worried about returning to services and ensuring patients whom have been referred are treated quickly.

This will occur via a number of ways including:

- Targeting people to come forward via the Food banks route
- Targeting people by using specific evidence-based messages that will 'nudge' people to make a change in behaviour via posters and social media channels. This is being delivered via the Community and Charity sector, Local Authority staff; Barnsley Homes and GP practice staff
- The Well centre staff have been trained to encourage patient to stay on their treatment routes even if worried about COVID transmission
- BHNFT continue to prioritise diagnostics and treatment spaces for cancer patients
- Transport is being provided for Barnsley patients whom need to go to Weston Park and find it difficult to access the hospital
- GP practices continue to prioritise patients whom have suspected cancer symptoms and practice staff are contacting patients to support them through the referral process

3. Responding to the increase in Referral and Diagnostic Capacity Required to meet Demand

The overall patient list size and volume of long waiters (past 62 days from referral) has reduced over the last 6 months. As of the 17th of December, 670 patients were on an active suspected cancer GP 62-day referral pathway current within the Trust. From this number less than 10% were for pathways for referrals that are over day 62.

In the last 6 months the Trust has met the recovery target set by the CCG and has been set a new target. At this time the Trust is within the trajectory to achieve this and continues to strive to bring the number down overall.

Focused Capacity and Demand improvement work across all cancer pathways and key Diagnostic services is underway to support overall recovery. This includes focusing on the front end to reduce the risk of patient being on 'long' pathway to continue to improve the overall Trust position and patient outcome.

Additional funding has also been allocated to BHNFT for a Nurse Led Flexible Cystoscopy and prostate Service to increase staff capacity to meet the demand on Urology services. The CCG is also piloting with BHNFT and GP Practices a Community based Breast Health clinic for people whom have breast pain and that can be removed from a suspected cancer referral route quickly. The CCG Clinical Forum questioned how useful this service would be and therefore the pilot will be closely monitored to assess if any benefits do occur.

4. Screening Recovery and Ongoing Improvements

Currently all screening programmes are running to full capacity.

Current rates from the PHE Profile data (updated December 2021) indicate that the uptake in cervical rates is positive. Although across all the screening programmes there is a variation in uptake across the different GP Practice areas especially for breast screening. This was the same pattern of uptake as pre-covid. As per the outlined in the table below:

Type 20/21 data	UK average %	CCG	Lowest level of uptake
Screened Breast age 50-70	61.3	51.9	24.3
Cervical aged 25-49	69.1	75.8	68.4
Cervical aged 50-64	75.0	77.2	63.9
Bowel 60-74	66.8	68.9	58.9

This difference in uptake levels may also be due to Breast screening service recovery having taken longer than bowel and cervical screening programmes. The breast screening recovery has recently been accelerated by the provision of an additional mobile screening unit being funded and located at BHNFT. Data also is indicating that patients are booking an appointment but a number are not attending. BHNFT are therefore using evidence based targeted text messages content to reduce this occurrence. This is already increasing the number of women whom are attending compared to having no targeted communication in place.

The cervical screening extended hour's service continues to run on Saturday and Sunday and has been fully utilised by patients. Practices also continue to offer appointments to patients and in February will start to use targeted communication to patient groups whom traditionally have a low uptake of taking part in this programme.

Over the last 6 months the screening team have also been targeting people whom have a learning disability to come the Bowel screening test, by informing the local LD Nursing staff if the person has been invited. These staff are then taking the pro-active action to contact the person to encourage them to take part and to allay any fears the person may have about the test.

5. Community Diagnostic Centre Update and Lung Health Check Programme

To improve diagnostic capacity and ease of access for patients Barnsley in November 2021 was successful in bidding for funding (£2.3 million) to develop a community diagnostic centre (CDC) to be based at the Glassworks, town centre location. This is part of the National NHS Programme that is planning to deliver 165 CDCs across England. Barnsley is viewed as one of the forerunners of this programme delivery as the Glassworks centre is viewed by the Government as an innovative project.

This additional location to the hospital will have an additional breast screening machine and new Xray, ultrasound, echocardiogram and DEXA scanning equipment. Phlebotomy will also be based at this location. Moving this routine diagnostics provision to the Glassworks will in turn free up space at the hospital main site to increase the number of endoscopy and MRI slots that can be provided. It will also train the additional staff that BHNFT will need to meet the rising demand for diagnostics over the next 3 years.

It is anticipated that the new location will be open from April 2022. The focus in Year 2 will be to embed the Glassworks CDC provision and bid for a CT scanner and future 'spokes' for diagnostic modalities provision e.g. that can be delivered from Goldthorpe Centre.

In addition, Barnsley has been successful in receiving funding for 3 years to run a lung health check programme to begin in 2022. This funding will provide lung health checks to people at high risk of having early lung cancer. This will support Barnsley low uptake of people whom have lung cancer coming forward at an early stage. The Doncaster programme has been operational since mid-March 2021. As at 1st October 2021: 4,079 lung health check calls

	<p>and 1,970 initial scans have taken place; 49 suspected lung cancers have been identified, of which 7 early-stage lung cancers have been confirmed and treated; 1 stage 4 late lung cancer was also found along with 2 renal cancers; the remaining patients are awaiting further tests/investigations.</p> <p>6. Conclusion</p> <p>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 is therefore asked to approve this assurance report.</p>
Refer	<p>DELIVERY OF STATUTORY AND GOOD GOVERNANCE REQUIREMENTS</p> <p>No material issues identified</p>
3.1	<p>Management of Conflicts of Interest (s14O)</p> <p>Not Appropriate</p>
3.2	<p>Discharging functions effectively, efficiently, & economically (s14Q)</p> <p>Not appropriate</p>
3.3	<p>Improving quality (s14R, s14S)</p> <p>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.</p>
3.4	<p>Reducing inequalities (s14T)</p> <p>This programme will focus on reducing HIE to areas/people affected by impact of covid conditions on the cancer programme deliverables.</p>
3.5	<p>Public Involvement & Consultation (s14Z2)</p> <p>As outlined in the report</p>
3.6	<p>Data Protection and Data Security (GDPR, DPA 2018)</p> <p>Not Appropriate</p>
3.8	<p>Human Resources</p> <p>Not Appropriate</p>
3.9	<p>Environmental Sustainability Not appropriate</p>
5.	<p>RISKS TO THE CLINICAL COMMISSIONING GROUP</p>
	<p>1. Risk to delivery of the 62 days 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.</p> <p>2. Risk to delivery of early diagnosis if:</p> <p>(a) the CCG does not work in partnership with BMBC and PHE to promote to the people of Barnsley the national screening programme</p> <p>(b) Practices do not consistently apply NICE guidance for cancer diagnosis and referral and deliver the PCN DES via clinical systems and project delivery plan .</p> <p>3. Risk that, if the CCG does not have a clear local strategy for delivering</p>

	<p>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.</p> <p>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.</p> <p>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.</p> <p>The risks to the CCG are:</p> <ol style="list-style-type: none"> 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. <p>Risk to Barnsley population due to temporary change in non-oncology face to face appointments at BHNFT not being available. Placed on CCG risk register December 2021 – oversight for this risk is via the CCG QPSG remit.</p>
6.	CONCLUSIONS & RECOMMENDATIONS
	<p>Governing body are asked to:</p> <ol style="list-style-type: none"> 1. Accept this assurance report.

GOVERNING BODY (Public)

20 January 2022

Mental Health Update

PART 1A – SUMMARY REPORT

1. THIS PAPER IS FOR															
	<div> <div>Decision</div> <div><input type="checkbox"/></div> <div>Approval</div> <div><input type="checkbox"/></div> <div>Assurance</div> <div><input checked="" type="checkbox"/></div> <div>Information</div> <div><input checked="" type="checkbox"/></div> </div>														
2. PURPOSE															
	<p>The purpose of this report is to provide Governing Body members with an update on the mental health services being delivered within the Borough and the achievement, or otherwise, of nationally recommended targets.</p>														
3. REPORT OF															
	<table border="1"> <thead> <tr> <th></th><th>Name</th><th>Designation</th></tr> </thead> <tbody> <tr> <td>Executive / Clinical Lead</td><td>Dr. Mark Smith</td><td>GP Mental Health Clinical Lead</td></tr> <tr> <td>Author</td><td>Patrick Otway</td><td>Head of Commissioning (Mental Health, Children's and Maternity)</td></tr> </tbody> </table>				Name	Designation	Executive / Clinical Lead	Dr. Mark Smith	GP Mental Health Clinical Lead	Author	Patrick Otway	Head of Commissioning (Mental Health, Children's and Maternity)			
	Name	Designation													
Executive / Clinical Lead	Dr. Mark Smith	GP Mental Health Clinical Lead													
Author	Patrick Otway	Head of Commissioning (Mental Health, Children's and Maternity)													
4. SUMMARY OF PREVIOUS GOVERNANCE															
	<p>The matters raised in this paper have been subject to prior consideration in the following forums:</p> <table border="1"> <thead> <tr> <th>Group / Committee</th><th>Date</th><th>Outcome</th></tr> </thead> <tbody> <tr> <td>Governing Body</td><td>May 2021</td><td>Noted</td></tr> <tr> <td>Governing Body</td><td>March 2020</td><td>Noted</td></tr> <tr> <td>Governing Body</td><td>Sep 2019</td><td>Noted</td></tr> </tbody> </table>			Group / Committee	Date	Outcome	Governing Body	May 2021	Noted	Governing Body	March 2020	Noted	Governing Body	Sep 2019	Noted
Group / Committee	Date	Outcome													
Governing Body	May 2021	Noted													
Governing Body	March 2020	Noted													
Governing Body	Sep 2019	Noted													
5. EXECUTIVE SUMMARY															
	<p>The four guiding principles / priorities set out for mental health in the NHS Long Term Plan are:</p> <ul style="list-style-type: none"> Preventing people from developing mental health problems where possible Improving access to support for everyone who needs it 														

- Supporting people to recover and live well in the community
- Tackling inequality

To support delivery of these priorities, NHS E/I published the Mental Health Implementation Plan 2019 – 2024 and we are on target to deliver the recommendations within this plan. NHS E/I have also provided additional funds to support the transformation of mental health services within each locality

Within Barnsley, as members are aware, oversight/ steer of local mental health service transformation is provided by a system-wide partnership of the Mental Health Partnership Board.

To further support local transformation, the Mental Health Partnership Board agreed to revise the Barnsley All-age Mental Health and Wellbeing Strategy. A strong collaboration of partners (including service users and carers) has resulted in a final draft of the mental health strategy being utilised as part of a public engagement process that commenced on 17th December 2021 and will end on 26th January 2022. Feedback received from the public during this process will be incorporated into a final version of the strategy to be presented and adopted at the February 2022 Health and Wellbeing Board meeting. An easy read version of the strategy will then be developed.

Once the strategy has been adopted a Strategy Delivery Plan will outline how each aspect of the strategy will be implemented and a local Mental Health Dashboard will be developed in order to measure progress and to highlight any areas that require additional focus.

Transformation of Mental Health Services is a key priority of both local and national plans and South Yorkshire and Bassetlaw ICS are providing a greater steer as we transform to an ICB.

Overall, the demand for mental health services in general remains high, although referrals to some services are reducing. However, the level of acuity of presentation continues to be high and people are requiring more intensive support. The system pressures continue to be felt primarily within in-patients, crisis care and Eating Disorder services.

Local Mental Health service updates are outlined below:

Specialist Perinatal Mental Health

Barnsley CCG have agreed to invest sufficiently to enable the service to achieve all national targets, which have been achieved within Barnsley earlier than in the other South Yorkshire localities.

The next phase of transformation is to extend the perinatal mental health service, which currently supports women during the first 12 months of the birth, to support women up to 24 months of the birth.

Barnsley are also progressing the development of the Maternal Mental Health Service (SY ICS being an early implementer for this service) which supports women suffering from trauma as a result of the birth (e.g., PTSD or removal).

Adult Common Mental Health Illnesses (IAPT)

Achieving national access targets continues to be a challenge for Barnsley IAPT, (and other South Yorkshire IAPT services). At the end of November 2021, the Barnsley IAPT were 951 short of the access target i.e., to be on track to achieve the national target by the end of March 2022, then at the end of November, the cumulative number of people entering treatment (from April 2021 to Nov 2021) needed to be 4,424 whereas the number of people who had actually entered treatment within that time period was 3,473.

The IAPT service continues to promote the service widely on social media and within community settings and offers both virtual and face to face options. The service also offers on-line therapy and on-line support.

There are also 2nd waits developing in relation to counselling, Psychological Wellbeing Practitioners and CBT pathways. These waits are generally less than 3 months, with the exception of the CBT pathway. The Governing Body have approved additional, non-recurrent funding to be invested into the CBT pathway to reduce the length of time waiting (currently around 9 months) and an update on the impact of this funding will be provided to Governing Body in March 2022.

For those people who do enter treatment, over 50% 'move to recovery' with over 70% making a reliable improvement.

Adult Severe Mental Illnesses (SMI) Community Care

Barnsley's Early Intervention Psychosis (EIP) service continues to be one of the top performing EIP services in the country.

IPS (Individual Placement Support)

Barnsley CCG are partners within the South Yorkshire and Bassetlaw Integrated Care System Individual Placement and Support workstream who have commissioned an IPS service from South Yorkshire Housing Association. This service is performing well in Barnsley and the current contract, due to expire at the end of August 2021 has been extended to March 2022. As the provision of IPS is a 'must do' of the Long Term Plan, provision is being made for an IPS service to continue beyond March 2022.

Community Mental Health Transformation

Community Mental Health transformation is aligned to the Community Mental Health Framework (2019) for adults and older adults which describes how the Long Term Plan's vision for a place-based community mental health model can be realised, and how community services should modernise to offer whole-person, whole population approaches, aligned with Primary Care Networks.

Of the three 'must do's contained within the criteria to be able to access the national funding, Barnsley are prioritising the development of a local adult eating disorder pathway and partners are working closely together to achieve this. Progression is also being made towards enhancing community rehabilitation services and improving services for people with Personality Disorder – these areas will be

focussed on for further development in 2022/23.

Updates of all of the workstreams covered by the community mental health transformation are provided at the monthly Mental Health Partnership Board meetings.

Crisis Alternative

As members are aware, NHSE approved funding to be utilised to develop crisis alternative solutions to divert people away from A&E so that they can access the appropriate support. Additional funding was also approved by Governing Body to ensure a more robust solution was deliverable. The Crisis Alternative to be delivered will be based upon the successful Safe Space service currently being delivered in Doncaster, which has received significant, national recognition.

A bespoke service specification for a Barnsley Safe Space service is being finalised and a competitive procurement process will be undertaken in early January 2022 to ensure that a service will be in operation from April 2022.

There are a number of issues arising in relation to S136 detained patients in that Barnsley's S136 Suite at Oakwell has been closed on a number of occasions recently due to staff shortages. There are also issues with regards to no cross-border working of Barnsley AMHP's, who are only on duty until 2:00am, whereas neighbouring localities are available 24/7. In addition to this, there is no other Place of Safety within Barnsley where South Yorkshire Police or Ambulance staff can transport people to but we are looking at the potential of developing the Safe Space, once operational, to be able to provide this aspect of support. Within South Yorkshire, with the exception of Sheffield, there are no Places of Safety for Children and Young people and the SY ICS are looking at how future provision is best developed.

A Barnsley S136 working group has been established, chaired by the Head of the Adult Mental Health and Disability Team (an in-house provision at BMBC), to work through the issues outlined above and to progress solutions.

Mental Health Liaison and Crisis Care

The Mental Health Partnership Board (and Delivery Group) is enabling more robust oversight of the services being delivered within Barnsley to better support the local populations mental wellbeing and stronger collaborations and partnerships are developing as a result.

There is however, an increase in the numbers of young people who are remaining as in-patients within Barnsley hospital, who are physically fit for discharge but who are needing a mental health in-patient bed (Tier 4). The increase in numbers is primarily in relation to young people with an eating disorder and discussions are occurring between partners locally to better understand how these young people can best be supported.

The lack of Tier 4 beds is a national issue and has been escalated via the relevant channels locally, regionally and nationally.

CYPMHS Steering Group

As members are aware, the Children and Young People's Mental Health Services Steering Group are overseeing the implementation of the CAMHS Service Specification whilst remaining focused on sustaining and improving the reduction in waiting times.

The launch of the Single Point of Contact (between CAMHS and Compass), which was due to take place on 4th January 2022, has been delayed due to the current system pressures and potential increase in staff absences due to the continued impact of Covid-19. Discussions are also progressing in extending the Children in Care pathway to 0 – 25 years and actions are being taken to enhance the ADHD pathway, which continues to see reductions in both waiting times and in the number of young people waiting.

Overall, the number of referrals into CAMHS, whilst still high, has reduced slightly in the past three months but the acuity of presentation remains high. There are particular pressures within the Eating Disorder service which is still signposting young people to partners for support, where appropriate and accepting only the most acutely unwell.

The Barnsley Eating Disorder working group have drafted a business case which will enhance the support provided to young people and could be funded via investment already approved by Governing Body

Discharge and seasonal pressures funding

In late November 2021, NHSE / I informed CCGs that they would be allocating ring fenced non-recurrent funding of £230,000 to provide resilience and support mental health providers to respond to seasonal pressures, minimise related increases in hospital activity and remove barriers that may delay discharge from Hospital.

The funding is non-recurrent and is to be utilised within this financial year (i.e., by the end of March 2022). There is no bid process to be followed and NHSE/I instructed that schemes were to be implemented as soon as possible. Schemes have successfully been implemented in previous years, funded via similar 'winter pressure monies' and therefore there is evidence of positive impact.

Opportunities have been discussed with mental health providers and members of the Mental Health Partnership to agree the allocation of this funding as set out below:

Scheme Overview	Area of Impact	Expected Benefits	Cost	Provider
Scheme 1	Adult Housing / homelessness agency workers (similar posts are Band 4)	To support discharge of people who are homeless to avoid DTOCs and for improved patient outcomes	£40k	SWYPFT
Scheme 2	All-age Staff (likely agency) for the mental health liaison team, in-reach to A&E / local acute trust	To support diversion away from A&E	£50k	SWYPFT

	Scheme 3	CYP Support for the eating disorder pathway: youth worker, meal-planner	To alleviate pressure on the pathway by introducing new roles / outsourcing tasks (likely agency)	£55K	SWYPFT
	Scheme 4	All-age a) Work with local VCS to research health inequalities of communities e.g., homeless population or those for whom English is not their first language b) Launch Comms based on research following generic mental health support comms.	<ul style="list-style-type: none"> To understand the needs of certain groups in terms of mental health support where health inequalities may exist. To boost knowledge of support available to the population at this time of year. 	£25k	VCSE / Comms
	Scheme 5	Adults DTC – provision of temporary, non-hospital accommodation while tenancy issues are resolved e.g., repairs / white goods	Support system flow and better patient outcomes	£30k	SWYPFT / BMBC
	Scheme 6	All-age <ul style="list-style-type: none"> Currently we have an all-age bereavement pilot in place, mainly sees CYP and also adults who have experienced child-loss. High demand seen. One counsellor in place since Jun-21; a second is due to commence in Jan-22. This funding would support the salary of the second counsellor for 3 months and in addition, development of a training package for the workforce (health and education) 	<ul style="list-style-type: none"> Salary for second bereavement counsellor to reduce the waiting list for service. Increase local understanding in health and education professionals of how to support CYP experiencing bereavement 	£25k	Compass
	Scheme 7	Adult Neighbourhood cafes, this is part of the CMHT work and would be start-up costs to secure premises	Drop in cafes framed around support post-A&E / suicide prevention – all linked back to the Recovery College	£5k	SWYPFT
<p>A number of these schemes have been successfully implemented in previous years and we know they will positively impact on discharge and we know the CYP Bereavement service will benefit significantly from a second counsellor – Compass are already accessing funding to enable the second counsellor to continue to support young people beyond March 2022. The promotion and research work</p>					

	<p>outlined is part of next years work programme but bringing this forward will see any benefits being realised much earlier.</p> <p>NHSE/I will require a submission in Feb/March 2022 outlining the impact of this additional funding and this report will be shared with Governing Body members for further assurance.</p>
6.	THE GOVERNING BODY / COMMITTEE IS ASKED TO:
	<ul style="list-style-type: none"> • Note the report
7.	APPENDICES / LINKS TO FURTHER INFORMATION
	NA

Agenda time allocation for report:	<i>10 mins</i>
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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 (<i>place ✓ beside all that apply</i>):			
	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	
	3.2 Maximising Elective Activity		9.1 Digital and Technology	
	4.1 Mental Health	x	10.1 Compliance with statutory duties	
	5.1 Integrated Care @ System		11.1 Delivery of Enhanced Health in Care Homes	
	5.2 Integrated Care @ Place		12.1 Delivering The Covid Vaccination Programme & Meeting The Needs of Patients with Covid-19	
	5.3 Implementing Population Health Management And Personalised Care			
	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 (<i>place ✓ beside all that are relevant</i>):			
	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 (<i>these will be especially relevant where a proposal or policy is brought for decision or approval</i>)			
3.1	Clinical Leadership			
	Have GB GPs and / or other appropriate clinicians provided input and leadership?			Y
	<i>If relevant provide brief details here OR cross refer to detailed report if used</i>			
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
	<i>If relevant provide brief details here OR cross refer to detailed report if used</i>			

3.3	Discharging functions effectively, efficiently, & economically (s14Q)								
	<table border="1"> <tr> <td data-bbox="279 241 1268 300">Have any financial implications been considered & discussed with the Finance Team?</td> <td data-bbox="1268 241 1412 300">Y</td> </tr> <tr> <td data-bbox="279 300 1268 358">Where relevant has authority to commit expenditure been sought from Management Team (<£100k) or Governing Body (>£100k)?</td> <td data-bbox="1268 300 1412 358">NA</td> </tr> <tr> <td colspan="2" data-bbox="279 358 1412 416"><i>If relevant provide brief details here OR cross refer to detailed report if used</i></td> </tr> </table>	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	<i>If relevant provide brief details here OR cross refer to detailed report if used</i>			
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Where relevant has authority to commit expenditure been sought from Management Team (<£100k) or Governing Body (>£100k)?	NA								
<i>If relevant provide brief details here OR cross refer to detailed report if used</i>									
3.4	Improving quality (s14R, s14S)								
	<table border="1"> <tr> <td data-bbox="279 506 1268 542">Has a Quality Impact Assessment (QIA) been completed if relevant?</td> <td data-bbox="1268 506 1412 542">Y/N/NA</td> </tr> <tr> <td data-bbox="279 542 1268 600">Have any issues or risks identified been appropriately addressed having taken advice from the Chief Nurse (or Deputy) if appropriate?</td> <td data-bbox="1268 542 1412 600">Y/N/NA</td> </tr> <tr> <td colspan="2" data-bbox="279 600 1412 658"><i>If relevant provide brief details here OR cross refer to detailed report if used</i></td> </tr> </table>	Has a Quality Impact Assessment (QIA) been completed if relevant?	Y/N/NA	Have any issues or risks identified been appropriately addressed having taken advice from the Chief Nurse (or Deputy) if appropriate?	Y/N/NA	<i>If relevant provide brief details here OR cross refer to detailed report if used</i>			
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<i>If relevant provide brief details here OR cross refer to detailed report if used</i>									
3.5	Reducing inequalities (s14T)								
	<table border="1"> <tr> <td data-bbox="279 748 1268 784">Has an Equality Impact Assessment (EIA) been completed if relevant?</td> <td data-bbox="1268 748 1412 784">Y/N/NA</td> </tr> <tr> <td data-bbox="279 784 1268 842">Have any issues or risks identified been appropriately addressed having taken advice from Equality Diversity & Inclusion Lead if appropriate?</td> <td data-bbox="1268 784 1412 842">Y/N/NA</td> </tr> <tr> <td colspan="2" data-bbox="279 842 1412 900"><i>If relevant provide brief details here OR cross refer to detailed report if used</i></td> </tr> </table>	Has an Equality Impact Assessment (EIA) been completed if relevant?	Y/N/NA	Have any issues or risks identified been appropriately addressed having taken advice from Equality Diversity & Inclusion Lead if appropriate?	Y/N/NA	<i>If relevant provide brief details here OR cross refer to detailed report if used</i>			
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3.6	Public Involvement & Consultation (s14Z2)								
	<table border="1"> <tr> <td data-bbox="279 990 1268 1025">Has a s14Z2: Patient and Public Participation Form been completed if relevant?</td> <td data-bbox="1268 990 1412 1025">Y/N/NA</td> </tr> <tr> <td data-bbox="279 1025 1268 1084">Have any issues or risks identified been appropriately addressed having taken advice from the Head of Comms & Engagement if appropriate?</td> <td data-bbox="1268 1025 1412 1084">Y/N/NA</td> </tr> <tr> <td colspan="2" data-bbox="279 1084 1412 1142"><i>If relevant provide brief details here OR cross refer to detailed report if used</i></td> </tr> </table>	Has a s14Z2: Patient and Public Participation Form been completed if relevant?	Y/N/NA	Have any issues or risks identified been appropriately addressed having taken advice from the Head of Comms & Engagement if appropriate?	Y/N/NA	<i>If relevant provide brief details here OR cross refer to detailed report if used</i>			
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GOVERNING BODY (PUBLIC)

20 January 2022

Local Maternity Service Update

PART 1A – SUMMARY REPORT

1.	THIS PAPER IS FOR																	
	<i>Decision</i> <input type="checkbox"/>	<i>Approval</i> <input type="checkbox"/>	<i>Assurance</i> <input type="checkbox"/>	<i>Information</i> <input checked="" type="checkbox"/>														
2.	REPORT OF																	
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Governing Body	08/07/2021	Noted																
4.	EXECUTIVE SUMMARY																	
	<p>Governing Body continue to be kept informed of the progress made within the South Yorkshire ICS Local Maternity Network System (SY ICS LMNS) 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.'</p> <p>One of the key challenges highlighted, and a priority as one of the Long -Term</p>																	

Plan ambitions, is the drive towards continuing to implement delivery of maternity services utilising the Continuity of Carer (CoC) model. Barnsley have already achieved the March 2022 target of 51%. This is not the case however in all other South Yorkshire Localities, with Sheffield and Doncaster currently below the nationally recommended target.

Governing Body members were previously made aware of the outcomes and recommendations contained within the Ockenden report and the implementation of the essential actions. In addition to implementing these immediate actions, each maternity service also had to submit to NHS England and Improvement numerous amounts of evidence as part of their Assurance Assessment Tool. Barnsley have received their feedback from this process and the feedback is that Barnsley maternity services have provided a very good level of assurance and is in a very good position.

The second report of the Independent Review of Maternity Services at the Shrewsbury and Telford NHS Trust is expected to be published no later than 24 March 2022.

Mental Health and Wellbeing

In terms of Maternal wellbeing the Specialist Mental Health Midwife continues to provide an appropriate level of support given the current limitations. Barnsley are also progressing with the development of the Maternal Mental Health service (as part of a regional early implementer site) which has been established to better support those women who suffer some form of birth trauma (e.g., PTSD, removal). The relevant midwifery and psychology posts have been recruited to and the local service will be fully operational in the New Year.

Barnsley's Specialist Perinatal Mental Health Service, provided by SWYPFT, continues to perform well and is ahead of schedule in terms of achieving national targets. In 2022, the focus of the service will be:

- Increase access from 8.6% to 10% with the service already achieving the 8.6% and currently working towards the 10%
- It's expansion in terms of offering appropriate support to women within 24 months of the birth of their child. The current provision supports women within 12 months of the birth of their child.
- There is no clear timescale in terms of extending the service from birth to 24 months, but the expectation is that this will be in place by 2023/24.
- 2022 will also see a focus on developing evidence- based assessment, signposting and support to partners of pregnant women, an area that has seen little improvement to date, but which has been identified as a priority locally.

Smoking in Pregnancy

Everyone is aware of the potential harm to unborn babies of smoking and whilst Barnsley's rate of women who are still smoking at the time of delivery has been

decreasing over the past few years, it is still the highest rate in South Yorkshire.

In terms of Smoking in Pregnancy, the Tobacco dependence treatment services: the new delivery model V2.0, and the recommended maternity model, expand on recommendations in NICE guidance, including NG92, to drive increased engagement through funded intensive interventions delivered directly by maternity services. One such intervention being introduced is a pilot smoking cessation incentive that will encourage mums to stop smoking during pregnancy.

The maternity model builds on the Saving Babies' Lives Care Bundle version 2 (SBLCB), where all pregnant women are assessed for carbon monoxide (CO) exposure at booking, the 36-week antenatal appointment and other appointments as appropriate. Any woman, or their partner with elevated CO levels are to be immediately referred to a specialist stop smoking service team for support. The treatment offer is of weekly face-to-face behavioural support and licensed pharmacotherapy, with a preference for a combination of NRTs (Nicotine Replacement Therapies) where this is agreed.

The model and practical framework have been co-developed with a range of national, regional and system partners to support delivery of NHS-funded tobacco dependence treatment services in line with the NHS Long Term Plan commitments (LTP, 2019). Delivery models developed by Early Adopter sites provide the background, context, and practical criteria for the framework. Elements of the delivery model continue to be tested to further stress-test the model pathways so they can be refined prior to full national rollout.

The SY funding schedule for the next 3 years has been allocated based on the Tobacco dependence treatment services: delivery model V2.0 and the recommended Maternity model. This delivery model and funding schedule assume care to be delivered by Band 3 tobacco support workers and NRT to be provided for the duration of treatment.

Funding is to ensure that all pregnant women are being offered the maternity service delivery model by year 3 (2023/24) of the NHS Long Term Plan. In the first year (2021/22) 40% of women are expected to be offered the service model and pathway by March 2022 and by the end of year 2 (2022/23) 75% of women should be offered the service model and pathway. The intention is that all women (100%) will be offered the recommended maternity tobacco dependence model by the start of 2024.

Barnsley has been allocated £25k in 2021/22 to begin offering the service model and pathway by March 2022. The expected level of investment for 2022/23 is £47k and a further £62k in 2023/24.

SI's (Serious Investigations)

Over the past 3/4 months there have been 4 Serious Investigations reported within Barnsley Maternity Services. For a maternity service the size of Barnsley's this number of reported SI's would not be unexpected, but it is unusual for Barnsley. Learning from these incidents includes implementing additional training around CTG's (Cardiotocography), particularly in terms of their interpretation.

	<p>MVP (Maternity Voice Partnership)</p> <p>A Maternity Voices Partnership (MVP) is a NHS working group: a team of women and their families, commissioners and providers (midwives and doctors) working together to review and contribute to the development of local maternity care.</p> <p>Whilst Barnsley has an established MVP it is not as robust nor as effective as we would like it to be, however we currently do not fund the MVP, with payment only being for expenses via a claim process. All other South Yorkshire localities recurrently fund their MVP's so, in order to eradicate this inequity, we are in discussion with the MVP chair and colleagues to identify the potential recurrent funding required to enable the Barnsley MVP to flourish and influence future service design.</p> <p>The National Maternity Voices (the association of Maternity Voices Partnership independent lay chairs in England) suggest that good practice in setting up and developing MVPs among commissioners and provider staff of maternity services in England will ensure:</p> <ul style="list-style-type: none"> • Every woman on the maternity pathway has a chance to have her voice heard about the service she is receiving through an MVP • Every MVP is adequately resourced to engage in true co-production of maternity services • Local MVP chairs and service user members feel networked and supported in their role • MVPs are involved in work in their local communities and also represented at Local Maternity System (LMS) level <p>SYB LMNS have now appointed a Service User lead who will work closely and will support the work of the MVP across SYB</p> <p>To improve the maternity experience of mothers from the Black & Ethnic Minority Community.</p> <p>Recent research provides evidence of B&ME mothers being five times more likely to die during childbirth than their White British counterparts.</p> <p>A group was established in Barnsley to look at the possible inequalities within maternity. There was a clear sense that whilst all mothers' experiences and feedback were welcomed, there appeared to be a language barrier and a gap in terms of information being accessible to all. To help reduce these inequalities there is an expectation that 75% of women from B&ME background receive continuity of care.</p> <p>Work has commenced to look at ways to hear the voice of B&ME women in maternity, with the active promotion of greater B&ME service user participation in the design and delivery of maternity services through the MVP and to look at opportunities for B&ME women to influence and effect change including encouraging involvement in the work of the MVP.</p>
5.	THE GOVERNING BODY IS ASKED TO:

	<ul style="list-style-type: none">• Note the contents of this report
6.	APPENDICES / LINKS TO FURTHER INFORMATION
	<ul style="list-style-type: none">• None

Agenda time allocation for report:	<i>10 minutes</i>
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GOVERNING BODY ASSURANCE REPORT

20 JANUARY 2022

CHC ADULTS AND SPECIALIST CLINICAL PORTFOLIO

PART 1A – SUMMARY REPORT

1.	THIS PAPER IS FOR											
	<i>Decision</i>	<input type="checkbox"/>	<i>Approval</i>									
		<input type="checkbox"/>	<i>Assurance</i>									
		<input checked="" type="checkbox"/>	<i>Information</i>									
		<input checked="" type="checkbox"/>										
2.	PURPOSE											
	The report is to provide assurance to Governing Body that CHC is in a healthy position providing a quality service to the people of Barnsley.											
3.	REPORT OF											
	<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr style="background-color: #d9e1f2;"> <th style="width: 35%;"></th> <th style="width: 35%;">Name</th> <th style="width: 30%;">Designation</th> </tr> </thead> <tbody> <tr> <td>Executive / Clinical Lead</td> <td>Jayne Sivakumar</td> <td>Chief Nurse</td> </tr> <tr> <td>Author</td> <td>Sheena Moreton</td> <td>Operational Lead CHC</td> </tr> </tbody> </table>				Name	Designation	Executive / Clinical Lead	Jayne Sivakumar	Chief Nurse	Author	Sheena Moreton	Operational Lead CHC
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5.	EXECUTIVE SUMMARY											
	THE CURRENT CHC SERVICE Staffing The acting team Leader for Learning Disability (LD) patients remains on Maternity leave until the 20 th April 2022. The support to this area of the service is being provided by both the general team leader and Personalised Health Budget (PHB) Lead. There is no long-term sickness reported within the team although Covid absence has impacted on the team. The CHC team will have B6 x2 WTE leaving to go on Maternity leave in February 2022. An options paper has been shared with the Chief Nurse to address the											

deficit in staffing from February 2022.

The LD B6 WTE vacancy has not been filled. The post was advertised 3 times and although the post was viewed substantially, the actual applicants was extremely low or no interest. The B5 0.6 WTE LD nurse has temporarily been lifted to a B6 0.8 WTE to cover the deficit on case management for LD patients till March 2022. The CCG has agreed to fund a LD agency nurse to support the CHC LD service from January to March 2022.

It will be necessary to keep CHC LD service on the risk register due to the deficit in staffing.

The Operational Lead with support from the team has undertaken a capacity and demand piece of work to identify the gaps in service, impact on the team with increased workload from case management and provide a formal report to the Chief Nurse with its outcomes.

The Operational Lead continues to meet with the Chief Nurse to discuss, progress and update the work plan for the service, identifying gaps/ risks/ solutions for the service.

The Operational lead also meets with NHSE CHC lead and SYB CHC leads monthly.

COVID19 Backlog Cases

Barnsley CHC has zero number of COVID backlog cases, and this continues to be reported on the NHSE tracker every 2 weeks.

The CCG have had confirmation from NHSE regarding continuation of funding for the D2A process and that the 4 weeks funding is to continue for both Q3 and Q4 2021/2022.

Current Adult CHC Position

The service has received a total of 231 checklist referrals from 1/4/2021 to 13/12/2021.

164 of these referrals have required a full assessment using the Decision Support Tool which is completed by health and social care jointly.

From the 1/4/2021 to 13/12/2021 CHC have received 574 fast track referrals.

All the Fast tracks received are processed through the service and care packages arranged to meet the patients current and ongoing needs will be procured. All these patients will be case managed and reviewed by the CHC team.

There are 3 KPI's from NHSE which CHC are required to meet and are reported monthly to NHSE

1. Less than 15% of new assessments completed in acute setting
2. 80% of DST completed in 28 days
3. Incomplete referrals exceeding 28 days by 12 to 26 weeks/ or 10 or more cases delayed by 12 to 26 weeks

CHC have met the following: June, July, August, September, but met only 1 and

3 KPIs in October, November. The reasons for CHC not meeting the KPIs in October and November were:

- external Local Authorities not being able to provide Social Workers to attend the Decision Support Tool Assessments
- delays in Social Workers signing the completed Decision Support Tool,
- Social Workers not agreeing with the recommendation and requesting a Local Resolution Discharge Meeting with CHC.
- families requesting appointment dates for the Decision Support Tool Assessment to be changed to enable them to be present as they could not make the allocated appointment date.
- Awaiting information from other health and social care professionals

The DOH report submitted for Q1 and Q2 2020/21 met the standards required. Q3 data is not due till 31/12/2021.

From Q1 2022 NHSE are requiring all CCG CHC team to submit Patient Level Data monthly alongside the Quarterly DOH data for 20 22/2023.

The CHC team have completed 417 assessments which has gone through the process for CHC from 1/4/2021 to 13/12/21.

The number of Fast Tracks currently funded by CHC is 75 and there are 13 outstanding reviews.

CHC have trajectories in place to track all outstanding reviews, these are monitored weekly by the CHC Operational Lead and discussed with the Chief Nurse.

CHC ensure that all reporting functions are maintained especially for DOH quarterly reports, NHSE monthly reports, QPSC and Sit Reports on a 2 weekly basis regarding COVID19 backlog cases.

The CHC service has been adapted to undertake assessments virtually, but it still holds the principles of the framework at the centre, engaging and liaising with our health and social care partners has been paramount to develop a virtual process.

Care Package Agreement Panel

In November 2020 the Care Package Agreement Panel was introduced in the service, this for all care packages costing over £850 per week to be presented to panel where senior clinicians and finance manager attends. These panels are to ensure that there is a governance /scrutiny process in place to reduce both clinical and financial risk to the organisation.

Joint Package of Care Splits

A tool for calculating the % splits of Joint package of care has been introduced at the beginning of November 2021 and this will be trialled in Q3/Q4 2021/2022 and reviewed by both CCG and BMBC.

Patient Experience

Patient experience is very important to CHC and it links into the values of the CCG and in November 2021 CHC introduced the patient experience feedback

form.

21 patient experience forms were sent out in November 2021 and CHC received only 1 returned completed patient experience feedback form.

The CHC team will be contacting the patients the patient experience feedback forms were sent out to. The themes from the Patient Experience Feedback Forms will be shared at team meetings and these can be used to shape and influence the CHC service going forward.

Appeals

Doncaster Share Services who provide the Appeals service on behalf of Barnsley CCG send a monthly report on Appeals (Appeals are when the patient and or their representative does not agree on the outcome of the assessment the Multidisciplinary team)

Doncaster Shared Services have received a total of 11 appeals since April 2021 to present. There are 3 which are still open appeals in December.

Independent Reviews (IRP)

CHC have 1 IRP pending.

Audit

A Continuing Healthcare Audit was undertaken by 360 Assurance in December 2019 and the service was given a limited assurance audit opinion.

The audit focused on the controls in place from the assessment of a patient as eligible for CHC or NHS-funded Nursing Care (FNC) through to authorisation of payments.

The report findings resulted in 1 high, 5 medium and 6 low risk actions.

In November 2021 the CCG agreed a revisit Audit for CHC. The overall objective of the revisit audit is to repeat the sample testing carried out as part of the CHC Audit in 2019 to establish whether the actions taken since have resulted in mitigating the risks identified in the 2019 Audit. The timeframe for the revisit Audit will be undertaken between 19th November 2021 – 14th February 2022 with the final report for the Audit Committee completed by the 17th March 2022

Safeguarding

In November there has been 6 safeguarding's referrals where CHC have had to complete safe and well checks on all patients funded by CHC with that provider (either 24-hour placement or domiciliary care provider).

Complaints

There have been no complaints received in October, November, or December 2021.

Training

The Competency Framework has been introduced and the Operational Lead and Team Leader have undertaken a training matrix to understand the training needs

of the team.

Risks

- Financial risk- if reviews are not undertaken as planned there is a financial risk to the organisation
- Staffing risk – maintenance of staffing health and wellbeing during COVID19 to preventing sickness which could affect trajectory/ reviews / KPIs.
- Framework providers – due to the ongoing issues with commissioning care in the community from domiciliary providers not having the capacity, Providers of last resort and spot providers are having to be utilised to provide care. Unfortunately, these providers are able to charge a much higher rate than our commissioned framework of providers which increases the cost of care for patients in CHC. JCU are working with these providers. JCU are reviewing arrangements for packages located in more challenging locations. JCU have been working on the future home care framework.

NHSE Update

The monthly meeting with NHSE provided positive feedback to the CCG. NHSE were extremely happy with the recovery position of the CHC service and position of the number of outstanding reviews.

NHSE voiced no concerns regarding Barnsley CHC.

SPECIALIST CLINICAL PORTFOLIO

CCC and IFR

The total number of active cases has reduced to 14 currently. Two new referrals have been received and are currently being screened.

Complaints / Media Issues

No new complaints.

Safeguarding / Child Protection

There have been no safeguarding issues raised.

Staffing

The CCC Nurse Assessor / Case Manager left his post at the end of November to pursue a more patient facing role. Whilst this is a huge loss to the team it has presented an opportunity to look at things differently to support service improvement. A business case was accepted by SMT in which the Band 7 post will take on TCP Children and Young People's case management and deputise for the DCO and an additional 0.6 WTE Nurse Assessor / Case Manager post has been added. An advert has just gone out for both posts. An interim agency Nurse Assessor is being employed until the end of March to cover the recruitment period and ensure CCC cases are reviewed and case managed and

to cover new assessments.

S117 Non TCP

There has been an increase in cases overall since the beginning of Q1. This has resulted in an overall increased spend. There have been some very complex discharges this year to date and this reflects the data in the system suggesting that there is increased acuity and complexity across the mental health community and inpatient areas in Barnsley.

Safeguarding

One case that was previously a TCP case remains in an ongoing safeguarding inquiry. The individual is currently admitted to an Assessment and Treatment Unit within SWYPFT. The CCQM is joined to the process.

Court of Protection

An ongoing case will be delayed as the person is now on remand in prison. There are 4 new Section 21A DoLS challenges. The CCG has negotiated legal representation from BMBC legal services on all cases. This will represent a unified position with BMBC and also will save on legal costs.

Good practice / successes / new initiatives

The CCQM and BST colleague are developing the use of SystmOne to streamline and adequately record reviews, panels and communications in terms of case management.

TCP

This remains an area of high budget pressure and provider led pricing.

Safeguarding

Ongoing NHSEI led quality surveillance at the recently opened Mayman Lane supported living complex in Kirklees. The situation is improving steadily.

The Complex Case Manager is currently completing Safe and Well checks for 16 patients as a result of the investigations into Cawston Park hospital which have had national media coverage. The checks have been requested by NHSEI. This is a major piece of work taking place until the end of January 2022. Members of the SCP team are completing new CTRs / CETR in order to support the Complex Case Manager. This has had a significant impact into team capacity.

Good practice / successes / new initiatives

A meeting has taken place with the NHSEI TCP lead for South Yorkshire to discuss the move from West Yorkshire TCP. This was a very productive meeting and resulting actions will move things forward at pace.

Specialist Funding

Funding in this line covers:

	<ul style="list-style-type: none"> • Neuro Rehabilitation Individual Funding Requests (IFR) • Specialist Psychiatric Inpatient Beds in Independent Hospitals • General Acute Psychiatric beds re: SWYPFT bed pressures <p>Neuro Rehabilitation IFR</p> <p>Two existing cases have been given notice that CCG funding will be withdrawn, as they have reached their rehabilitation potential. CHC assessments are due to be completed on both cases.</p> <p>There are two new cases and these are being monitored by the CCQM.</p> <p>Specialist Psychiatric Inpatient Beds</p> <p>Two patients remain in independent out of area Psychiatric Intensive Care Unit beds. This is due to lack of bed capacity within SWYPFT. Discussions are progressing in terms of addressing this from a wider commissioning perspective. The CCG is requesting repatriation to SWYPFT bed for both patients.</p> <p>General Acute Psychiatric Beds</p> <p>There are currently no patients occupying out of area independent beds.</p> <p>Good practice / Successes / Initiatives</p> <p>Work continues on the Neuro Rehab pathways and processes and a process map has been agreed which will be presented in a paper to the next GB meeting.</p> <p>The CCC and S117 areas currently are being revisited by 360 Assurance Audit.</p> <p>The team continue to work on improving information and data systems and also on increasing the robustness of processes.</p>
6.	THE GOVERNING BODY IS ASKED TO:
	<p>Consider the information in this report and take assurance that CHC continues to function and provide a high-quality service to the people of Barnsley.</p> <p>Note the updated position in the Specialist Clinical Portfolio.</p>
7.	APPENDICES / LINKS TO FURTHER INFORMATION
	NA

Agenda time allocation for report:	10 mins
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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 (<i>place ✓ beside all that apply</i>):			
	1.1 Urgent & Emergency Care		6.1 Efficiency Plans	
	2.1 Primary Care		7.1 Transforming Care for people with LD	
	3.1 Cancer		8.1 Maternity	
	4.1 Mental Health		9.1 Digital and Technology	
	5.1 Integrated Care @ System		10.1 Compliance with statutory duties	
	5.2 Integrated Care @ Place		11.1 Delivery of Enhanced Health in Care Homes	
	The report also provides assurance against the following red or amber risks on the Corporate Risk Register:		CCG 21/02 CCG 21/03 CCG 20/03 CCG 21/01	
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)		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			
3.1	Clinical Leadership			
	Have GB GPs and / or other appropriate clinicians provided input and leadership?			
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?			
3.3	Discharging functions effectively, efficiently, & economically (s14Q)			
	Have any financial implications been considered & discussed with the Finance Team?			
	Where relevant has authority to commit expenditure been sought from Management Team (<£100k) or Governing Body (>£100k)?			
3.4	Improving quality (s14R, s14S)			
	Has a Quality Impact Assessment (QIA) been completed if relevant?			
	Have any issues or risks identified been appropriately addressed having taken advice from the Chief Nurse (or Deputy) if appropriate?			

3.5	Reducing inequalities (s14T) <table border="1" data-bbox="282 210 1406 329"> <tr> <td data-bbox="282 210 1262 241">Has an Equality Impact Assessment (EIA) been completed if relevant?</td> <td data-bbox="1262 210 1406 241"></td> </tr> <tr> <td data-bbox="282 241 1262 304">Have any issues or risks identified been appropriately addressed having taken advice from Equality Diversity & Inclusion Lead if appropriate?</td> <td data-bbox="1262 241 1406 304"></td> </tr> <tr> <td colspan="2" data-bbox="282 304 1406 329"></td> </tr> </table>		Has an Equality Impact Assessment (EIA) been completed if relevant?		Have any issues or risks identified been appropriately addressed having taken advice from Equality Diversity & Inclusion Lead if appropriate?					
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3.10	Environmental Sustainability <table border="1" data-bbox="282 1252 1406 1337"> <tr> <td data-bbox="282 1252 1262 1314">Have any significant (positive or negative) impacts on the environment or the CCG's carbon footprint been identified?</td> <td data-bbox="1262 1252 1406 1314"></td> </tr> <tr> <td colspan="2" data-bbox="282 1314 1406 1337"></td> </tr> </table>		Have any significant (positive or negative) impacts on the environment or the CCG's carbon footprint been identified?							
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GOVERNING BODY

20 January 2021

Outcomes of the Joint Local Area Inspection of Services for Children and Young People with Special Educational Needs in Barnsley

PART 1A – SUMMARY REPORT

1.	THIS PAPER IS FOR											
	<i>Decision</i>	<input type="checkbox"/>	<i>Approval</i>									
		<input type="checkbox"/>	<i>Assurance</i>									
		<input checked="" type="checkbox"/>	<i>Information</i>									
		<input checked="" type="checkbox"/>										
2.	PURPOSE											
	To inform the Governing Body of the outcomes of the Joint Local Area Inspection of Services for children and young people with special educational needs, including a disability (SEND) which was recently undertaken in the Borough by the Care Quality Commission (CQC) and Ofsted, together with the next steps.											
3.	REPORT OF											
	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr style="background-color: #d3d3d3;"> <th style="width: 35%;"></th> <th style="width: 35%;">Name</th> <th style="width: 30%;">Designation</th> </tr> <tr> <td>Executive / Clinical Lead</td> <td>Jamie Wike</td> <td>Chief Operating Officer</td> </tr> <tr> <td>Author</td> <td></td> <td></td> </tr> </table>				Name	Designation	Executive / Clinical Lead	Jamie Wike	Chief Operating Officer	Author		
	Name	Designation										
Executive / Clinical Lead	Jamie Wike	Chief Operating Officer										
Author												
4.	SUMMARY OF PREVIOUS GOVERNANCE											
	The matters raised in this paper have been subject to prior consideration in the following forums:											
	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr style="background-color: #d3d3d3;"> <th style="width: 45%;">Group / Committee</th> <th style="width: 15%;">Date</th> <th style="width: 40%;">Outcome</th> </tr> <tr> <td>Senior Management Team</td> <td></td> <td>Noted to outcomes of the inspection and the next steps including development of an action plan to respond to the findings</td> </tr> </table>			Group / Committee	Date	Outcome	Senior Management Team		Noted to outcomes of the inspection and the next steps including development of an action plan to respond to the findings			
Group / Committee	Date	Outcome										
Senior Management Team		Noted to outcomes of the inspection and the next steps including development of an action plan to respond to the findings										
5.	EXECUTIVE SUMMARY											
	Barnsley's Local Area SEND Inspection took place during the period 20th to 24th September 2021. The inspection was led by one of Her Majesty's Inspectors from Ofsted, with a team including an Ofsted inspector and a children's services inspector from the CQC.											

The purpose of the inspection was to review how well the local area meets its responsibilities for children and young people (aged 0-25) who have SEND. The inspection team looked at evidence for how well children and young people with SEND are supported through three distinct areas:

1. How well we identify the needs of this group of children and young people.
2. How well we assess and meet the needs of such children and young people.
3. How successful we are at getting the best outcomes for children and young people with SEND.

During the week before the inspection, and throughout the week-long inspection period, the inspectors were provided with information about Barnsley's children and young people with SEND, as well as the available services on offer to support them and their families. Inspectors looked at case files, data, reports and other information that is published online or internal to Barnsley services.

Over thirty focus groups and meetings were held with a wide range of participants from education, health and children's social care services. This included leaders, managers and front-line practitioners who work directly with children and young people. The inspectors visited several settings, including primary and secondary schools, special schools, our further education college, alternative provision providers and early years settings to gather evidence.

It is estimated that inspectors met or interviewed around two hundred people, during the inspection. In addition, the Barnsley SEND Youth Forum, and children and young people in local schools/settings, had meetings with the inspection team and over six hundred parents and carers' completed an online survey in preparation for the joint inspection.

The letter which details the outcome of the joint local area inspection was published on 19th November 2021 and is appended to this report. The inspection letter noted the progress which local statutory partners had made in addressing the needs of children and young people with SEND, together with their families and identified a number of strengths but also highlighted a number of areas for development where further progress is required.

We know that whilst significant progress has been made, we are not where we need to be, particularly in respect of the following two areas identified in the inspection letter as being areas of significant concern:

1. The engagement of, and communication with, parents and carers. Local statutory partners need to ensure that the lived experience of families is influencing their strategic plans for services and provision.
2. Improving the identification of, and provision for, children and young people with SEND but without an Education and Health Care Plan.

To address these areas along with the other areas identified as requiring further development, the Council and the CCG supported by the Barnsley Alliance for Schools and other partners will produce and submit a Written Statement of Action (WSOA) to Ofsted, no later than Monday 28 February 2022, which sets

	<p>out our plan for improving these areas of significant concern. The process will consist of the following steps:</p> <ol style="list-style-type: none"> 1. The local area must submit a Written Statement of Action (WSOA), within 70 working days of receiving the inspection report to, Ofsted and the CQC, and publish this on its Web site. 2. Ofsted and CQC will review the fitness and purpose of the WSoA usually within 10 working days (if deemed 'not fit for purpose' the local area must re-submit within 20 working days). 3. When the WSoA is deemed 'fit for purpose', the DfE, working with NHS England, will provide support and challenge to the local area, including on the development of the WSoA, with a minimum of four review meetings over an 18-month-period. Wider support will also be provided through funded delivery partners. 4. As is the case for Barnsley, areas inspected after June 2021 requiring a WSoA will not be re-visited under this current framework. Any subsequent visit or inspection activity for these areas will be under the new area SEND inspection framework, which is currently being developed. <p>Once the WSoA has been approved by Ofsted and the CQC, the local statutory partners will continue to work together to implement these actions. This will form part of the ongoing Borough SEND Improvement Programme, which is already established and includes representatives from across the local area from education, health and children's care services.</p>
6.	THE GOVERNING BODY IS ASKED TO:
	<ul style="list-style-type: none"> • Note the outcomes of the Joint Local Area Inspection and the next steps to develop and improvement action plan in response to the findings and particularly to two areas identified in the inspection letter as being areas of significant concern.
7.	APPENDICES / LINKS TO FURTHER INFORMATION
	<ul style="list-style-type: none"> • Appendix 1 – CQC/OFSTED Letter – Joint Area SEND Inspection in Barnsley, 15 November 2021

Agenda time allocation for report:	10 mins
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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 (<i>place ✓ beside all that apply</i>):			
	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	
	3.2 Maximising Elective Activity		9.1 Digital and Technology	
	4.1 Mental Health		10.1 Compliance with statutory duties	
	5.1 Integrated Care @ System		11.1 Delivery of Enhanced Health in Care Homes	
	5.2 Integrated Care @ Place		12.1 Delivering The Covid Vaccination Programme & Meeting The Needs of Patients with Covid-19	
	5.3 Implementing Population Health Management And Personalised Care			
	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 (<i>place ✓ beside all that are relevant</i>):			
	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 (<i>these will be especially relevant where a proposal or policy is brought for decision or approval</i>)			
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

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15 November 2021

Melanie John-Ross
Executive Director of Children's Services
Barnsley Metropolitan Borough Council
1 Westgate
Western Street
Barnsley
S70 2DR

Jamie Wike, Chief Operating Officer, Barnsley Clinical Commissioning Group
Lisa Loach, Local Area Nominated Officer, Barnsley Metropolitan Borough Council

Dear Ms John-Ross and Mr Wike

Joint area SEND inspection in Barnsley

Between 20 September 2021 and 24 September 2021, Ofsted and the Care Quality Commission (CQC) conducted a joint inspection of the local area of Barnsley to judge the effectiveness of the area in implementing the special educational needs and/or disabilities (SEND) reforms as set out in the Children and Families Act 2014.

The inspection was led by one of Her Majesty's Inspectors from Ofsted, with a team of inspectors including another Her Majesty's Inspector and a children's services inspector from the CQC.

Inspectors spoke with children and young people with SEND, parents and carers, and local authority and National Health Service (NHS) officers. They visited a range of providers and spoke to leaders, staff and governors about how they were implementing the SEND reforms. Inspectors looked at a range of information about the performance of the area, including the area's self-evaluation. Inspectors met with leaders for health, social care and education. They reviewed performance data and evidence about the local offer and joint commissioning.

As a result of the findings of this inspection and in accordance with the Children Act 2004 (Joint Area Reviews) Regulations 2015, Her Majesty's Chief Inspector (HMCI) has determined that a Written Statement of Action (WSOA) is required because of significant areas of weakness in the area's practice. HMCI has also determined that

the local authority and the area's clinical commissioning group (CCG) are jointly responsible for submitting the written statement to Ofsted.

In reaching their judgements, inspectors took account of the impact of the COVID-19 pandemic on SEND arrangements in the area. Inspectors considered a range of information about the impact of the pandemic and explored how the area's plans and actions had been adapted as a result.

This letter outlines our findings from the inspection, including some strengths and areas for further improvement.

Main findings

- Area leaders were slow to implement the 2014 reforms. This has led to high levels of dissatisfaction among parents and carers. Over the past two years, work has been done to start to mend what, leaders recognise, was a broken SEND system. Two key issues remain. First, the strategic influence of parents and carers is extremely limited. Second, the outcomes for pupils with SEND, without an education, health and care (EHC) plan, at SEND support are poor.
- Parents and carers have too little say in strategic decision-making about the area's services. Many parents and carers report dissatisfaction with their experience of the SEND system in Barnsley. The special educational needs and disabilities information advice and support service plays a significant role in supporting families and is effective.
- Leaders in the area do not communicate clearly with parents and carers. Parents and carers are not aware of ongoing improvement work or how to access support while waiting. They do not know about the significant improvement in waiting times for autism spectrum disorder assessments.
- Over time, many parents and carers have had to battle to get the provision and support their child needed. This is changing. In most cases, the voice of parents and carers is now listened to by practitioners. More and more individual plans are being co-produced with parents and carers. Co-production is a way of working where children and young people, families and those who provide the services work together to create a decision or a service which works for them all.
- There is a shortage of specialist education provision pre-16 years of age. There are insufficient school places locally for children and young people with SEND. This is leading to a reliance on out-of-area placements and late school placement decisions. Area leaders are aware of this and have plans to increase the amount of specialist provision locally.
- Outcomes for children and young people who have EHC plans are positive. Their placements are ambitious and meet their needs. However, the attainment, attendance and level of exclusions for pupils at SEND support are weak. The support provided to many pupils at SEND support does not meet their needs well.

Area leaders have developed training and monitoring systems to improve the help given to pupils at the SEND support stage. This work is not yet embedded.

- Barnsley local authority and the Barnsley clinical commissioning group (BCCG) have worked together to refresh and review the joint strategic needs assessment and the area's self-evaluation. The area's improvement plans explain clearly the work to be done in Barnsley. The priorities in the improvement plans fit well with the reforms in the Children and Families Act (2014). Since 2019, area leaders have worked on their priority areas with a true sense of purpose and commitment to the children and young people and their families in Barnsley. However, a significant amount of time was lost between 2014 and today. Many leaders were appointed since 2019 and are at the start of improving provision and outcomes for children and young people with SEND.
- Area leaders have taken advice from external advisers and reviewed waiting lists for services. This has led to changes in how services are organised. At local authority level, for example, the arrangements for managing requests for statutory assessment and the EHC plan process have changed. The BCCG reviewed the delivery of autism assessments. Steps taken by leaders have led to a reduction in the backlog of EHC plan assessments and improved waiting times for autism spectrum disorder diagnosis.
- The voice of children and young people with SEND is strong in Barnsley. Recommendations from the specialist youth forum have a clear route to the area's decision makers. Leaders have trained some young people with SEND as commissioners. As young commissioners, they advise on how services should be organised. The success of their work can be seen in the revised specification for the child and adolescent mental health service (CAMHS).
- In the early years of a child's life, health and children's services work together well. Staff from health, early years settings and family centres work in close partnership to offer effective support to parents and carers.
- The number of young people with SEND who progress into education or employment is strong. Area leaders ensure young people have targeted careers advice, guidance and support. Once a young person with SEND reaches Year 9, they are allocated a transition, individual advice and guidance (TIAG) team worker who supports them personally with their next steps post 16.
- The post-16 education and training offer is effective. Young people with SEND and their parents and carers are happy with the support and learning available at this point. Young people's studies broaden their awareness of themselves and help them to find employment.

The effectiveness of the area in identifying children and young people's special educational needs and/or disabilities

Strengths

- Area leaders use data to forecast the need for, and improve the effectiveness of, health and children's services. For example, health leaders redesigned the autism spectrum disorder diagnosis pathway to address long waiting times.
- Health services for children who are identified with SEND from birth are working well. The midwifery service identifies potential needs early and shares this information promptly with other services. Health visitors offer additional visits and support when needs are identified in pregnancy. Women and their families receive the right support from the earliest opportunity.
- Early years providers appreciate termly meetings with health visitors and the support available from the local authority's early years specialists and the area special educational needs coordinator. The local authority's early years advisory team, in collaboration with health and social care, has produced a progress check for two-year-olds in Barnsley. The information gathered by the progress check is used well by partners. Services are quick to identify a child who may need additional assessments or specialist support. Family support workers and services such as speech and language therapy (SaLT) get involved quickly when needed. Over the past 18 months, COVID-19 has caused some delay in the completion of some of the follow-up assessments. There is a plan in place to address these gaps.
- The portage service is spoken of highly by parents and carers. Portage practitioners work with parents and carers who have a child who is struggling to communicate and interact with others. Portage staff support the transition from home to early years settings well. Early years staff hit the ground running with what is already working well for children.
- Children and young people in care have access to an additional CAMHS offer commissioned by the BCCG. This resource helps identify any escalating social, emotional or mental health needs in this vulnerable group of young people.
- There is an early help support worker in the children's emergency department. This helps parents and carers get follow-on help from health and social care services following a hospital visit.

Areas for development

- Some parents and carers feel that schools do not have sufficient knowledge to understand the needs of their child fully. Parents and carers feel this leads to inflexibility when behaviour management systems are applied, or a lack of additional support. The SEND-related expertise of staff differs from school to school and across services. Leaders have recognised this and are working with schools and services to improve support for children and young people with

emerging needs. Leaders have recently introduced a SEND toolkit for use by practitioners. However, this toolkit and the training programme that goes with it are a recent development. There is no evidence of impact yet.

- School exclusions for pupils at SEND support are too high. Education welfare officers work with schools to identify early interventions for pupils at risk of exclusion. This development is at a very early stage. It is too soon to evaluate the impact of this work.
- School leaders have not been able to access prompt specialist SEND advice from the local authority consistently. Area leaders recognise this issue and are trying to improve the level of support available. For example, the local authority has invested in a core offer to schools from the educational inclusion service. Schools can now access an educational psychologist when they need one. This new arrangement has only just been explained to school leaders. There is no measurable impact of leaders' actions.
- There is a comprehensive local offer website. Unfortunately, many parents and carers do not know about the local offer or the website. Leaders have plans in place to redesign the website. Leaders know they need to improve communication with parents and carers about where to go for SEND-related information.
- Parents and carers of children and young people with SEND feel isolated. They are keen to meet others who have similar experiences. Some parents and carers have set up self-help groups and small networks. More needs to be done by partners across the area to help parents and carers share their experiences and learn from each other. Area leaders have plans to refresh forums for parents and carers and provide a route for them to contribute to local area decision-making.

The effectiveness of the area in meeting the needs of children and young people with special educational needs and/or disabilities

Strengths

- Children and young people with SEND access health therapies, such as SaLT, occupational therapy and physiotherapy, promptly. During the pandemic, the SaLT team developed new ways of conducting assessments and offering information and advice. For example, they used visualisers during assessments and developed digital games and videos to demonstrate interventions. This meant there was no interruption to the therapeutic offer despite periods of local restrictions necessitated by COVID-19.
- Barnsley's sensory programme is valued by parents and carers. This programme is designed by health partners to help parents and carers understand their child's sensory needs. This means that parents and carers are better able to meet their child's sensory needs in the home.
- There is effective provision for children and young people with visual and/or hearing impairment in Barnsley. The sensory impairment team includes specialist

teachers and habilitation officers. The habilitation officers for visual impairment, for example, help children and young people be more independent. The sensory team talk to children and young people with SEND and their families about their goals and build support plans around these.

- EHC plan processes and procedures have been weak over time. Statutory timescales were not met. Annual reviews were not completed. Pupils with an EHC plan did not receive the support they needed. However, area leaders have invested heavily in this area. The local authority has developed an online EHC hub that brings together many aspects of the EHC plan process. Additional staff have been appointed to deal with the backlog of EHC plan assessments and reviews. EHC plans more accurately reflect the needs of the child or young person. Now, reviews are generally held within the statutory timeframe.
- The TIAG team has a strong presence in the area. In Year 9, each young person is assigned a personal adviser who remains with them until they move into adulthood. Young people with SEND spoke highly of TIAG support and independent travel training. The TIAG support and the independent travel training are contributing well to the high numbers of young people with SEND who progress to post-16 education and training.
- The community children's nurse provision supports children with complex needs well. Health leaders have invested in this service. This has led to a reduction in the number of children with complex needs being admitted to hospital. The service also provides health education and care advice to out-of-school providers in the area. Children with complex needs have more access to appropriate support in holiday and after-school clubs because of this provision.
- Waiting times for autism spectrum disorder assessments are reducing. Area leaders have put in more support for children, young people, and their families during the assessment period. The autism spectrum disorder assessment team is jointly commissioned by the BCCG and Barnsley local authority. They identified a gap in services for children and young people who did not meet the threshold for diagnosis. There is a newly formed neurodevelopment family support team which offers an 18-week programme to children and young people with communication and interaction difficulties and their families. This is a positive development.
- Individual health services have made changes to their provision in response to what parents and carers told them. For example, health leaders consulted with parents and carers about the development of the children's emergency department assessment unit. Parents and carers said the unit needed to be more autism friendly and advised on changes that would help achieve this. The unit is now easier for families to use.

Areas for development

- Too many children wait too long for support for their social, emotional and mental health needs in the area. Leaders have recognised this. Plans are in place to address the outstanding issues.

- While there are improvements around the completion of EHC plans, the contributions from health and social care are of variable quality. Area leaders are aware of this and have put in place new quality assurance processes. These processes are in the early stages of development. Their impact on improving the consistency of contributions to EHC plans is not evident.
- Barnsley does not have an embedded 'tell it once' approach for the families of children and young people with SEND, especially across health services. Health leaders are aware of this and are piloting new ways of sharing information across different health partners.
- Transition to adulthood is underdeveloped in some health services. For some young people there is no equivalent adult health service. This causes anxiety for the young people and their families. Leaders are aware of this issue and there are ongoing pilots to identify solutions.
- Children and young people with SEND rely heavily on their schools to make friends and experience social events. In Barnsley, there is a limited range of opportunities and support for doing things outside of school. Social participation is not being identified as a need at EHC plan reviews consistently.

The effectiveness of the area in improving outcomes for children and young people with special educational needs and/or disabilities

Strengths

- The proportion of children and young people with SEND who progress to appropriate education, employment and training destinations at the end of key stages 4 and 5 is high. This is, in part, due to the breadth of provision available post 16 and the effective information, advice and guidance children and young people receive from schools and the TIAG team.
- Children in the early years and key stage 1, with an EHC plan, achieve well from their individual starting points. The area has improved their partnerships with early years providers. The training and support the area provides to schools and early years practitioners is now more closely linked to children's complex needs.
- The youth justice service has a specialist team, commissioned jointly by the BCCG and the local authority, which includes a learning disabilities nurse, dedicated time from an educational psychologist and two CAMHS workers. This team has helped officers in the youth justice service to better understand and meet the additional needs of the children and young people who are referred to them. As a result, rates of reoffending and the numbers of cases that lead to a criminal sentence are reducing.
- Outcomes for children with SEND in the early years and up to the end of Year 1 are improving. For example, 52% of boys were identified as having below-average levels of speech at two years old; this had reduced to 15% on entry to school. The area also provides support for children with SEND who are not fluent readers.

Areas for development

- The academic outcomes achieved by pupils at SEND support are weak. By the end of Year 1, approximately six in every ten pupils at SEND support do not reach the expected standard in reading. While there have been some marginal improvements of late, across all key stages in primary and secondary schools, pupils at SEND support achieve poorly.
- Leaders acknowledge that rates of absence and exclusion for children and young people at SEND support are too high. They are right to be concerned. For example, during the 2018/19 academic year, the proportion of suspensions for these pupils was nearly double the national average for the same pupil group. Furthermore, pupils at SEND support miss too many days of school. This contributes to weaker academic outcomes over time. Leaders have recently appointed a specialist education and welfare officer to work on this issue with school partners. There is no measurable impact yet.

There are insufficient opportunities in the area for children and young people with SEND to socialise with their peers. This is limiting the development of social skills that will help children and young people with SEND prepare for adulthood.

The inspection raises significant concerns about the effectiveness of the area

The area is required to produce and submit a WSOA to Ofsted that explains how it will tackle the following areas of significant weakness:

- The engagement of, and communication with, parents and carers. Area leaders need to ensure that the lived experience of families is influencing their strategic plans for services and provision.
- Improving the identification of, and provision for, children and young people with SEND but without an EHC plan.

Yours sincerely

Patricia Head
Her Majesty's Inspector

Ofsted	Care Quality Commission
Emma Ing Regional Director	Mani Hussain Deputy Chief Inspector, Primary Medical Services, Children Health and Justice
Patricia Head	Claire Mason

HMI Lead Inspector	CQC Inspector
Lee Elliott HMI	

Cc: Department for Education
Clinical commissioning group
Director of Public Health for the area
Department of Health
NHS England

Governing Body

20 January 2021

Quality & Patient Safety Committee - Quality Highlights Report

PART 1A – SUMMARY REPORT

1.	THIS PAPER IS FOR											
	<i>Decision</i> <input type="checkbox"/>	<i>Approval</i> <input type="checkbox"/>	<i>Assurance</i> <input checked="" type="checkbox"/>	<i>Information</i> <input checked="" type="checkbox"/>								
2.	PURPOSE											
	Provide the January 2022 Governing Body with the agreed highlights of the discussions at the Quality & Patient Safety Committee on 16 December 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											
	<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr style="background-color: #d9e1f2;"> <th></th> <th style="text-align: left;">Name</th> <th style="text-align: left;">Designation</th> </tr> </thead> <tbody> <tr> <td>Executive / Clinical Lead</td> <td>Jayne Sivakumar</td> <td>Chief Nurse</td> </tr> <tr> <td>Author</td> <td>Hilary Fitzgerald</td> <td>Quality Manager</td> </tr> </tbody> </table>				Name	Designation	Executive / Clinical Lead	Jayne Sivakumar	Chief Nurse	Author	Hilary Fitzgerald	Quality Manager
	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: <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr style="background-color: #d9e1f2;"> <th style="text-align: left;">Group / Committee</th> <th style="text-align: left;">Date</th> <th style="text-align: left;">Outcome</th> </tr> </thead> <tbody> <tr> <td>Quality and Patient Committee</td> <td>16 December 2021</td> <td>To raise as highlights to the Governing Body</td> </tr> </tbody> </table>			Group / Committee	Date	Outcome	Quality and Patient Committee	16 December 2021	To raise as highlights to the Governing Body			
Group / Committee	Date	Outcome										
Quality and Patient Committee	16 December 2021	To raise as highlights to the Governing Body										
5.	EXECUTIVE SUMMARY											
	<p>At the Quality and Patient Safety Committee meeting on 16 December 2021, it was agreed that the following quality issues are highlighted to the Governing Body and rated:</p> <ul style="list-style-type: none"> Green – BHNFT's Digital Transformation Strategy Amber – Barnsley Hospice CQC Update Amber – Oncology Provision Amber - Lymphoedema Service Update Red – Urology Incidents Red - Staff Changes in Core Quality Team 											

	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 confirm whether further assurances are required in relation to the items rated amber or red.
7.	APPENDICES / LINKS TO FURTHER INFORMATION
	Appendix A – Quality Highlights Report

Agenda time allocation for report:	10 minutes.
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PART 1B – SUPPORTING INFORMATION & ASSURANCE

1.	Links to Corporate Priorities, GBAF and Risk Register																								
	<p>This report provides assurance against the following corporate priorities on the Governing Body Assurance Framework:</p> <table border="1"> <tr> <td>1.1 Urgent & Emergency Care</td><td></td><td>6.1 Efficiency Plans</td><td></td></tr> <tr> <td>2.1 Primary Care</td><td></td><td>7.1 Transforming Care for people with LD</td><td></td></tr> <tr> <td>3.1 Cancer</td><td>✓</td><td>8.1 Maternity</td><td></td></tr> <tr> <td>4.1 Mental Health</td><td></td><td>9.1 Digital and Technology</td><td>✓</td></tr> <tr> <td>5.1 Integrated Care @ System</td><td></td><td>10.1 Compliance with statutory duties</td><td>✓</td></tr> <tr> <td>5.2 Integrated Care @ Place</td><td></td><td></td><td></td></tr> </table>	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			
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	<p>This report has been prepared with regard to the following CCG statutory duties set out in Chapter A2 of the NHS Act:</p> <table border="1"> <tr> <td>Management of conflicts of interest (s14O)</td><td></td><td>Duties as to reducing inequalities (s14T)</td><td>✓</td></tr> <tr> <td>Duty to promote the NHS Constitution (s14P)</td><td></td><td>Duty to promote the involvement of each patient (s14U)</td><td></td></tr> <tr> <td>Duty to exercise its functions effectively, efficiently and economically (s14Q)</td><td>✓</td><td>Duty as to patient choice (s14V)</td><td>✓</td></tr> <tr> <td>Duty as to improvement in quality of services (s14R)</td><td>✓</td><td>Duty as to promoting integration (s14Z1)</td><td></td></tr> <tr> <td>Duty in relation to quality of primary medical services (s14S)</td><td></td><td>Public involvement and consultation (s14Z2)</td><td></td></tr> </table>	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)					
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3.	Governance Considerations Checklist																								
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	<table border="1"> <tr> <td>Have GB GPs and / or other appropriate clinicians provided input and leadership?</td><td>Y</td></tr> <tr> <td colspan="2">Jayne Sivakumar, Chief Nurse</td></tr> </table>	Have GB GPs and / or other appropriate clinicians provided input and leadership?	Y	Jayne Sivakumar, Chief Nurse																					
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3.3	Discharging functions effectively, efficiently, & economically (s14Q)																								
	<table border="1"> <tr> <td>Have any financial implications been considered & discussed with the Finance Team?</td><td>N</td></tr> <tr> <td>Where relevant has authority to commit expenditure been sought from Management Team (<£100k) or Governing Body (>£100k)?</td><td>NA</td></tr> </table>	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																				
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3.4	Improving quality (s14R, s14S)																								
	<table border="1"> <tr> <td>Has a Quality Impact Assessment (QIA) been completed if relevant?</td><td>NA</td></tr> <tr> <td>Have any issues or risks identified been appropriately addressed having taken advice from the Chief Nurse (or Deputy) if appropriate?</td><td>NA</td></tr> <tr> <td>See Appendix A</td><td></td></tr> </table>	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																			
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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
Medway Presentation	BHNFT's Director of ICT gave a comprehensive presentation on the Trust's Digital Transformation Strategy, including the work completed to date and future projects.	QPSC agreed that the presentation provided reassurance that the Committee is making good progress to transform BHNFT's digital capabilities and these will generate quality improvements.
Barnsley Hospice CQC Update	<p>QPSC was briefed on the improvements made at Barnsley Hospice, including those that are required by the CQC. Work is still required to strengthen the Hospice's overall governance systems.</p> <p>The Chief Executive meets fortnightly with the CQC, and they are reassured regarding the progress of the Hospice's action plans. The CCG's Chief Nurse continues to meet regularly with the Hospice's Chief Executive to discuss the progress of improvements and wider quality and patient safety matters.</p>	QPSC noted the ongoing work to implement the required CQC actions and agreed the Committee would continue monitor the progress.
Oncology Provision	<p>QPSC received an update on Oncology provision for Barnsley patients following the temporary decision by Weston Park Hospital to cease providing face-to-face appointments at Barnsley Hospital for colorectal and breast oncology patients.</p> <p>The Committee received details of a range of actions being taken to mitigate potential risks with the temporary arrangements and to improve patient experience whilst a long-term solution is developed.</p>	QPSC noted the latest position in relation to Oncology provision and will continue to monitor the impact of the current arrangements upon patient safety and experience.
Lymphoedema Service Update	QPSC received an update about the progress of plans to transfer the Lymphoedema Service to South West Yorkshire Partnership NHS Foundation Trust (SWYPFT). The Trust has requested that the CCG continues to operate the service for a few more weeks until additional staff have been recruited to SWYPFT to provide the service.	<p>The Committee agreed the service needs to be transferred as quickly as possible given that the CCG is not a provider of health services.</p> <p>The Chief Nurse is to formulate a response to SWYPFT outlining the CCG's concerns.</p>

Issue	Consideration	Action
	Discussions in the Committee highlighted that the patients have been clinically triaged by the CCG and therefore a service could be managed within the Trust's existing resources until new staff are in place.	
Urology Incidents	<p>Q&PSC received the results of a thematic review of Urology incidents which have been reported to the CCG via the national NHS incident reporting system, StEIS, between 1 April 2021 and to date. The Committee was also informed about the actions being undertaken by BHNFT in response to these incidents. The update also alerted the Committee to wider concerns by the CCG about the Trust's systems and processes for tracking patients that require follow up or surveillance.</p> <p>The CCG has previously received an update on the Urology action plan at the BHNFT Clinical Quality Board on 08/10/2021. The CCG requested a copy of the action plan on 25/11/2021 but at the time of this report, the action plan has not yet been received.</p> <p>The CCG's Chief Nurse has requested an extra-ordinary meeting with the Trust to seek further assurances about the measures being taken in relation to Urology incidents and wider issues about patient follow up.</p>	<p>QPSC noted the update and agreed it was not sufficiently assured regarding the actions being undertaken by BHNFT to address the risks around patient follow up in Urology.</p> <p>It was agreed that the outcome of the assurance meeting should be presented to the next QPSC meeting.</p>
Staff Changes in CCG's Core Quality Team	The Committee was informed that the CCG's Quality Manager is due to leave the CCG on 18 February 2022. Recruitment for a permanent replacement has been delayed due to a job matching query. There is a significant risk to the ability of the CCG to maintain its complaints and quality monitoring functions if there is a staffing gap between the departure of the Quality Manager and the start of their replacement. The Chief Nurse outlined actions being taken to obtain interim support.	QPSC noted the potential risk to the Quality function and the arrangements being taken to mitigate this.

GOVERNING BODY

20 January 2021

RISK AND GOVERNANCE EXCEPTION REPORT

PART 1A – SUMMARY REPORT

1.	THIS PAPER IS FOR							
	<i>Decision</i>	<input type="checkbox"/>	<i>Approval</i>	<input checked="" type="checkbox"/>	<i>Assurance</i>	<input checked="" type="checkbox"/>	<i>Information</i>	<input type="checkbox"/>
2.	PURPOSE							
	<ul style="list-style-type: none"> To assure the Governing Body re the delivery of the CCG's annual strategic objectives To assure the Governing Body that the current risks to the organisation are being effectively managed and monitored appropriately 							
3.	REPORT OF							
		Name	Designation					
	Executive Lead	Richard Walker	Head of Governance & Assurance					
	Author	Paige Dawson	Governance, Risk & Assurance Facilitator					
4.	SUMMARY OF PREVIOUS GOVERNANCE							
	The matters raised in this paper have been subject to prior consideration in the following forums:							
	Group / Committee	Date	Outcome					
	All Committees	Various	Review extracts of the GBAF and Risk register at every meeting					
5.	EXECUTIVE SUMMARY							
5.1	Governing Body Assurance Framework <p>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.</p>							

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 (November 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 14 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 14/10 (rated score 16 'extreme') - If the Barnsley area is not able to attract & retain a suitable & sufficient Primary Care clinical workforce e.g. due to delays in recruiting into the ARRS roles there is a risk that:
(a)Primary Medical Services for patients are inconsistent (b)The people of Barnsley will receive a poorer quality of healthcare services (c)Patients services could be further away from their home.
- 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 (rated score 16 'extreme') - 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 (rated score 16 'extreme') - 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 21/03 (rated score 20 'extreme') - If issues in the timely reporting of data continue in relation to Continuing Health Care (Adult and Children) and complex case management (Including S117), this is likely to result in the financial forecast for this area to be misstated and lead to variation in the forecast position, creating financial risk.
- Ref CCG 13/13 (rated score 15 'extreme') - 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.
- Ref CCG 21/05 (rated score 16 'extreme') - There is a risk that Barnsley patients will not have the option to have face to face oncology appointments at BHNFT due a shortage of consultant capacity for oncology across SY&B. This will impact on patients choice and access to the service.
- Ref CCG 21/06b (rated score 16 'extreme') - There is a risk that if the CCG is unable to reprocur at the end of March 2022 for the Medical Oversight of the Acorn Unit, that potentially medical oversight at the Unit will not exist.
- Ref CCG 21/02 (rated score 20 'extreme') - If the Barnsley and South Yorkshire and Bassetlaw System are unable to commission care that demonstrates value for money for complex patients, there is a risk that the market of private provision will create significant financial risk to the CCG. This is a national issue with provision for this cohort of patients being limited and therefore costly. The CCG needs to shape and develop the home care and residential care provider market working with the Local Authority and across the ICS where complex case provision needs development. If this does not happen and the provider framework is not reviewed the quality of care may be jeopardised, patients may need to be placed outside of area and it is likely the costs will continue to rise.

Update:

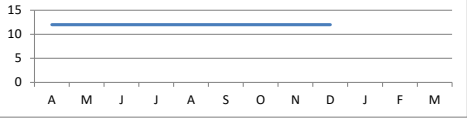
In relation to risk 13/13 re YAS subsequent to the latest update to the risk register, YAS has communicated its intention to suspend routine patient transport journeys to planned care clinics from Wednesday 12 January 2022 until further notice as a result of the current wave of Covid19. In addition, the ambulance service is coming under intense pressure due to the recent surge in cases resulting in a decline in performance against response time targets and an increase in the number of serious incidents reported by the service. In light of this, in the opinion of the Chief Nurse the risk score should be increased to $4 \times 5 = 20$.

6.	THE GOVERNING BODY IS ASKED TO:	
	<ul style="list-style-type: none"> • Review the GBAF for 2021/22, 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 increased risk score to ref CCG 13/13 of 4x5=20. 	
7.	APPENDICES / LINKS TO FURTHER INFORMATION	
	<ul style="list-style-type: none"> • Appendix 1 – GBAF 2021/22 • Appendix 2 – Corporate Risk Register 	
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	✓
	2.1 Primary Care	✓
	3.1 Cancer	✓
	4.1 Mental Health	✓
	5.1 Integrated Care @ System	✓
	5.2 Integrated Care @ Place	✓
	6.1 Efficiency Plans	✓
	7.1 Transforming Care for people with LD	✓
	8.1 Maternity	✓
	9.1 Digital and Technology	✓
	10.1 Compliance with statutory duties	✓
	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)	
	Duty to promote the NHS Constitution (s14P)	✓
	Duty to exercise its functions effectively, efficiently and economically (s14Q)	
	Duty as to improvement in quality of services (s14R)	
	Duty in relation to quality of primary medical services (s14S)	
	Duties as to reducing inequalities (s14T)	
	Duty to promote the involvement of each patient (s14U)	
	Duty as to patient choice (s14V)	
	Duty as to promoting integration (s14Z1)	
	Public involvement and consultation (s14Z2)	
3.	Governance Considerations Checklist <i>(these will be especially relevant where a proposal or policy is brought for decision or approval)</i>	
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

PRIORITY AREA 1: URGENT & EMERGENCY CARE				Delivery supports these CCG objectives:		PRINCIPAL THREATS TO DELIVERY		
<ul style="list-style-type: none">Increased clinical assessment of calls to NHS 111 & CASPromote the use of NHS 111 as a primary route into all urgent care services - maximise the use of booked time slots in A&EDelivery 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 servicesEnhance Same Day Emergency Care including acute frailty services, increasing the proportion patients discharged on the day of attendance and avoiding unnecessary hospital admission.Improved patient flow and reduce length of stayRollout of the 2-hour crisis community health response at home (8am-8pm, seven days a week) by April 2022				Highest quality governance		If partners locally and across the ICS do not engage constructively together, to develop a model for urgent care at a South Yorkshire and Bassetlaw and Barnsley level, in line with best practice and national guidance there is a risk that urgent care services are unable to meet the growing demand, constitution standards for urgent care are not achieved and the quality of patient care is negatively impacted.		
				High quality health care				
				Care closer to home				
				Safe & sustainable local services				
				Strong partnerships, effective use of £				
				Links to NHSE/ Planning Guidance				
				E2 - Ensuring the use of NHS111 as the primary route to access urgent care and the timely admission of patients to hospital who require it from emergency departments				
Committee Providing Assurance			FPC	Executive Lead		JW	Clinical Lead	JH & MS
Risk rating	Likelihood	Consequence	Total				Date reviewed	Dec-21
Initial	3	4	12				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.	
Current	3	4	12					
Appetite	3	4	12					
Approach	Tolerate							
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, Enhancement 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 Plan is in place and agreed by partners Barnsley are engaged in a SYB Improving Urgent and Emergency Care programme being supported by NHSE national improvement teams to support further improvement of UEC services.			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 COO and Barnsley Hospital Director of 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 in place 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 Integrated 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 Decision 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 have been remodeled as part of the Neighbourhood Team mobilisation and includes PCN/Neighbourhood developments.		

PRIORITY AREA 2: PRIMARY CARE				Delivery supports these CCG objectives:		PRINCIPAL THREATS TO DELIVERY							
<p>Delivery of the Long Term Plan</p> <p>Delivery of the Primary Care Network Contract DES to support the continued development of the Primary Care Network and sustainable primary care medical services.</p> <p>Support the reset of core GMS/PMS/APMS contract delivery across primary care</p> <p>Support the embedding of new ways of working learned from the pandemic</p> <p>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).</p> <p>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"</p> <p>Ensure recruitment/retention/development of the clinical and non-clinical workforce</p> <p>Work with the PCN to maximise recruitment under the Additional Roles Reimbursement Scheme and take action to support them to meet recruitment plans</p> <p>Support the recruitment and retention of extra doctors working in general practice.</p> <p>Improve access particularly during the working week with more bookable appointments at evenings and weekends.</p> <p>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</p> <p>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</p> <p>Meet 2021/22 trajectories set out in the Network Contract DES and support planning to achieve the KPIs.</p> <p>Improve infrastructure, digital capability, digital literacy and inclusion.</p> <p>Deliver delegated Primary Care functions to be confirmed via mandated internal audit reviews</p>				<p>Highest quality governance</p> <p>High quality health care</p> <p>Care closer to home</p> <p>Safe & sustainable local services</p> <p>Strong partnerships, effective use of £</p>		<p>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:</p> <ul style="list-style-type: none">- 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							
				<p>Links to NHSE/I Planning Guidance</p>									
				<p>D1 - Restoring and increasing access to primary care services</p>									
<p>Committee Providing Assurance</p>				<p>PCCC</p>		<p>Executive Lead</p>		<p>JW / JF</p>		<p>Clinical Lead</p>		<p>MG</p>	
<p>Risk rating</p>		<p>Likelihood</p>		<p>Consequence</p>		<p>Total</p>				<p>Date reviewed</p>		<p>Dec-21</p>	
<p>Initial</p>		<p>3</p>		<p>4</p>		<p>12</p>				<p>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.</p>			
<p>Current</p>		<p>3</p>		<p>4</p>		<p>12</p>							
<p>Appetite</p>		<p>3</p>		<p>4</p>		<p>12</p>							
<p>Approach</p>		<p>TOLERATE</p>											
<p>Key controls to mitigate threat:</p>						<p>Sources of assurance</p>						<p>Rec'd?</p>	
<p>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.</p>						<p>National database regularly updated to show workforce</p> <p>National PCN Dashboard developed and evolving</p> <p>CCG to monitor recruitment by PCN</p>						<p>Ongoing</p>	
<p>Additional investment above core contracts through PDA delivers £4.2 to Barnsley practices to improve sustainability and attract workforce to the Barnsley area</p>						<p>Ongoing monitoring of PDA (contractual / QIPP aspects via FPC, outcomes via PCCC).</p>						<p>Ongoing</p>	
<p>Optimum use of BEST sessions</p> <p>A contract is in place with BHF for the BEST programme which enables the CCG to support the programme</p>						<p>BEST programme and Programme co-ordination being led by BHF</p> <p>Contract management meetings in place to assess and reporting via PCCC</p>						<p>Ongoing</p>	
<p>Established a Primary care Strategy Group and delivery Group to support delivery of the primary Care Transformation programme.</p> <p>Development of Neighbourhood working within each of the 6 Neighbourhoods supported by the PCN and CCG.</p> <p>Bi-monthly PCN meetings established for all practices in the PCN.</p> <p>The 3 service specification from the Network Contract DES are now being undertaken by practices across each Neighbourhood.</p> <p>Work with the PCN to prepare for the next Service Specifications</p> <p>Work with the PCN regarding tackling health inequalities which have been further impacted by Covid.</p> <p>PCN Manager meetings set up with the CCG PC Team to support the Long Term Plan and DES delivery.</p>						<p>Primary Care Strategy Group working as a sub-group of PCCC</p> <p>Primary Care Delivery Group working to deliver the transformation programme</p> <p>6 Neighbourhood Networks have been agreed with the support of a single Primary Care Network facilitated by the GP Federation.</p> <p>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.</p> <p>Meetings are set for the year to ensure that the PCNs are able to meet regularly.</p>						<p>Ongoing</p>	
<p>BHF - Existence of strong federation supports Primary Care at Scale</p>						<p>BHF contract monitoring, oversight by PCCC</p>						<p>Ongoing</p>	
<p>Practices increasingly engaging with Community, voluntary and social care providers</p> <p>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.</p> <p>Work towards joining the services together as directed in the Network Contract DES.</p> <p>Collaboration to deliver primary care transformation and service delivery</p>						<p>Personalisation and Social Prescribing are key elements in the Long Term Plan.</p> <p>Care Coordinators, Health and Wellbeing Coaches are in place to support people with self care.</p> <p>Primary Care Strategy Group working as a sub-group of PCCC</p> <p>Primary Care Delivery Group working to deliver the transformation programme</p>						<p>Ongoing</p>	
<p>Engagement and consultation with Primary Care (Membership Council, Practice Managers etc.)</p>						<p>NHS England 360 Stakeholder Survey results shared with stakeholders and published on the CCG website.</p> <p>Ensuring BCCG stakeholders have a high level of satisfaction with the CCG's leadership & engagement.</p>						<p>Ongoing</p>	
<p>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.</p>						<p>BCCG is represented on all workforce groups.</p> <p>Reporting is via PCCC for Primary care.</p>						<p>Ongoing</p>	
<p>Gaps in assurance</p>						<p>Positive assurances received</p>							
<p>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.</p> <p>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.</p> <p>JULY 2021 - BEST contract still requires work around KPI reporting and achievement.</p>						<p>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.</p> <p>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.</p> <p>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.</p>							
<p>Gaps in control</p>						<p>Actions being taken to address gaps in control / assurance</p>							
<p>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.</p>						<p>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.</p> <p>Working closely with BHF to ensure the PCN maximise the recruitment opportunity for Barnsley.</p> <p>Practices encouraged to look at skill mix with innovative recruitment.</p> <p>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.</p> <p>The PC Team work closely with the PCN Managers to ensure delivery is on track.</p> <p>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.</p> <p>Requested the the CCG Medical Director be involved with the planning of the BEST sessions as per contract.</p> <p>2021-22 PDA includes reference to work required for PC from the Planning Guidance.</p>							

PRIORITY AREA 3.1: CANCER				Delivery supports these CCG objectives:		PRINCIPAL THREATS TO DELIVERY	
<ul style="list-style-type: none">Preventing cancer incidenceReduced Inequalities especially those diagnosed at emergency admission.Improved cancer diagnosed rates at stage 1 or 2Early Diagnosis - Implement rapid assessment and diagnosis pathways for all tumour sitesImprove care and treatment - embed new cancer waiting times systemImprove Patient Experience along pathways and LWBACIncreasing Positive Experience at EOL by increasing early identification and reducing 3 or more admissions in last 3 months of lifeDeliver Survivorship Program (LWABC) including recovery package and stratified pathwaysCommissioning for Value adopted if appropriateAchieve 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	✓	<p>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.</p> <p>2. Risk to delivery of early diagnosis if:</p> <p>(a) the CCG does not effectively promote to the people of Barnsley the national screening programme</p> <p>(b) Practices do not consistently apply NICE guidance for cancer diagnosis and referral and deliver the PCN DES .</p> <p>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 .</p> <p>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.</p>	
				High quality health care	✓		
				Care closer to home	✓		
				Safe & sustainable local services	✓		
				Strong partnerships, effective use of £	✓		
Links to NHSE/ Planning Guidance							
C2 - Restore full operation of all cancer services							
Committee providing assurance		FPC	Executive Lead		JW	Clinical Lead	Dr H Kadarsha
Risk rating	Likelihood	Consequence	Total			Date reviewed	Dec-21
Initial	3	4	12			<p>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</p>	
Current	5	4	20				
Appetite	5	4	20				
Approach	Treat						
Key controls to mitigate threat:				Sources of assurance		Rec'd?	
Programme Governance arrangements							

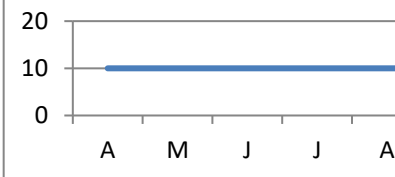
Date reviewed Dec-21

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

<p>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.</p>	<p>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. 6 weekly reporting to SMT about minimising harm and P3 restoration programme delivery progress plus areas that require escalation delete</p>	<p>Ongoing</p>
<p>62 Day Waits and 28 FDS</p>		
<p>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 65% September 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 .</p>	<p>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</p>	<p>Ongoing</p>
<p>Prevention</p>		
<p>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.</p>	<p>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 .</p>	<p>Ongoing</p>
<p>Early Diagnosis</p>		

<p>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. .</p>	<p>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.</p>	Ongoing
<i>Better treatment and care</i>		
<p>Waiting times: Start again rolling out timed pathway to reduce pressure on system. Tele dermatology : CCG Gov body agreed VEAT & contract to 31/03/2022- 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 and increase in serious incidentreporting . Producing harm policy with CA that is more holistic definition that includes psychological harm of being on a prolonged pathway .</p>	<p>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.</p>	Ongoing
LWABC		
<p>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 prolonged delays on local completion - working BHNFT to address. New men's peer group for prostate cancer completed and being taken foward as outcomes were positive .</p>	<p>Barnsley LWABC steering group governance framework in place and LWABC Leads membership of CA LWABC programme ensures programme reported to CCG</p>	Ongoing
End of Life		
<p>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. Palliative care GP for ICS and Barnsley engaging with practices to identify how EOL working can be improved and working on supporting PCN.</p>	<p>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</p>	Ongoing
<i>Communication and engagement</i>		
<p>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.</p>	<p>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 .</p>	
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				Delivery supports
<p>There are four key areas of work:</p> <p>1. Clinical Prioritisation - Continue to prioritise the clinically most urgent patients and address the longest waiters whilst ensuring health inequalities are tackled.</p> <ul style="list-style-type: none">• <i>Greatest Harm</i> - 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 prioritisation tool (FSSA recovery prioritisation matrix) to support the prioritisation of all referrals & draw on both primary and secondary care knowledge• <i>Long waiters</i> - 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 <p>2. Communication - maintain effective communication with patients including proactively reaching out to those who are clinically vulnerable.</p> <ul style="list-style-type: none">• Develop a system wide communications plan to inform public of approach and maintain effective proactive communication with patients. <p>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.</p> <ul style="list-style-type: none">• <i>Advice and Guidance</i> - (Maintain) Increased mobilisation of advice and guidance to provide specialist advice (this supports low conversion rates to outpatient appointments)• <i>Patient initiated follow-up</i> (PIFU) - Expansion of programme so that PIFU is available in at least three major outpatient specialties by the end of Q2.• <i>Remote Appointments</i> - 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). <p>4. Elective Activity / Elective Recovery Fund</p> <ul style="list-style-type: none">• Monitoring elective recovery against the 95% target: From July 2021 deliver 95%				<p>Highest quality governance</p> <p>High quality health care</p> <p>Care closer to home</p> <p>Safe & sustainable</p> <p>Strong partnerships</p> <p>Links to NHSE/ PIP</p> <p>C1 - Maximise elective activity</p>
Committee Providing Assurance			TBC	Executive Lead
Risk rating	Likelihood	Consequence	Total	
Initial	3	4	3	
Current	3	4	4	
Appetite	3	4	12	
Approach	Tolerate			
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 and Communication and Engagement Plan

Operational planning process for the 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 around 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 awaiting operation and increased pressure on services to deliver.

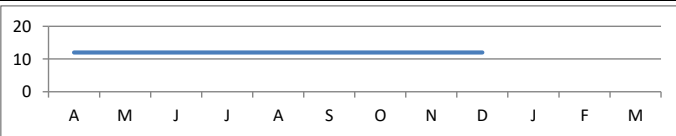
A further issue is the reticence of local residents to travel outside of Barnsley for treatment.

work 2021-22

these CCG objectives:		PRINCIPAL THREATS TO DELIVERY	
ernance		<p>There is a risk that the CCG will not be able to maximise elective activity if the following issues are not mitigated:</p> <ol style="list-style-type: none"> 1. Clear and effective communication to the public about delays to treatment and prioritisation. 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	✓		
i, effective use of £	✓		
Planning Guidance			
tive activity			
JW		Clinical Lead	
		MG,MS,J	
<p>S O N D J F M</p>		Date reviewed Dec-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?	

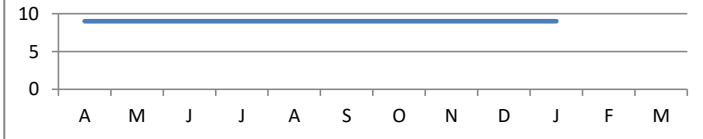
<p>Chief Operating Officer, CCG Chair and 2 x Governing Body members are represented on the board.</p> <p>Work is ongoing to align the elective care system wide plan to the planning Guidance and other NHSE Guidance on the transformation of outpatients / specialty redesign. The group has recently established the scope of 'elective care' and set key deliverables for 2021/22.</p>	Ongoing
<p>Planned Care Board is established to provide oversight of the programme. The Board has representation from all partners.</p> <p>Clear priorities have been agreed as part of development of the Barnsley Place Plan.</p> <p>Comms and Engagement Plan is being delivered as part of wider system work around pressures in the H&SC system</p>	In Progress
<p>Chief Operating Officer, CCG Chair and 2 x Governing Body members are represented on the Planned Care board.</p> <p>Work is ongoing to ensure alignment of the elective care system wide plan to the planning Guidance and other NHSE Guidance on the transformation of outpatients / specialty</p>	Ongoing
	Actions being taken to address gaps in control / assurance
<p>social distancing, and covid. This is a risk.</p>	<ul style="list-style-type: none"> • 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 clinically vulnerable
<p>in terms of ipc and waiting their</p>	<ul style="list-style-type: none"> • 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 PIFU and comms.

NHS Barnsley CCG Governing Body Assurance Framework 2021-22

PRIORITY AREA 4: MENTAL HEALTH				Delivery supports these CCG objectives:		PRINCIPAL THREATS TO DELIVERY					
<p>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 implement the new co-produced service specification focusing on establishing a Single point of Contact.</p> <p>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</p> <p>IAPT services to be expanded to the level of investment available and working towards delivering the recoemendations of the NHS Long Term Plan. Access targets will be challenging and the recommended targets unlikely 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%</p> <p>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.</p> <p>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 established and funding agreed to achieve the necessary expansion to achieve the LTP access requirements for 2021/22</p> <p>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</p> <p>The Mental Health Investment Standard (MHIS) will be ahcieved.</p> <p>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.</p> <p>66.7% of people with dementia aged >65 should receive a formal diagnosis.</p>				Highest quality governance		<p>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</p>					
				High quality health care							
				Care closer to home							
				Safe & sustainable local services							
				Strong partnerships, effective use of £							
Links to NHSE/I Planning Guidance				<p>C3 - Expand and improve mental health services and services for people with a learning disability and/or autism</p>							
Committee providing assurance		FPC & QPSC		Executive Lead		PO		Clinical Lead		Dr M Smith	
Risk rating	Likelihood	Consequence	Total					Date reviewed		Dec-21	
Initial	4	3	12								
Current	4	3	12								
Appetite	4	3	12								
Approach	Tolerate										

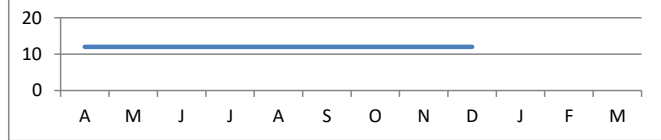
Key controls to mitigate threat:	Sources of assurance	Rec'd?
The Future in Mind funding allocations are now part of the CCG's baseline allocations and will continue to be utilised towards delivering the ambitions of the NHS Long Term plan	Quarterly Assurance reports / feedback to NHS England; monitored 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 Programme Board are leading on a regional workforce strategy to cover the next 5 years	Monitored at ICS level SYB ICS MHL D Steering Group.	Ongoing
Commissioning capacity for the adult autism service has been increased for 2021/22 and non-recurrent 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 Barnsley's children and young peoples autism assessment and diagnostic pathways 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 is shared with GB. Autism 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 picture. Work is underway via the SYB ICS MHL D. Minutes of the SYB ICS MHL D Steering Group.	Ongoing
IAPT access targets are a key challenge in Barnsley - the 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 available in future years.		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 Barnsley 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 stakeholders 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 MHL D 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	

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							
<p>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.</p> <p>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 for 22/23. 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 2022/23 will need to finalised for April 22. White paper on the formation of statutory ICS published Dec 20 with an ambition for statutory ICS to form in July 2022, legislation going through parliament and designate appointments are being made</p>				Highest quality governance		✓		<p>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.</p> <p>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.</p>					
				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						Date reviewed		Jan-22	
Initial		3	3	9						<p>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.</p>			
Current		3	3	9									
Appetite		3	4	12									
Approach		Tolerate											
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 JCCCCG						Ongoing	

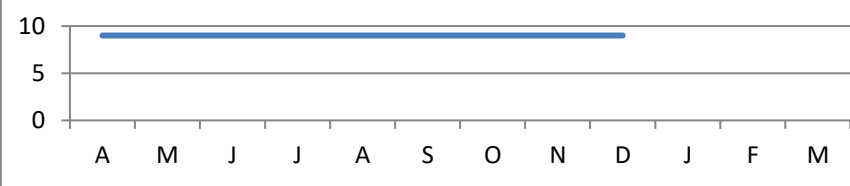
Collaborative Partnership Board (CPB) provides strategic direction and oversight of the ICS, while the Joint Commissioning Committee of CCGs facilitates collective commissioning decisions over defined areas.	Minutes of both CPB and JCCC of CCGs are taken through the Governing Body	Ongoing
ICS Memorandum 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.	
	governing body receives regular updates, HEG minutes and every other month meets as the focussing on the transition to ICB	
Gaps in control		Actions being taken to address gaps in control / assurance

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PRIORITY AREA 5.2: INTEGRATED CARE AT PLACE LEVEL				Delivery supports these CCG objectives:		PRINCIPAL THREATS TO DELIVERY					
<p>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 2022. This will include -</p> <p>-Development of the primary care network and neighbourhood networks</p> <p>- Embedding population health management to improve outcomes across the borough and targeted local action on health inequalities</p> <p>- Left-shift of investment and provision from secondary care to primary, community and out-of-hospital care</p> <p>- Strengthen joint commissioning between the CCG and Barnsley Council</p> <p>- Workforce and organisational development to system leadership and working</p> <p>- Growing the workforce for the future</p> <p>- Optimum use of the health and care estate across the borough and investment to facilitate shift of activity from hospital into community</p> <p>- Development of integrated governance and shared leadership</p> <p>- Supporting and promoting the role of the community, voluntary and social enterprise sector in Barnsley in health and care</p>				Highest quality governance		✓		<p>There is a risk that if the following threats are not effectively managed and mitigated the key deliverables will not be achieved:</p> <p>- Financial pressures and maturity of the local partnership to manage risk -</p> <p>- 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</p> <p>- Challenging timescales for organisational change with the reading of the draft integrating care bill delayed</p> <p>- 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</p> <p>- Clarity of the role of Barnsley Health and Wellbeing Board and local democratic accountability in the new system</p> <p>- Role of GPs and clinical commissioning in the new system</p> <p>- Staff retention through COVID recovery and system change</p> <p>- 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</p> <p>- Impact of COVID on the community, voluntary and social enterprise sector</p> <p>- Failure to demonstrate the impact and benefits of new ways of working in order to generate support and increase engagement</p> <p>- Lack of capacity to support expansion of student placements</p> <p>- Ability to recruit into new roles including additional roles in primary care</p> <p>- Sufficient focus and investment in transformation</p>			
				High quality health care		✓					
				Care closer to home		✓					
				Safe & sustainable local services		✓					
				Strong partnerships, effective use of £		✓					
				Links to NHSE/ 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					Date reviewed		Dec-21	
Initial	3	4	12					<p>Rationale:</p> <p>- 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</p> <p>- Likely (3) as it is possible that the impacts could recur occasionally</p>			
Current	3	4	12								
Appetite	3	4	12								
Approach	Tolerate										
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.
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PRIORITY AREA 5.3: IMPLEMENTING POPULATION HEALTH MANAGEMENT AND PERSONALISED CARE				Delivery supports these CCG objectives:		PRINCIPAL THREATS TO		
<p>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 -</p> <ul style="list-style-type: none">- Use of person-centred segmentation and risk stratification to identify at-risk groups, those with the greatest health inequalities or the most complex needs, and those awaiting multiple appointments- Provide proactive, multidisciplinary, cross sector support to these patients, in line with the NHS Comprehensive Model for Personalised Care- Developing robust plans for the prevention of ill-health such as expansion of smoking cessation services, improving uptake of the NHS diabetes prevention programme and CVD prevention and high impact actions to support stroke, cardiac and respiratory care- Accelerating the delivery of existing requirements, including personal health budgets, social prescribing referrals and personalised care and support plans				Highest quality governance			<p>There is a risk that the CCG will r</p> <p>Population Health Management a</p> <p>issues are not mitigated:</p> <ul style="list-style-type: none">- Lack of capacity in primary and- because of ongoing operational p- Failure to successfully recruit, tr- primary care including social pres- health and wellbeing coaches- Ability to access linked person-l- interventions and demonstrate ou- Lack of sufficient technical analy- Failure to properly engage and i- and service development	
				High quality health care		✓		
				Care closer to home		✓		
				Safe & sustainable local services		✓		
				Strong partnerships, effective use of £		✓		
Links to NHSE/I Planning Guidance				D2 - Implementing Population Health Management and Personalised Care				
Committee Providing Assurance		TBC	Executive Lead		JB	Clinical Lead		
Risk rating	Likelihood	Consequence	Total					Date reviewed
Initial	3	3	9					Rationale: <ul style="list-style-type: none">- Major (3) impact dueobjective not being me- Likely (3) as it is pos:occasionally
Current	3	3	9					
Appetite	3	3	9					
Approach	Tolerate / Treat							
Key controls to mitigate threat:				Sources of assurance				

Executive leadership and sponsorship	Designated executive leads for tackling health inequalities across all partner organisations. Workshop for health inequalities leads and in care delivery group representatives with outputs and framework endorsed by ICPG. Health inequalities cross-cutting theme in Barnsley Health and Wellbeing Plan 2021/22 that has been endorsed by partners
Improving health intelligence infrastructure across the partnership	Health intelligence group established with positive engagement from across the partnership. Population segmentation analysis completed. Population health management analyst hosted by Barnsley Hospital funded through COVID monies. Increased information sharing through COVID and ICPG agreement endorsed by all partners. Regular reporting of health surveillance. Integrated Care Outcomes Framework adopted by ICPG and Barnsley Health and Wellbeing Board
Risk stratification tool to support proactive case finding	Eclipse platform embedded within medicines management team. Secondary care data into Eclipse for pathway development
Prevention programmes in place and/or in development	Warm home healthy people team. Shaping Places Healthy Lives. Mental health social prescribing service. Primary care network social prescribing link workers, care coordinators and health and wellbeing coaches. Diabetes prevention programme. Barnsley Hospital Health Lives Team established. Barnsley Hospital selected to pilot an Alcohol Care Team. Get fit first to support people to lose weight and stop smoking before surgery to reduce risk of complications and achieve better outcomes
Personalised budgets	Embedding with NHS Continuing Healthcare practice and adult social care
Personalised care planning	Patient activation measures embedded with the SWYPFT long term conditions management services. Year of care in primary
Gaps in assurance	Positive assurances received
Gaps in control	Actions being taken to address gaps in control

Pending publication of PCN service specification for anticipatory care	Working group established to develop proactive care for frailty building on the learning from supporting vulnerable population segmentation analysis. Ongoing work to configure local pathways for Barnsley beginning with the Vulnerability Index
Pending publication of PCN service specification for personalised care	Personalisation is identified as one of the cross-cutting themes of the Care Plan 2021/22. Providing joint training and development for care staff including strengths-based practice and aligning priorities of the Barnsley Health and Care Plan with the group
Strength and balance offer for people at risk of falls	BMBC have identified funding and proposals are being developed for a prevention offer for healthy ageing

DELIVERY	
<p>not be able to successfully implement and Personalised Care if the following</p> <p>community care to support delivery pressures</p> <p>ain, develop and retain additional roles in scribing link workers, care coordinators and</p> <p>evel data to identify priority cohorts, target itcomes and impact</p> <p>atical capability and tools to support delivery</p> <p>nvolve people in decisions about their care</p>	
	Dr M Guntamukkala
Dec-21	
<p>to potential slippage leading to a key et and potential for external challenge sible that the impacts could recur</p>	
	Rec'd?

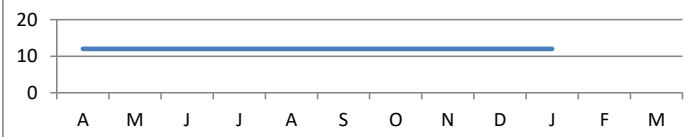
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n across lation ough high-level veillance. ley Health	Ongoing
aring of	Ongoing
y Best Life nk etes lished. st in place o reduce	Ongoing
al care	Ongoing
	Ongoing
ol / assurance	

care model focussed on mild to moderate
vulnerable people through COVID and
with NHS Prescribing Solutions to
with frailty. Development of the Barnsley

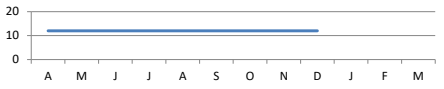
cutting themes of the Barnsley Health and
development opportunities for health and
shared decision making is one of the
being taken forward through the workforce

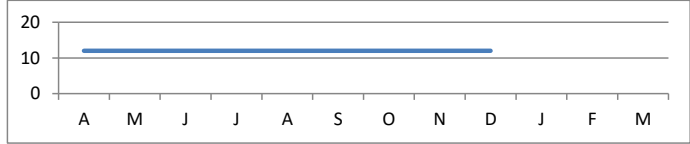
in development to strengthen the local

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					
<ul style="list-style-type: none">• 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 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 2022/23.			
				High quality health care		✓					
				Care closer to home		✓					
				Safe & sustainable local services		✓					
				Strong partnerships, effective use of £		✓					
				Links to NHSE/ Planning Guidance							
				F5 - Implement ICS-level financial arrangements							
Committee Providing Assurance			FPC	Executive Lead			RN	Clinical Lead		Various	
Risk rating	Likelihood	Consequence	Total							Date reviewed	Jan-22
Initial	4	4	12							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.	
Current	3	4	12								
Appetite	3	4	12								
Approach	Tolerate										
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							
				The CCG will deliver its financial duties in 2021/22 and will report delivery of efficiencies on a non recurrent basis and it expected to deliver a surplus year end position, however the wider objectives linked to this priority area are unlikely to be achieved due to the continued impact of Covid-19. Discussions with partners remain positive and are ongoing in relation to the contract position for 2022/23 and beyond. Despite a lack of national guidance the CCG has begun developing its financial plan for 2022/23.							

Gaps in control	Actions being taken to address gaps in control / assurance
<p>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.</p>	<p>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 2022/23 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 approach 2022/23.</p>

PRIORITY AREA 7: TRANSFORMING CARE FOR PEOPLE WITH LEARNING DISABILITIES AND / OR AUTISTIC SPECTRUM CONDITIONS				Delivery supports these CCG objectives:		PRINCIPAL THREATS TO DELIVERY							
<p>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:</p> <ul style="list-style-type: none">-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 reviewsOfsted readiness in terms of the imminent local area Joint SEND InspectionImprove 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 pathways remain NICE compliant				Highest quality governance		<p>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:</p> <ul style="list-style-type: none">-People with a learning disability or autistic spectrum conditions will enter hospital inappropriately-There will be difficulty 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 communityInsufficient funding to develop improved pre and post diagnostic support for people with autism / ADHD / LD							
				High quality health care									
				Care closer to home									
				Safe & sustainable local services									
				Strong partnerships, effective use of £									
Links to NHSE/ Planning Guidance													
C&S E1 - Expand and improve mental health services and services for people with a learning disability and/or autism & Transforming community services and improve discharge													
Committee providing assurance				FPC & QPSC		Executive Lead		PO / AR		Dr M Smith			
Risk rating		Likelihood		Consequence		Total				Date reviewed		Dec-21	
Initial		4		3		12				<p>Rationale: likelihood assessed as 4 'likely' because the local market is not sufficiently developed to enable all aspects of the transforming care plan to be delivered. Consequence judged to be moderate (3) because in terms of direct impact higher levels of care are viewed as 'safer' but longer term promoting independence and quality of life is compromised, hence this focus by NHSE.</p>			
Current		4		3		12							
Appetite		4		3		12							
Approach		Tolerate											
Key controls to mitigate threat:								Sources of assurance				Rec'd?	
<p>A Complex Case Manager for Transforming Care patients has been in post from May 2019. The postholder will ensure 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.</p> <p>Appropriate services are being developed within Barnsley, where appropriate, 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</p> <p>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.</p> <p>An all-age Autism strategy is being developed to support service transformation and improve the life outcomes of people with autism.</p> <p>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.</p> <p>The SEND lead for the CCG has been identified 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 responsibility for the SEND agenda from a CCG perspective. Barnsley local area are still awaiting the CQC/Ofsted Joint SEND Inspection. The outcomes of the inspection will be shared with Governing Body members</p> <p>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</p>								<p>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</p> <p>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.</p>				Ongoing	
												Ongoing	
												Ongoing	
												Ongoing	
								Ongoing					
								Ongoing					
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								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 checks for people with LD													

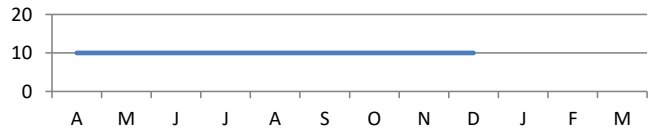
PRIORITY AREA 8: MATERNITY				Delivery supports these CCG objectives:		PRINCIPAL THREATS TO DELIVERY		
<p>Continue to work towards delivering the recommendations of 'Better Births' and the ambitions of the NHS Long Term Plan.</p> <p>implement the Saving Babies' Lives care bundle version 2 to further reduce still birth, neonatal deaths, maternal deaths and brain injuries.</p> <p>Implement the SYB LMS (Local maternity service) -</p> <p>- 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</p> <p>Deliver all recommendations contained within the Ockenden report within the required timescales</p> <p>Achieve the recommended targets in respect of the continuity of carer model</p>				Highest quality governance		<p>There is a risk that the key deliverables will not be achieved if the following risks to delivery are not appropriately managed and mitigated:</p> <p>1/ Lack of sufficient investment in additional staff resources to enable 'continuity of carer'</p> <p>2/ LMS to oversee responses to Ockenden report and influence developments of all localities implementing the recommendations of 'Better Births'</p> <p>3) LMS to invest transformation funding fairly within the locality to ensure local service developments can be implemented as agreed</p> <p>4/ Lack of staff rotation between hospital and community based services may reduce the likihood of fully delivering continuity of carer</p>		
				High quality health care				
				Care closer to home				
				Safe & sustainable local services				
				Strong partnerships, effective use of £				
				Links to NHSE/ Planning Guidance				
				C4 - Deliver improvements in maternity care, including responding to the recommendations of the Ockenden review				
Committees providing assurance			FPC & QPSC	Executive Lead		PO	Clinical Lead	Dr M Smith
Risk rating	Likelihood	Consequence	Total				Date reviewed	Dec-21
Initial	4	3	12				<p>Rationale: Likely primarily due to the staffing issue inherent in delivering continuity of carer and there are no additional funding streams available.</p> <p>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.'</p>	
Current	4	3	12					
Appetite	3	4	12					
Approach	Tolerate							
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		

NHS Barnsley CCG Governing Body Assurance Framework 2021-22

PRIORITY AREA 9: DIGITAL AND TECHNOLOGY				Delivery supports these CCG objectives:		PRINCIPAL THREATS TO DELIVERY			
<div>1. Development of a system wide shared care record</div> <div>2. Ensure the delivery of the GP IT Futures Model to:</div> <div>- Comply with mandatory core standards re: interoperability and cyber security</div> <div>- Ensure HSCN supports effective and fast connectivity</div> <div>- Support the identification of equipment that poses a threat to cyber security e.g. pre Windows 10 software</div> <div>- Support the implementation and roll out of the GPIT refresh of IT equipment</div> <div>- Support the wider use of digital technology as described within the Long Term Plan</div> <div>- Working closely with the SY&B digital and IT workstream to deliver the digital road map</div> <div>- Delivery of O365 across Barnsley</div> <div>- Support the transition of video and online consultation software as the Doctorlink contract ends</div> <div>- Support the delivery of the Digital Primary Care First projects</div> <div>- Support the development of the Digital Citizen project in collaboration across "place"</div> <div>- Support the GP practices with digitisation of the Lloyd George records when confirmed by NHSEI</div> <div>- Support the roll out of the corporate Wi-Fi solution</div> <div>- Support the resilience work at Hilder House with the servers and CCG corporate IT needs</div> <div>- Support the upgrade to utilise digital technology for telephony resilience across GP practices and Hilder House</div> <div>3. Development of a Barnsley "place" Digital Strategy that reflects the "system" digital strategy and aligns with the emerging Eststes strategy</div>				Highest quality governance		<div>There is a risk that the key deliverables will not be achieved if the following threats to delivery are not appropriately managed and mitigated:</div> <div>- Lack of IT technical expertise locally for input into projects and programmes of work / lack of technical support to ensure deliverables are robust</div> <div>- Primary Care colleagues fatigued with the amount of IT work scheduled</div> <div>- Short timelines to deliver projects</div> <div>- Supplier and equipment delays</div> <div>- constructive and timely engagement by system partners to deliver a SCR by 20/21</div> <div>- system wide strategic digital strategy and planning currently under-resourced with no dedicated Barnsley resource available to progress this work</div> <div>- Incomplete information available from NHS Futures regarding future work.</div>			
				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									
Committees providing assurance				PCCC & SMT	Executive Lead	JB	Clinical Lead	JH	
Risk rating	Likelihood	Consequence	Total					Date reviewed	Dec-21
Initial	3	4	12						
Current	3	4	12						
Appetite	3	4	12						
Approach	Tolerate			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 Digital 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

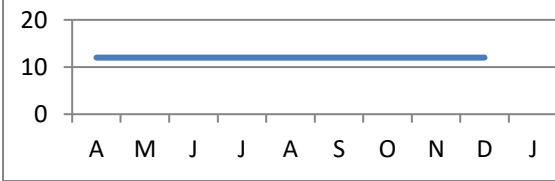
Redcentric become the commissioned service to maintain HSCN	Transition to new HSCN network now complete across the Barnsley CCG & primary care estate	Complete
Gaps in assurance	Positive assurances received	
Governance process to be established for the IT groups eg link with the IT Strategy group and the CCG Operational Group		
Gaps in control	Actions being taken to address gaps in control / assurance	

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			
<ul style="list-style-type: none">• 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/ Planning Guidance					
Committee Providing Assurance			Audit Committee	Executive Lead		RW	Lay / Clinical Leads	MG,JS,NBa, NBe, CM	
Risk rating	Likelihood	Consequence	Total					Date reviewed	Dec-21
Initial	2	5	10					Rationale: Likelihood is 'unlikely' as arrangements now well established. Consequence is catastrophic due to very significant quality, financial & reputational impact of failure.	
Current	2	5	10						
Appetite	3	4	12						
Approach	Tolerate								
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 third 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 via 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 & Inclusivity 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	
	<p>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.</p> <p>The CCG received a 'significant assurance' opinion from Internal Audit following its review of the Governance & Risk Management arrangements (Sep 2019).</p> <p>The CCG received a 'significant assurance' opinion from internal audit on its conflicts of interest arrangements (Dec 2020).</p> <p>The CCG received a 'substantial assurance' opinion from internal audit on the Integrity of the General Ledger and Financial Reporting (Jan 2021).</p> <p>The CCG received a 'significant assurance' Head of Internal Audit Opinion at the conclusion of the 2020-21 Internal Audit programme (June 2021)</p> <p>The CCG received an unqualified opinion from KPMG on the CCG's Annual report & Accounts 2020-21 (June 2021)</p>	
Gaps in control	Actions being taken to address gaps in control / assurance	

<p>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.</p>	<p>For details of mitigating actions see Corporate Risk Register 20/03. Latest update states: Nov 2021 O/S reviews at just over 6% which is a good position. Team on target to meet quarterly NHSEI DST targets. Recruitment to LD team remains a problematic issue. Demand and capacity exercise complete and results being analysed. Discussions re: improving PHB position ongoing.</p>
<p>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.</p>	<p>The risk rating remains red due to continued concerns about current levels of demand and a further serious incident involving an ambulance delay for a Barnsley patient.. Performance monitoring continues. Regular consideration of YAS incident reporting by QPSC and GB to understand the frequency and severity of incidents associated with ambulance response.</p>
<p>RR 14/15 Discharge medication risks related to poor or incomplete D1 discharge letters</p>	<p>For details of mitigating actions see corporate risk register 14/15. latest update states: The BHNFT D1 working group has been put on hold until spring 2022 - due to the hospital prioritising COVID 19 backlog and expected winter system pressures. 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.</p>

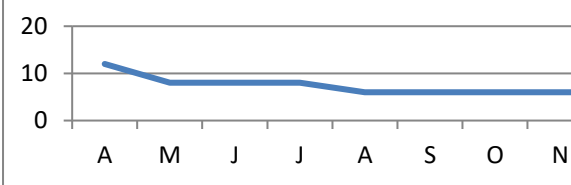
PRIORITY AREA 11: DELIVERY OF ENHANCED HEALTH IN CARE HOMES				Delivery supports these CCG objectives:	
<p>Delivery of all 17 elements and sub elements of the Barnsley Care Homes Delivery Plan. This includes the elements of the Enhanced Health in Care Homes (EHCH) Framework and the Covid-19 Pandemic specific support.</p> <p>1. Engagement with care homes on all requisites of the delivery plan</p> <p>2. EHCH Primary Care Network (PCN) Specification</p> <p>3. Named Clinician for each care home</p> <p>4. Coordinated health and social care MDT support</p> <p>5. Specialist Support</p> <p>6. Out of Hours support</p> <p>7. Infection Prevention and Control (IPC) including Personal Protective Equipment (PPE)</p> <p>8. Mutual Aid</p> <p>9. Testing / Swabbing</p> <p>10. Medicines</p> <p>11. Equipment</p> <p>12. Discharge to Assess (D2A) and Intermediate Care (IMC)</p> <p>13. Secondary Care support</p> <p>14. Personalised care</p> <p>15. Workforce support</p> <p>16. Technology</p> <p>17. Integrated Care System link-in</p>				Highest quality	
				High quality health	✓
				Care closer to home	✓
				Safe & sustainable	✓
				Strong partnerships,	✓
				Links to NHSE/ Planning Guidance	
Committee Providing Assurance			Q&PSC	Executive Lead	
JW					
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 assurance	
Delivery work plan and risk log in place				Monitored and managed by BMBC Head of J and Bronze Discussed in BMBC Minutes and actioned by BMBC Leads and co-leads delivery – supervisory structures Escalation of risk to forums as required Regular reporting Risk log updates	
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 BMBC Head of J agree priorities and arrangements as	
Gaps in assurance				Positive assurance	

Gaps in control	Actions being

2021-22

PRINCIPAL THREATS TO DELIVERY		
<p>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:</p> <ol style="list-style-type: none">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 sustainability3. Financial pressures and priorities4. CCG not having direct input and oversight of quality assurance monitoring and safeguarding in care homes5. Best use of technology in care homes - variance types of technology used and in consistency of use6. Potential IG issues in current methods of remote consultation using IT equipment7. 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		
Clinical Lead		Dr J MacInnes
F M	Date reviewed	Dec-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.	
Finance		Rec'd?
Managed via a multi - agency Delivery Group Large and Out of Hospital Group. on logs available. ids in place with clear responsibility for ision of leads within line management s and issues to Silver and other appropriate ed. g to Quality and Patient Safety Committee ; as indicated by BRAG rating		Ongoing
by the CCG Chief Operating Officer and oint Commisisoning. Will feed into ICDG to nd future governance and delivery part of place based arrangements.		Ongoing
Funders received		

taken to address gaps in control / assurance

PRIORITY AREA 12: DELIVERING THE COVID VACCINATION PROGRAMME & MEETING THE NEEDS OF PATIENTS WITH COVID-19				Delivery supports these CCG objectives																			
<ul style="list-style-type: none">• All adults to be offered a first dose of the vaccination by the end of July 2021• Maximise uptake by engaging 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)• Delivery of COVID 19 booster programme from Autumn• Support delivery of COVID 19 vaccination of Children - in line with 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/ Planning Guidance																			
				B - Delivering the covid vaccination program continuing to meet the needs of patients with																			
Committee Providing Assurance			TBC	Executive Lead																			
Risk rating	Likelihood	Consequence	Total	 <table><caption>Risk Rating Data</caption><thead><tr><th>Month</th><th>Risk Rating</th></tr></thead><tbody><tr><td>A</td><td>12</td></tr><tr><td>M</td><td>8</td></tr><tr><td>J</td><td>8</td></tr><tr><td>J</td><td>8</td></tr><tr><td>A</td><td>6</td></tr><tr><td>S</td><td>6</td></tr><tr><td>O</td><td>6</td></tr><tr><td>N</td><td>6</td></tr></tbody></table>		Month	Risk Rating	A	12	M	8	J	8	J	8	A	6	S	6	O	6	N	6
Month	Risk Rating																						
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Initial	3	4	12																				
Current	2	4	8																				
Appetite	3	4	12																				
Approach	Tolerate																						
Key controls to mitigate threat:				Sources of assurance																			
South Yorkshire and Bassetlaw COVID Vaccination Steering Board established providing oversight to the wider programme and ensuring arrangements for coordination across SYB including of vaccine allocations, addressing inequalities and ensuring appropriate mechanisms for delivery across Vaccination Centres, Hospital Hubs, General Practice and Community Pharmacy				Monthly - Steering 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 by allocation of the vaccine progress across all Workstreams including engagement, communication																			
Barnsley Vaccination Group in place, bringing together local partners across Primary, Community and Acute Care and the Local Authority to support delivery of the local delivery programme in Barnsley				Weekly - Chaired by on partnership support responding to challenges usage etc. Successful 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 I of engagement act Every Contact Cou have regular conta Inequalities in upta communities and c targetted to reachi
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 provision 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	Designated sites w Valley Group Prac Hubs are managed practices. All local sites. Roaving vaccinatio vulnerable groups patients Pop up clinics in G of patients who ma designated site. A range of booking invited and access messages, vaccine All targets/expecta 50's offered a vacc offered a first dose Delivery has comm
Barnsley School Age Vaccination and Immunisation Service is leading the delivery of the school age vaccination programme for health 12 - 15 year olds.	Schedule in place vaccination. Arrangements in p attending school fo Arrangements in p those not vaccinat
Gaps in control	
<ul style="list-style-type: none"> • 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. 	
<ul style="list-style-type: none"> • 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		Dec-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 support		Ongoing
by SRO for the Primary Care Programme, coordinates vaccine 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 port, working together, developing delivery models, rges to guidance or requirements in relation to vaccine ssfully coordinated delivery of vaccination programme for ind phase 1 of the overall vaccination programme.		Ongoing

<p>by Service Director for Public Health, BMBC. Coordination activities and development of approaches including 'Make it count' to maximise the reach of all teams across partners who work with local people and communities.</p> <p>Work has been identified across different geographical areas to ensure certain groups of the population and activity has been targeted to these and maximising uptake.</p>	Ongoing
<p>Barnsley have signed up to delivery of the Vaccine Delivery Enhanced Service.</p> <p>Delivery of the programme on behalf of BP practices with the support of the practice in relation to delivery of local clinics in practice, recruitment and inviting patients for vaccine/following up and recalling</p>	Ongoing
<p>Services were approved by NHS England at Apollo Court, Dearne and Priory Campus. These Local Vaccination Services are delivered by BHF on behalf of the Primary Care Network/GP practices. Local vaccination activity is coordinated via the 3 designated Local Vaccination Centres.</p> <p>Work on models in place to deliver to residential settings, such as those who are homeless and to housebound.</p> <p>GP practices have taken place to deliver vaccine to groups who may not have been able to access the vaccine at a local level.</p> <p>Various methods are in place to ensure everyone is able to be vaccinated for a vaccine. This has included telephone calls, text messages, a call centre and letter.</p> <p>Significant improvements on uptake levels have been achieved with all over 16s vaccinated by mid April and the remainder of the adult population vaccinated by the end of July 2021.</p> <p>Work has been completed to 16-17 year olds and eligible 12-15 year olds</p>	Ongoing
<p>Work to visit each secondary school in Barnsley to provide information and support to those who are home schooled or not in school for other reasons.</p> <p>Work to utilise local vaccination sites to offer vaccination to those who are not in school.</p>	Ongoing
Actions being taken to address gaps in control / assurance	

RISK REGISTER – January 2022

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)	11	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

Ref	Domain	Risk Description	Initial Risk Score			Mitigation/Treatment	Lead Owner of the risk	Source of Risk	Residual Risk Score			Date Risk Assessed	Progress/ Update	Date for re-assessment
			Likelihood	Consequence	Score				Likelihood	Consequence	Score			
COVID 1	5, 6	COVID demand surge The new Omicron variant appears to be more transmissible than previous variants and the two-dose vaccine programme is less effective at preventing illness. There is a risk that a surge in COVID cases could have a very significant impact on urgent and emergency care with high levels of staff absence due to COVID infection at the same time as increased COVID admissions.	5	5	25	COVID booster programme Surge planning, Operational Pressure and Escalation Framework Close monitoring of staff absence through the Local Resilience Forum Coordination of local response from the multi-agency bronze, Tactical Coordination Group and Integrated Care Delivery Group Business Continuity Plans Local communications and engagement strategy	Director of Commissioning CCG Gold Command F&PC	COVID-19	4	4	16	12/21	December 2021 Local surge and escalation plans updates External assurance process for surge plans with NHS EI. Oct 2021 No further update. Sept 2021 Planned Care Programme Board continues to have oversight of the elective recovery work.	01/22

Ref	Domain	Risk Description	Initial Risk Score			Mitigation/Treatment	Lead Owner of the risk	Source of Risk	Residual Risk Score			Date Risk Assessed	Progress/ Update	Date for re-assessment
			Likelihood	Consequence	Score				Likelihood	Consequence	Score			
													Referral levels are now in line with pre-pandemic and above in some areas and therefore prioritisation and addressing Health Inequalities are key considerations.	
COVID 2	1,5,6	COVID planned care backlog During the earlier part of the pandemic there was a significant drop off in people being referred to secondary care for treatment which enabled providers to create capacity to prepare to treat high numbers of COVID patients. Throughout the pandemic there have been social distancing/infection prevention and control measures that mean some services have	5	5	25	Elective Recovery Framework Planned care and outpatients work programme SYB Cancer Alliance “hidden harms” work including behavioural insights Recovery plans for screening services PCN specifications for early cancer detection and hypertension case finding Communications and engagement strategy	Director of Commissioning CCG Gold Command F&PC	COVID-19	4	4	16	12/21	December 2021 Barnsley continues to have relatively low numbers of long waiters (12 months +) Oct 2021 No further update. Sept 2021 Planned Care Programme plan is in place to support elective recovery and reduce waiting lists – the number of 52 week waits	01/22

			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
		had less capacity to treat patients. This has resulted in a backlog of patients waiting for treatment. Some known to services (on a waiting list) and others that have not presented. There is a risk that the backlog results in harm to patients and services.											continues to reduce in spite of increased referral rates. Aug 2021 No further update.	
CCG 21/02		If the Barnsley and South Yorkshire and Bassetlaw System are unable to commission care that demonstrates value for money for complex patients, there is a risk that the market of private provision will create significant financial risk to the CCG. This is a national issue with provision for this cohort of patients being limited and therefore costly. The CCG needs to	5	4	20	Chief Nurse to work across South Yorkshire and Bassetlaw to determine level of risk and action plan to be developed to develop the market within NHS providers and within the private sector. The Chief Nurse to work with the LA/JCU to develop the	Chief Nurse Finance and Performance Committee and QPSC	Complex Case team within the CCG	5	4	20	12/21	Dec 2021 Current provision: There are currently 5 contracted providers on the framework and BMBC and CHC are contacting approx.30 additional home care providers operating in Barnsley weekly to pick up packages on a spot contract basis. BMBC are	01/22

			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
		shape and develop the home care and residential care provider market working with the Local Authority and across the ICS where complex case provision needs development. If this does not happen and the provider framework is not reviewed the quality of care may be jeopardised, patients may need to be placed outside of area and it is likely the costs will continue to rise.				<p>Framework of providers.</p> <p>The Chief Nurse to work with the SY&B Chief Nurses to explore options for a wider ICB solution.</p>							<p>reviewing arrangements for packages located in more challenging locations and will consider if these can be better managed through a block contract arrangement. If this is the case then procurement activity will be required to tender and set up a block contract.</p> <p>Future Home Care Framework developments and approximate time scales: Draft specification complete by End December 2021 Consultation January - February 2022 Final specification March 2022 Out to tender April 2022</p>	

Ref	Domain	Risk Description	Initial Risk Score			Mitigation/Treatment	Lead Owner of the risk	Source of Risk	Residual Risk Score			Date Risk Assessed	Progress/ Update	Date for re-assessment
			Likelihood	Consequence	Score				Likelihood	Consequence	Score			
													Evaluation & Moderation June 2022 Contract award July 2022. Contract Start Date August 2022.	
CCG 18/04	1,2, 3, 5,6, 8	If the health and care system in Barnsley is not able to commission and deliver out of hospital urgent care services which have sufficient capacity and are effective in supporting patients in the community to avoid the need for hospital attendance or non-elective admission there is a risk that non-elective activity will exceed planned levels potentially leading to (a) failure to achieve NHS Constitution targets (with associated reputational damage, and (b) contractual over performance	5	4	20	Regular review of activity data as part of contract and performance management and monitoring arrangements. Other data reviewed and analysed to identify new opportunities to reduce non elective activity e.g. NHS Rightcare Packs, Dr Foster data etc. A&E Delivery Board is established (Barnsley Urgent and Emergency Care Delivery Board) with responsibility for delivering improvements to urgent care services and achieving related targets. The Board is overseeing work to develop appropriate services to ensure that patients are able to access appropriate care	Chief Operating Officer (Finance & Performance Committee)	Contract and Performance Monitoring	5	4	20	12/21	December 21 Increase COVID infection rates is impacting upon non elective hospital admissions and UEC capacity due to workforce challenges November 21 iUEC work identified access to alternative services to Hospital as a priority – work is underway to ensure all services are appropriately mapped and included on DoS	01/22

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		resulting in financial pressure for the CCG.				<p>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.</p> <p>Engagement with regional and SYB programme to implement 'Think 111' (Talk before you walk) model in partnership with Integrated Urgent Care providers</p> <p>Work ongoing with NHSE Emergency Care Improvement and Support Team (ECIST) and iUEC programme to review pathways</p> <p>Additional Primary Care Capacity is in place for same day appointments through IHEART and Home Visiting Services</p> <p>Community 2 Hour rapid response in place accessed through the Rightcare Barnsley SPA</p> <p>Priority areas of work</p>							<p>October 21</p> <p>Activity levels continue to be higher than expected and ongoing covid restrictions are creating significant challenges with bed capacity and flow. Work continues to delivery UEC plan and identify further actions to mitigate pressures.</p>	

Ref	Domain	Risk Description	Initial Risk Score			Mitigation/Treatment	Lead Owner of the risk	Source of Risk	Residual Risk Score			Date Risk Assessed	Progress/ Update	Date for re-assessment
			Likelihood	Consequence	Score				Likelihood	Consequence	Score			
						identified to support ICP vision and principles for proactive care and care out of hospital.								
CCG 21/03		If issues in the timely reporting of data continue in relation to Continuing Health Care (Adult and Children) and complex case management (Including S117), this is likely to result in the financial forecast for this area to be misstated and lead to variation in the forecast position, creating financial risk.	5	4	20	Chief Nurse and CHC/complex case team to work on systems and processes within the team to ensure data is recorded and reported in a timely manner. The Chief Nurse, CHC/complex case and Finance team will also work with BMBC to ensure reporting issues relating to the brokerage of care are improved with a clear process in place from within BMBC brokerage/PHB and finance team.	Chief Nurse Finance and Performance Committee QPSC	Finance Team	5	4	20	01/22	<p>Jan 2022 Discussion at BMBC interface meeting on 21/12/21. Proforma to be put in place for SWs to complete when care packages change. This will ensure that the CCG is sighted on any increase or decrease and it will generate a clinical conversation.</p> <p>Dec 2021 CHC Lead / Complex Portfolio Manager/ Finance manager and BMBC Head of Service meet monthly to discuss any issues within</p>	02/22

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													<p>processes of the services . A process has been agreed to enable current and accurate data is shared with CHC at the time of new assessments and joint package of care reviews.</p> <p>The BST manager has implemented processes for recording of data on the database</p> <p>CHC have implemented process for receiving information of audited care packages of PHBs and these are monitored by the PHB Lead.</p> <p>There is a dedicated person</p>	

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													in PHB Brokerage service who is responsible for liaising with the dedicated BST in CHC regarding data . The introduction of the CPA panel has enhanced the service of CHC / S117/ TFC/Childrens CC / Complex cases by providing agreement on costs of all care packages above £800.	
18/02	1,2, 5,6	If the CCG and BMBC do not develop a collaborative commissioning approach underpinned by shared values there is a risk that BMBC commissioned services will not	4	4	16	Escalation of CCG concerns to BMBC senior management Escalation via SSDG and health & wellbeing board To be raised and discussed at H&W Board development Session (August 2018)	Jeremy Budd (SSDG)	Added to the Corporate Risk register in context of long standing and frequently articulated concerns with respect to a basket of	4	4	16	12/21	December 2021 All programme SROs have agreed revised priority and milestone plans for the winter months. Oct 2021 Barnsley Health	01/22

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			Likelihood	Consequence	Score				Likelihood	Consequence	Score			
		meet the requirements and aspirations of the CCG for the people of Barnsley leading to increased health inequalities and poorer health outcomes.						BMBC commissioned services notably: 0-19 Health Checks Weight management & smoking cessation					and Care Plan agreed by both CCG GB and BMBC cabinet. Joint commissioning being developed through active closer team working.	
21/06 Part B Added Dec 21		There is a risk that if the CCG is unable to reprocure at the end of March 2022 for the Medical Oversight of the Acorn Unit, that potentially medical oversight at the Unit will not exist.	4	4	16	<ul style="list-style-type: none"> BHNFT and the CCG agreed that BH would take oversight until the end of March 2022 and work on a plan this financial year to finalise in Q4 and implement in April 2022. Workshops taking place to go through options to reprocure. Emergency Team supporting the group of looking at model now and what is needed going forward. Right care Barnsley pulling together data to be reviewed	Q&PSC Chief Nurse		4	4	16	12/21		01/22

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			Likelihood	Consequence	Score				Likelihood	Consequence	Score			
						by the CCG.								
21/05 Added Dec 21		There is a risk that Barnsley patients will not have the option to have face to face oncology appointments at BHNFT due a shortage of consultant capacity for oncology across SY&B. This will impact on patients choice and access to the service.	4	4	16	<ul style="list-style-type: none"> Awareness of the issues via Cancer Alliance. Conversations are ongoing about an interim solution to ensure there is efficient capacity in the service. Providing transport for patients to travel who are unable to or may struggle to get where the oncologists are based. Greater use of visual virtual appointments. Continue face to face appointments where necessary. Cancer Alliance working on longer term solution after short term solution is in place Working with HEE about having additional roles to 	Jamie Wike (SL) Q&PSC	Cancer alliance	3	4	16	12/21		01/22

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						upskill existing staff in oncology service. Weston park are tracking patients attending or not attending for appointments to monitor and reduce the impact on patient care .								
CCG 14/10	2, 5, 6	If the Barnsley area is not able to attract & retain a suitable & sufficient Primary Care clinical workforce e.g. due to delays in recruiting into the ARRS roles there is a risk that: (a)Primary Medical Services for patients are inconsistent (b)The people of Barnsley will receive a poorer quality of healthcare services (c)Patients services could be further away from their home.	3	3	9	<p>The Long Term Plan includes a section on workforce planning and Network Contract DES includes provision for a number of Primary Care specific roles that will support the delivery of services.</p> <p>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.</p> <p>The Primary Care Strategy Group has a workforce element included within its transformation plans and will support the Barnsley "Place" Workforce Plan.</p>	Head of Primary Care. (Primary Care Commissioning Committee)	Governing Body	4	4	16	12/21	<p>Dec 2021 Workforce Plan has been submitted for ARRS to fully utilise available additional roles. Good progress is being made on recruitment but there are still risks associated with turnover. The ARRS has supported increase in primary care workforce numbers and roles.</p> <p>Nov 2021 There was an October submission from PCN to CCG, this</p>	01/22

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			Likelihood	Consequence	Score				Likelihood	Consequence	Score			
						<p>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".</p> <p>NHS England has published an Interim People Plan to support the workforce challenge.</p> <p>Links have been developed with the Medical School to enhance attractiveness of Barnsley to students.</p>							has not yet gone to NHSE (Deadline end of November for CCG to submit). This has any changes to recruitment since last submission and forward projections for 2022/23 & 2023/24 - the same risks of retention and unable to recruit are there, and ongoing discussions being held between CCG and PCN.	
20/03	3,5, 6	If the Barnsley and South Yorkshire and Bassetlaw System are unable to commission care that demonstrates value for money for complex patients, there is a risk that	5	4	20	<p>Adverts currently out to fill 3 vacant posts</p> <p>Extension of contracts of 2 agency nurses to 26.2.21 will support clearance of covid backlog</p> <p>Seeking to recruit a further 2</p>	<p>Chief Nurse</p> <p>Finance & Performance Committee</p> <p>And</p> <p>Quality &</p>	SMT discussion	5	4	20	01/22	<p>Jan 2022</p> <p>O/S reviews are at 7.5 % which maintains the good position of the service. The Team are on target to meet DOH for Q3,</p>	02/22

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		the market of private provision will create significant financial risk to the CCG. This is a national issue with provision for this cohort of patients being limited and therefore costly.				<p>agency nurses to support with both backlog and new cases although it is currently difficult to find available suitably qualified individuals</p> <p>Discussion of risks and issues to take place at Governing Body in January 2021</p> <p>Development of training plan for the CHC team on case management and handling difficult conversations with patients, families and carers.</p> <p>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.</p>	Patient Safety Committee						<p>NHSE KPI met for December with 100% which is improvement from October and November 2021. Vacancey still present for LD nurse WTE B6 and two B6 WTE will be going on Maternity leave from February 2022. No change in position of PHB or capacity and demand work. No change in risk rating</p> <p>Nov 2021 O/S reviews at just over 6% which is a good position. Team on target to meet quarterly NHSEI DST targets. Recruitment to LD team remains a problematic issue. Demand and capacity exercise</p>	

			Initial Risk Score						Residual Risk Score					
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													<p>complete and results being analysed. Discussions re: improving PHB position ongoing.</p> <p>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.</p>	

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14/15	1, 5, 6	There are two main risks: 1. Scant or absent information relating to why medication changes have been made. Poor communication of medication changes, even if changes are appropriately made for therapeutic/safety reasons, creates a patient safety risk when post discharge medicines reconciliation is being undertaken by the GP practice. The risk being that the GP practice may either accept inappropriate changes when all the patients' risk factors have not been accounted for by the hospital clinicians or an error has been made or not accept clinically important changes as not	4	4	16	<p>Ongoing discharge medication risks escalated to BCCG Chief Officer and Chief Executive of BHNFT resulted in 2 quality risk meetings (August and November 2016).</p> <p>Area Prescribing Committee (APC) monitor concerns and will report 2017 audit to the Quality & Patient Safety Committee.</p> <p>A working Group (with reps from Practice managers Group & BHNFT) looking at D1 Discharge Summary Letters.</p>	<p>Head of Medicines Optimisation</p> <p>(Quality & Patient Safety Committee)</p>	Risk Assessment & audit of discharge letters	4	5	20	11/21	<p>November 2021</p> <p>The BHNFT D1 working group has been put on hold until spring 2022 - due to the hospital prioritising COVID 19 backlog and expected winter system pressures. June 2021</p> <p>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.</p> <p>BHNFT is arranging a</p>	12/21

Ref	Domain	Risk Description	Initial Risk Score			Mitigation/Treatment	Lead Owner of the risk	Source of Risk	Residual Risk Score			Date Risk Assessed	Progress/ Update	Date for re-assessment
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		<p>confident about the reasons for the change.</p> <p>2. Clinically significant safety alerts, such as contraindicated combinations of medication, are being frequently triggered by primary care prescribing systems during post discharge medicines reconciliation when adding medicines to the Patients Primary Care Record. This indicates that either the hospital is not reconciling medicines using the GP Practice Summary Care Record or that the reconciliation is not sufficiently robust.</p>											<p>meeting for the D1 Group.</p> <p>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.</p> <p>BHNFT is arranging a meeting for the D1 Group.</p>	
13/13	1,5, 6	If improvement in Yorkshire Ambulance Service (YAS)	4	5	20	July 2016 Regular consideration of YAS incident reporting by QPSC	Chief Nurse (Quality &	Risk Assessment	3	5	15	01/22	Jan 2022 The risk rating remains the same	02/22

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		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.				and GB to understand the frequency and severity of incidents associated with ambulance response.	Patient Safety Committee)						<p>due to continued concerns about current levels of demand coupled with increase in staff absences due to Covid19.</p> <p>Nov 2021 The risk rating remains the same due to continued concerns about current levels of demand and a further serious incident involving an ambulance delay for a Barnsley patient.</p> <p>August 2021 The risk has been increased due to concerns about current level demand and 2 serious incidents relating to Barnsley patients.</p>	

Ref	Domain	Risk Description	Initial Risk Score			Mitigation/Treatment	Lead Owner of the risk	Source of Risk	Residual Risk Score			Date Risk Assessed	Progress/Update	Date for re-assessment
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CCG 19/05 added Dec 2019	6	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:	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.	Chief Nurse	End of Life Team in BCCG Continuing Healthcare Team	5	3	15	12/21	December 2021 Following an informal consultation with the CHC Nurses who provide this function it was evident that utilising the BMBC Brokerage Service would add further steps into the process and would increase the length of time to commission a package of care for someone who is end of life. The BMBC domi care framework procurement has commenced.	01/22
	5	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.				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								
	3	b) Patients at home without a care package or a care package that is not being delivered as required.											August 2021 BMBC Brokerage will be taking the role of brokering EOL packages of care on behalf of the CHC Team from September	19

	2	<p>b) Financial Risks Increased costs to CCG due to having to obtain care from specialist providers</p> <p>Delayed discharges will affect CCG's efficiency plans</p> <p>c) Performance Risks Delayed discharges impact upon patient flow which could affect delivery of 4 hour A&E standard and elective waiting times.</p> <p>Increase in non-elective admissions to hospital because of patients being left without care in the community.</p>				<p>from neighbourhood nursing service/ palliative care services in Barnsley</p> <p>e) Care packages to be spot purchased from any provider</p> <p>f) CHC EOL team to contact care providers on Barnsley borders to identify if they could pick up packages just over the borders.</p>						<p>2021. Work is still ongoing in Joint Commissioning with regards to the domic. care provider framework.</p> <p>June 2021 BMBC have undertaken a review regarding the framework of domiciliary providers. CHC Operational Lead and Chief nurse discussed one provider approach for EOL care. There is a meeting arranged for June 2021 with BMBC Joint commissioner manager to scope out the possibility of one provider</p>	
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Governing Body

20 January 2022

Integrated Performance Report

PART 1A – SUMMARY REPORT

1.	THIS PAPER IS FOR											
	<table border="1"> <tr> <td><i>Decision</i></td> <td><input type="checkbox"/></td> <td><i>Approval</i></td> <td><input type="checkbox"/></td> <td><i>Assurance</i></td> <td><input checked="" type="checkbox"/></td> <td><i>Information</i></td> <td><input checked="" type="checkbox"/></td> </tr> </table>	<i>Decision</i>	<input type="checkbox"/>	<i>Approval</i>	<input type="checkbox"/>	<i>Assurance</i>	<input checked="" type="checkbox"/>	<i>Information</i>	<input checked="" type="checkbox"/>			
<i>Decision</i>	<input type="checkbox"/>	<i>Approval</i>	<input type="checkbox"/>	<i>Assurance</i>	<input checked="" type="checkbox"/>	<i>Information</i>	<input checked="" type="checkbox"/>					
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 30 th November 2021 or the latest available position.											
3.	REPORT OF											
	<table border="1"> <thead> <tr> <th></th> <th>Name</th> <th>Designation</th> </tr> </thead> <tbody> <tr> <td>Executive / Clinical Lead</td> <td>Roxanna Naylor/Jamie Wike</td> <td>Chief finance Officer/Chief Operating Officer</td> </tr> <tr> <td>Author</td> <td>Genna Miller/Azariah Speed</td> <td>Head of Finance (Management Accounts)/Contract, Performance Intelligence Manager</td> </tr> </tbody> </table>				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)/Contract, Performance Intelligence Manager
	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)/Contract, Performance Intelligence Manager										
4.	SUMMARY OF PREVIOUS GOVERNANCE											
4.1	<p>The matters raised in this paper have been subject to prior consideration in the following forums:</p> <table border="1"> <thead> <tr> <th>Group / Committee</th> <th>Date</th> <th>Outcome</th> </tr> </thead> <tbody> <tr> <td>Finance and Performance Committee</td> <td>6th January 2022</td> <td>Considered the paper and noted the actions</td> </tr> </tbody> </table>			Group / Committee	Date	Outcome	Finance and Performance Committee	6 th January 2022	Considered the paper and noted the actions			
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5.	EXECUTIVE SUMMARY
5.1	<p><u>2021/22 - Month 8 Finance Update</u></p> <p>The detailed finance report, attached at Appendix 2, provides an assessment of the 2021/22 financial performance of the CCG up to 30th November 2021. The report contains the headline messages along with monthly financial monitoring.</p> <p>As at 30th November 2021 the CCG is forecasting to achieve all financial duties and business rule requirements, with a balanced budget position, subject to further technical adjustments of £3.3m relating to the Hospital Discharge Programme (HDP) and Additional Roles Reimbursement Scheme (ARRS).</p> <p>The Finance and Performance Committee considered further risks and mitigations with the most likely scenario of a net mitigation (underspend) of £588k, which will be managed to the year end to deliver financial balance.</p> <p>Continuing Healthcare and Prescribing continued to be high risk areas, with forecast movements from M6 to M8 of (£174k) and (£42k) respectively. The risk and mitigation assessment does assume some further pressure and movement in forecasts for the remaining months of this financial year.</p> <p>The Additional Roles Reimbursement Scheme is forecasting to receive a further £1.3m allocation from NHS England, based on centrally held funding which is transferred as expenditure exceeds the £1.9m allocation held by Barnsley CCG. This continues to be assessed based on the recruitment plans within the Primary Care Network.</p> <p>Private Provider acute activity is showing an underspend of £0.7m relating to activity levels being lower than the 2019/20 budgeted levels for H2. We are not anticipating achievement of the Elective Recovery Fund threshold as an Integrated Care System, or to achieve the CCG commissioned private provider threshold levels.</p> <p>Further information on the CCG's financial performance targets is set out in section 2 of Appendix 2.</p> <p>As risks and mitigations emerge, the Governing Body will be updated through this report which is a standing agenda item of the committee.</p>
5.2	<p><u>Performance Update</u></p> <p>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 8 (November 2021) where data is available.</p> <p>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.</p> <p>Following a Data Quality and Performance Management Framework review undertaken by 360 Assurance, several metrics have now been included or updated in the report to provide additional assurance to relevant committees.</p>

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.

The CCG performance (64.69% in November) is being driven in the main by A&E performance against the 4-hour standard at BHNFT remaining below target at 62.29%. This is a further deterioration in performance from the October position.

Attendances at the Trust remain high and Barnsley partners continue to work on consistent messaging and signposting support to best utilise self-care and urgent care away from A&E. Work continues in relation to 'Front Door' navigation and a GP streaming model to address pressures in ED. The Directory of Services is also being reviewed and updated to address potential gaps in the profiles used by NHS111

Ambulance handover performance continues to be significantly below 2019/20 levels with a worsening position in November. This is directly related to longer waits in A&E. The CCG continues to work with BHNFT and Yorkshire Ambulance Service on several pathway changes that may support patients not requiring conveyance to hospital. Partners continue to work on embedding SDEC pathways for both medical and surgical specialities and developing identification of SDEC type services out of hospital.

Ambulance response times continue to perform poorly however there was a slight improvement in performance for response times across all categories in November.

Planned Care

With regards to Referral to Treatment times, 18-week RTT performance for the CCG has slightly improved in month from 84.85% in October to 85.33% in November. The number of 52-week waiters is has remained static at 279 in November.

The CCG's RTT performance is driven mainly by under-performance at BHNFT in the 92% referral to treatment standard. RTT figures for the Trust have not yet been updated for November however, they achieved 85.75% in October. The suspension of Orthopaedic elective surgery for 2 weeks late October has had an impact on the performance.

With regards to 104+ week waits, the CCG currently has 11 patients in this category as of November 21, the majority of which are at Leeds Teaching Hospitals and Barnsley Hospital. This position has decreased slightly from the previous month and we continue to plan to be at zero by March 2022.

With regards to Diagnostics performance, this has improved significantly again in month from 27.95% in October to 19.80% in November (Target of 1%). It is at its lowest numbers waiting for this financial year. Although on a positive trajectory, under-performance continues to be driven by longer waits for Colonoscopy and Gastroscopy at BHNFT and waits at Doncaster and Bassetlaw Teaching Hospitals mainly relating to Non-Obstetric Ultrasound.

	<p><u>Mental Health and Learning Disabilities</u></p> <p><i>Note: Due to the availability of data EIP data is reflective of the September 21 position. An update will be provided verbally if updated data becomes available</i></p> <p>With regards to IAPT performance, the number of people entering treatment against level of need has not met the updated target of 2.08% target in month (25% full year target). Performance has however improved compared to last month (1.82% compared to 1.59% in October).</p> <p>The proportion of people who complete treatment and are moving to recovery is now consistently achieving the 50% target after performance slipped in July.</p> <p><u>Cancer</u></p> <p>Performance on the majority of the cancer pathways continues to be below the national standards and there was a slight worsening across a number of measures from the October position, notably two-week waits (also including Breast). The only measures met in month were 31 day wait for second/subsequent treatment, where treatment is anti-cancer drug regimen or radiotherapy.</p> <p>Inadequate outpatient capacity has now overtaken patient choice as the main reason for Cancer two-week wait breaches. At BHNFT, Overall treatment volumes remain high as ongoing backlog recovery is well underway.</p>		
6.	THE FINANCE AND PERFORMANCE COMMITTEE IS ASKED TO:		
	<p>Note the contents of the report including:</p> <ul style="list-style-type: none"> • Performance to date 2021/22 • projected delivery of all financial duties, predicated on the assumptions outlined in this paper and mitigating actions 		
7.	APPENDICES / LINKS TO FURTHER INFORMATION		
	<p>Performance Section</p> <ul style="list-style-type: none"> • Appendix 1 – IPR M8 2021/22 <p>Finance Section</p> <ul style="list-style-type: none"> • Appendix 2 – Month 8 Finance update 		
<table border="1"> <tr> <td>Agenda time allocation for report:</td> <td>10 Minutes</td> </tr> </table>		Agenda time allocation for report:	10 Minutes
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



Performance & Delivery Report

2021/22 : Position statement
using latest information
for the January 2022 meeting
of the Governing Body

Performance Indicator	Target	CCG Quarterly	CCG Latest			CCG Performance	Latest Provider Performance	
			Monthly Position		YTD Position			
NHS Constitution								
Referral To Treatment waiting times for non-urgent consultant-led treatment	All patients wait less than 18 weeks for treatment to start	92%		Provisional 85.33%	Nov-21	Provisional 85.22%	<div><div></div></div>	Published Oct-21 85.75%
	No patients wait more than 52 weeks for treatment to start	0		279	Nov-21	2874	<div><div></div></div>	129
Diagnostic test waiting times	Patients waiting six weeks or more for a diagnostic test	1%		Provisional 19.80%	Nov-21		<div><div></div></div>	Published Oct-21 31.18%
			Q2 21/22					
A&E Waits	Patients are admitted, transferred or discharged within 4 hours of arrival at A&E	95%	69.44%	64.69%	Nov-21	71.39%	<div><div></div></div>	62.29%
	No patients wait more than 12 hours from decision to admit to admission	0		1	Nov-21		<div><div></div></div>	1
			Q2 21/22					Oct-21
Cancer Waits: From GP Referral to First Outpatient Appointment	2 week (14 day) wait from referral with suspicion of cancer	93%	93.95%	85.67%	Nov-21	90.77%	<div><div></div></div>	90.02%
	2 week (14 day) wait from referral with breast symptoms (cancer not initially suspected)	93%	90.25%	63.72%	Nov-21	76.75%	<div><div></div></div>	64.95%
Cancer Waits: From Diagnosis to Treatment	1 month (31 day) wait from diagnosis with suspicion of cancer to first treatment	96%	93.69%	95.60%	Nov-21	95.58%	<div><div></div></div>	94.74%
	1 month (31 day) wait for second/subsequent treatment, where treatment is anti-cancer drug regimen	98%	100.00%	100.00%	Nov-21		<div><div></div></div>	100.00%
	1 month (31 day) wait for second/subsequent treatment, where treatment is radiotherapy	94%	94.52%	98.04%	Nov-21	96.94%	<div><div></div></div>	
	1 month (31 day) wait for second/subsequent treatment, where treatment is surgery	94%	75.68%	70.59%	Nov-21	77.22%	<div><div></div></div>	83.33%
Cancer Waits: From Referral to First Treatment	2 month (62 day) wait from urgent GP referral	85%	68.18%	72.41%	Nov-21	71.84%	<div><div></div></div>	66.67%
	2 month (62 day) wait from referral from an NHS screening service	90%	85.71%	80.00%	Nov-21	82.11%	<div><div></div></div>	86.21%
	2 month (62 day) wait following a consultant's decision to upgrade the priority of the patient	(85% threshold)	84.21%	78.18%	Nov-21	85.62%	<div><div></div></div>	81.67%
Cancer Waits: Faster diagnosis standard	Cancer 28 day waits - Told within 28 Days	75%	64.96%	70.54%	Nov-21	66.23%	<div><div></div></div>	66.88%
Ambulance response times	Category 1 (life threatening) calls resulting in an emergency response arriving within 7 minutes (average response time)	7 mins		10mins 9secs	Nov-21		<div><div></div></div>	
	Category 1 calls resulting in an emergency response arriving within 15 minutes (90th percentile response time)	15 mins		17mins 27secs	Nov-21		<div><div></div></div>	
	Category 2 (emergency) calls resulting in an emergency response arriving within 18 minutes (average response time)	18 mins		42mins 0secs	Nov-21		<div><div></div></div>	
	Category 2 calls resulting in an emergency response arriving within 40 minutes (90th percentile response time)	40 Mins		1hrs30mins54secs	Nov-21		<div><div></div></div>	
	Category 3 (urgent) calls resulting in an emergency response arriving within 120 minutes (90th percentile response time)	120 mins		5hrs18mins58secs	Nov-21		<div><div></div></div>	
	Category 4 (less urgent) calls resulting in an emergency response arriving within 180 minutes (90th percentile response time)	180 mins		7hrs12mins36secs	Nov-21		<div><div></div></div>	
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		30.09%	Nov-21	21.58%	<div><div></div></div>	
	Ambulance Handover - reduction in the number of delays over 1 hour in clinical handover of patients to A&E	Local Reduction		11.99%	Nov-21	7.36%	<div><div></div></div>	
	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		11.30%	Nov-21	10.29%	<div><div></div></div>	
	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		0.86%	Nov-21	0.63%	<div><div></div></div>	
Mixed Sex Accommodation (MSA) breaches	Zero instances of mixed sex accommodation which are not in the overall best interest of the patient	0		2	Oct-21		<div><div></div></div>	1
			Q4 19/20					
Cancelled Operations	Operations cancelled, on or after the day of admission, for non-clinical reasons to be offered another date within 28 days	0	N/A	N/A	N/A	N/A	Data collection paused in April 2020 due to the coronavirus the need to release capacity across the NHS to support it will resume for Quarter 3 2021/22 data (to be published)	
								SWYPFT
Mental Health	People under adult mental illness specialties on CPA (Care Plan Approach) to be followed up within 7 days of discharge	100%		Data no longer collected at CCG level. To be replaced under the NHS Standard Contract, with new metric measuring 72-hour follow-up for all patients discharged from inpatient care				100.00%

Performance Indicator		Target	CCG Quarterly	CCG Latest			CCG Performance	Latest Provider Performance	
				Monthly Position		YTD Position		Barnsley Hospital	Psychosis
Mental Health									
								SWYPFT	
Early Intervention in Psychosis (EIP)	Proportion of EIP patients seen in 2 weeks	60%		95.00%	Sep-21			75.00%	
IAPT	Improved Access to Psychological Services-IAPT: People entering treatment against level of need	25% (2.08%)		1.82%	Nov-21	13.09%			
	Improved Access to Psychological Services-IAPT: People who complete treatment, moving to recovery	50%		52.14%	Nov-21				
	Proportion of people waiting 18 weeks or less from referral to first IAPT treatment appointment	95%		100.00%	Nov-21				
	Proportion of people waiting 6 weeks or less from referral to first IAPT treatment appointment	75%		97.30%	Nov-21				

Performance Indicator	Target	CCG Quarterly	CCG Latest		CCG Performance	Latest Provider
			Monthly Position	YTD Position		Barnsley Hospital

Performance Indicator	Target	CCG Quarterly	CCG Latest		CCG Performance	Latest Provider
			Monthly Position	YTD Position		Barnsley Hospital

ler Total Monthly sition
Yorkshire Ambulance Service
10mins 9secs
17mins 27secs
42mins 0secs
1hrs30mins54secs
5hrs18mins58secs
7hrs12mins36secs
30.09%
11.99%
11.30%
0.86%
us illness (COVID-19) and he response. The collection ned in February 2022).

ler Total Monthly osition
Yorkshire Ambulance Service

er Total Monthly sition
Yorkshire Ambulance Service

er Total Monthly sition
Yorkshire Ambulance Service

NHS Barnsley Clinical Commissioning Group

Finance Report 2021/22

Month 8



1 Headline Messages and Contents

Headline Messages	Contents	
<ul style="list-style-type: none"> The financial information contained within this report relates to April 2021 to March 2022 (including the H1 and H2 periods). The report to 30th November 2021 reflects a balanced position with the CCG forecasting to achieve financial duties and planning requirements. The Finance and Performance Committee considered details on the risks and mitigations with the current projections 'Most Likely' scenario indicating an underspend with headroom of £588k. This position is likely to fluctuate and will be managed to the year end, to ensure financial balance is achieved. The CCG expenditure and forecast position shows an overspend of £0.5m and £3.3m respectively, which relate to future allocation manual adjustments for the Hospital Discharge Programme and the Additional Roles Reimbursement Scheme. The Additional Roles Reimbursement Scheme (included within the delegated Primary Care Medical Contracts) is showing a forecast overspend of £1.3m linked to the phasing of recruitment to posts. Once Barnsley CCG exceeds the budgeted expenditure levels in December 2021, NHS England will release additional centrally held allocations up to the value of £1.5m. We are forecasting to underspend against the central budget by £0.2m with a total requirement of £1.3m. Work continues with the PCN to ensure this forecast remains up to date and reflects latest recruitment plans. Continuing Healthcare continues to be a high risk area, with monthly monitoring continuing to be agreed and reviewed by the Chief Nurse and Finance team. The forecast includes £0.1m relating to further data recording updates required in the Broadcare database, along with a non-recurrent benefit of £0.3m relating to the outcome of Personal Health Budget audit and the underutilisation of care packages, which is predominantly linked to the impact of Covid. Within the risk and mitigation analysis we have assumed some further pressure and movement in forecasts for the remaining months of this financial year. Primary Care prescribing data for Month 6 has been received, and the forecast position is under spent by £0.1m with the prescribing overspend of £0.4m being offset against underspends 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. Within the risks and mitigation analysis considered by the Finance and Performance Committee it is assumed some further pressure and movement in forecasts as changes in prescribing profiles are anticipated and there is likely to be some variation from the current forecast position, which have been considered by the Finance and Performance Committee. 	1	Headline Messages and Content
	2	Financial Performance Targets
	3	Monthly Finance Monitoring Statement – Executive Summary
	3.1	Detailed Summary Resource Allocation – Detailed Summary

2 Financial Performance Targets

1) Financial Duties – April 2021 to March 2022

NHS Act Section	Duty	2021/22 Target £'000	2021/22 Actual Performance £'000	2021/22 Actual Achievement
223H (1)	Expenditure not to exceed income	529,182	529,182	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	529,142	529,142	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	4,882	3,981	YES

2) Financial targets/NHS England Business Rules requirements – April 2021 to March 2022

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	1,868	1,868	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 £	BUDGET NON RECURRENT £	TOTAL BUDGET £	YTD BUDGET £	YTD ACTUAL £	YTD VARIANCE OVER / (UNDER) £	FORECAST £	VARIANCE OVER / (UNDER) £
PROGRAMME EXPENDITURE								
Acute	245,722	31,267	276,989	183,723	183,606	(118)	276,668	(321)
Patient transport	2,528	0	2,528	1,663	1,666	3	2,525	(3)
Mental Health	41,602	2,238	43,840	28,952	28,921	(31)	43,802	(38)
Community Health	52,865	(5,084)	47,781	32,089	32,067	(22)	47,746	(34)
Continuing Health Care	31,113	0	31,113	20,657	20,929	272	31,135	22
Primary Care Other	63,390	(899)	62,490	42,048	41,580	(468)	62,123	(367)
Primary Medical Services (Co-Commissioning)	43,330	(355)	42,976	29,222	29,012	(210)	44,087	1,112
Other Programme Costs	3,622	2,839	6,462	3,240	3,239	(1)	6,467	6
TOTAL COMMISSIONING SERVICES (INCLUDING PRIMARY CARE RESERVES)	484,171	30,006	514,177	341,594	341,020	(575)	514,553	376
Corporate Costs - EMBED/DSCRO	152	0	152	101	100	(1)	150	(2)
Corporate Costs - IFR	45	0	45	30	25	(4)	38	(6)
NHS Property Services/Community Health Partnerships	772	0	772	509	511	3	773	1
Depreciation Charges	20	(20)	0	0	0	0	0	0
TOTAL CORPORATE COSTS	989	(20)	969	640	637	(3)	961	(8)
Coronavirus Costs - PrimCare	327	1,609	1,937	1,654	1,653	(2)	1,934	(3)
Coronavirus Costs - CHC - Hospital Discharge Programme (Outside of Envelope)	0	695	695	695	888	193	1,562	867
Coronavirus Costs - Community - Hospital Discharge Programme (Outside of Envelope)	0	136	136	136	431	295	1,048	912
Coronavirus Costs - Other Prog. - Hospital Discharge Programme (Outside of Envelope)	0	127	127	127	161	33	261	133
TOTAL CORONAVIRUS COSTS	327	2,567	2,895	2,612	3,119	507	4,792	1,898
TOTAL PROGRAMME COSTS (INCLUDING PRIMARY CARE RESERVES)	485,487	32,554	518,040	344,846	344,775	(71)	520,306	2,265
RUNNING COSTS								
Pay	2,550	(19)	2,531	1,704	1,622	(81)	2,408	(123)
Non Pay	2,332	(581)	1,751	1,151	885	(266)	1,573	(178)
TOTAL RUNNING COSTS	4,882	(600)	4,282	2,855	2,507	(348)	3,981	(301)
CCG Reserves - 0.5% Contingency	1,868	0	1,868	1,432	1,432	0	1,868	0
CCG Reserves - Capacity Planning	0	120	120	40	40	0	120	0
CCG Reserves - Ageing Well	0	994	994	779	779	0	994	0
CCG Reserves - Intermediate Care	0	465	465	278	278	0	465	0
CCG Reserves - Mental Health Seasonal Pressures	0	91	91	30	30	0	91	0
CCG Reserves - Overseas Visitors	434	(434)	0	0	0	0	0	0
CCG Reserves - Risk Reserve	1,448	(1,420)	28	(814)	(814)	0	28	0
Risk Contingency - In year (over)/underspend	0	0	0	0	940	940	1,289	1,289
TOTAL RESERVES/CONTINGENCY (EXCL. PRIMARY CARE RESERVES)	3,751	(185)	3,566	1,745	2,685	940	4,855	1,289
TOTAL EXPENDITURE	494,119	31,769	525,888	349,446	349,968	522	529,142	3,253

PROGRAMME AND RUNNING COST AREAS	BUDGET RECURRENT £	BUDGET NON RECURRENT £	TOTAL BUDGET £	YTD BUDGET £	YTD ACTUAL £	YTD VARIANCE OVER / (UNDER) £	FORECAST £	VARIANCE OVER / (UNDER) £
Programme	420,588	58,486	479,074	317,887	317,887	0	479,074	0
Primary Care Co-Commissioning	41,344	588	41,932	28,305	28,305	0	41,932	0
Running Costs	4,882	0	4,882	3,255	3,255	0	4,882	0
RESOURCE ALLOCATIONS	466,814	59,074	525,888	349,446	349,446	0	525,888	0
SURPLUS/(DEFICIT)	(27,305)	27,305	(0)	0	(522)	(522)	(3,253)	(3,253)
Hospital Discharge Programme (HDP) - Month 7/8					522	522	1,912	1,912
ARRS - Month 8					0	0	1,341	1,341
Total Technical Adjustments awaiting allocations			0	0	522	522	3,253	3,253
SURPLUS/(DEFICIT) after technical adjustments			0	0	-0	-0	-0	-0

3.1 Resource Allocation – Detailed Summary

RESOURCE ALLOCATIONS - PROGRAMME, RESERVES & SURPLUS		ALLOCATION RECURRENT	ALLOCATION NON RECURRENT	TOTAL £000	RESOURCE ALLOCATIONS - RUNNING COSTS		ALLOCATION RECURRENT	ALLOCATION NON RECURRENT	TOTAL £000
Description	Month	£	£	£	Description	Month	£	£	£
Programme Allocation	M2	207,501		207,501	2021/22 Allocation	M2	2,441		2,441
Primary Care Co-Commissioning	M2	20,672		20,672	2021/22 Allocation	M8	2,441		2,441
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 - PROGRAMME, RESERVES & SURPLUS		ALLOCATION RECURRENT	ALLOCATION NON RECURRENT	TOTAL £000	RESOURCE ALLOCATIONS - RUNNING COSTS		ALLOCATION RECURRENT	ALLOCATION NON RECURRENT	TOTAL £000
Description	Month	£	£	£	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 - Transforming 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					
Local Maternity Systems (LMS) - Continuity of Carer & Equity - transfer to ICB	M5		(14)	(14)					
Online consultation software systems	M5		19	19					
Practice resilience programme - local	M5		20	20					
Primary care networks - development and support	M5		69	69					
Long Covid Management of Adults	M5		426	426					
Primary Care for Long Covid	M5		131	131					
Safeguarding Allocation - Radio campaign Safe sleeping	M5		6	6					
Elective Recovery Fund (ERF) Transfer From Lead (April and May Payment Refresh + 90% June)	M5		30	30					
Elective Recovery Fund (ERF) Transfer From Lead (10% June)	M6		2	2					
Programme Allocationation	M7	213,087	0	213,087					
Primary Care Co-Commissioning	M7	20,181	0	20,181					
Primary Care Co-Commissioning growth	M7	491	0	491					
MH: SDF/SR	M7		1,388	1,388					
SDF - PCN Leadership	M7		191	191					
SDF - GP IT	M7		29	29					
SDF - Improving Primary Care Access	M7		59	59					

RESOURCE ALLOCATIONS - PROGRAMME, RESERVES & SURPLUS		ALLOCATION RECURRENT	ALLOCATION NON RECURRENT	TOTAL £000
Description	Month	£	£	£
SDF - Pre Term Births	M7		24	24
SDF - NHS111 Capacity	M7		367	367
Diagnostics Programme: Early Adopter Community Diagnostic Hub	M7		575	575
Covid 19 vaccination costs - reducing inequalities Q2	M7		18	18
HDP Q2	M7		403	403
Provider top up	M8		9,211	9,211
Top up funding - CCG	M8		(329)	(329)
Top up funding - CCG	M8		4,083	4,083
Growth funding - Provider	M8		518	518
Growth funding - CCG	M8		957	957
Covid funding - Provider	M8		8,357	8,357
Covid funding - CCG	M8		4,269	4,269
Capacity Funding	M8		1,533	1,533
Cervical Screening Programme - audit funding for practices - Phase 1	M8		1	1
Primary Care Investment and Impact Fund - part 2	M8		457	457
MH: Winter pressures	M8		91	91
Barnsley Hospital NHS FT - Volunteering Services Fund 2021	M8		25	25
Diabetes Programme Transformation Fund H2	M8		35	35
Primary Care Networks - development and support	M8		68	68
Primary Care Networks - practice resilience programme	M8		20	20
Primary Care - online consultation software systems	M8		37	37
Ageing Well - Transforming Community Services	M8		488	488
Personalised Care Partnership Agreement Workforce Training	M8		65	65
Barnsley Place Rapid Diagnostic Centre - BHNFT	M8		29	29
Barnsley Place Rapid Diagnostic Centre - Band 4 BCCG	M8		32	32
Barnsley Place Rapid Diagnostic Centre - Primary Care	M8		63	63
TOTAL RESOURCE ALLOCATION		461,932	59,074	521,006

SUMMARY		£'000	£'000	£'000
Programme		420,588	58,486	479,074
Primary Care Co-Commissioning		41,344	588	41,932
Running Costs		4,882	0	4,882
TOTAL RESOURCE ALLOCATION		466,814	59,074	525,888

Comments

Section 3.1 provides details of the allocations received to 30th November 2021.

Minutes of the Meeting of the Barnsley Clinical Commissioning Group AUDIT COMMITTEE held on Thursday 25 November 2021 at 14.30pm via Microsoft Teams

PRESENT:

Nigel Bell	Audit Committee Chair – Lay Member for Governance
Dr Adebowale Adekunle	Elected Member Governing Body
Chris Millington	Lay Member for Patient and Public Engagement and Primary Care Commissioning (from minute reference AC 21/09/08)

IN ATTENDANCE:

Leanne Hawkes	Interim Director 360 Assurance
Paige Proud	Risk, Assurance and Governance Facilitator
Roxanna Naylor	Chief Finance Officer
Usman Niazi	Assistant Client Manager 360 Assurance
Richard Walker	Head of Governance and Assurance
Esther Short	HR Manager

APOLOGIES

Jayne Sivakumar	Chief Nurse
Salma Younis	Senior Manager, KPMG
Claire Croft	LCFS 360 Assurance (up to and including minute reference AC 21/09/07)

Ref	Agenda Item	Action	Dead line
AC 21/11/01	HOUSEKEEPING – Microsoft Teams Meeting etiquette was noted.		
AC 21/11/02	APOLOGIES – As noted above.		
AC 21/11/03	QUORACY - The meeting was declared quorate.		
AC 21/11/04	DECLARATIONS OF INTEREST, SPONSORSHIP, GIFTS AND HOSPITALITY		
	The Committee noted the Declaration of Interests Report. No other new declarations of interest were received.		
AC 21/11/05	MINUTES OF THE PREVIOUS MEETING HELD ON 16 SEPTEMBER 2021		

Ref	Agenda Item	Action	Dead line
	The Minutes of the meeting held on 16 September 2021 were approved as a correct record of the proceedings with the exception of 'Annual Audit Letter' being amended to 'Auditor's Annual report' on page 6.		
AC 21/11/06	MATTERS ARISING		
	<p>The Committee considered the Matters Arising Report.</p> <ul style="list-style-type: none"> • Minute Reference AC 21/09/07 LOCAL COUNTER FRAUD SPECIALIST PROGRESS REPORT This action was marked as ongoing. The Interim Director 360 Assurance will pick back up with the team. • Minute Reference AC 21/09/11 INCIDENT REPORTING AND MANAGEMENT POLICY The Head of Governance and Assurance confirmed that guidance had been drafted re information sharing and was to be shared at the TEG meeting next week. 		
AC 21/11/07	CCG CLOSEDOWN AND TRANSITION PROCESS TO INTEGRATED CARE BOARD DUE DILIGENCE		
	<p>The Chief Finance officer presented the CCG closedown checklist. Discussions took place including:</p> <ul style="list-style-type: none"> • 1.6.7 Consider if there are any 'hard to replace' services provided by independent sector providers that are not yet designated as Commissioner Requested Services – the Committee agreed that there was no further action to take. Currently marked as green. • 1.3.10 Open CQC action plans that would transfer – the Chief Finance Officer will pick this up further with the Chief Nurse. Currently marked as amber. • 1.3.13 Open risks that would transfer (provide risk register of all risks, including HR, financial / accounting, quality risks, etc – The Head of Governance and Assurance stated this to be classed as 'business as usual' work, therefore, marked as green. The Committee agreed that a paragraph to be included in the next update report to the Governing Body explaining the methodology that had been applied in RAG rating the items in the due diligence checklist. Currently marked as green. • 2.125 Details of any flexible working arrangements, whether contractual or custom and practice – ongoing 	RW	Dec 2021

Ref	Agenda Item	Action	Dead line
	<p>work being completed re this. Including to check all correct information is held on personal files and follow up audits to be completed in the new year. Another piece of work is to be completed on HR policies as to which will be adapted and taken forward into the ICB. Currently marked as amber.</p> <ul style="list-style-type: none"> • 2.128 Summary of accrued annual leave for transferring employees and agreements around carry forward (including the method of calculation) – held electronically on ESR. Currently marked as green. • 3.18 Agree and implement robust assurance arrangements including internal and external audit plans – it was confirmed that discussions commenced on extending contracts current held with 360 assurance and KPMG and highlighted that a board structure is now in place for the ICB. Awaiting further update from KPMG and discussions with 360 Assurance have commenced on how arrangements will work for 2022/23. 360 Assurance are also in the process of looking at the internal audit plan for next year. • 3.19 Ensure that the audit committee meetings are scheduled in line with the requirements of the business, including one very close to the 31 March 2022 to provide an appropriate formal closure report. Schedule meetings for approval to submit draft and final accounts and report – currently marked as green. • 3.3.51 Purchase to Pay: <ul style="list-style-type: none"> - Supplier template - NHS supplies - Locations template - Purchasing Positions template - Catalogue template - Non PO rules template - Payment configuration form - Vendor notifications" - part of SBS project plan. <p>Change and transition updates will start to include parts re DESIGN.</p> • 7.1.6 Agreed way to transfer and systematically store and retain legacy information – it was highlighted that in terms of risk for records management is not high level as records will be stored at the end of March in and be in the same place in April 2022. <p>The committee noted the complexity behind the checklist and all the hard work been completed. The meeting was deemed</p>		

Ref	Agenda Item	Action	Dead line
	useful and agreed that a meeting to be set up for the end of January 2022 to pick the checklist back up, at which further consideration would be given to whether an additional meeting would be required at the end of February February / early March 2022 shortly before the Accountable Officer is due to provide assurance to the ICB regarding the completeness of the CCG's due diligence process.	PD	Dec 2021
	The Audit Committee noted the checklist.		
AC 21/11/08	AUDIT COMMITTEE TRAINING REQUIREMENTS		
	Nothing to note.		
AC 21/11/09	ESCALATION OF ITEMS TO GOVERNING BODY		
	It was agreed that an update in the change and transition report will be included to confirm that this meeting took place and another to be set up for January 2022.		
AC 21/11/10	REFLECTION ON HOW WELL THE MEETING'S BUSINESS HAS BEEN CONDUCTED		
	The Committee concluded that the business of the meeting had been well conducted with all members having an opportunity to provide their input.		
AC 21/11/11	DATE AND TIME OF NEXT MEETING		
	The next meeting of the Audit Committee will be held on Thursday 13 January 2022 at 09.30 am, via Microsoft Teams.		

**Minutes of the Meeting of the NHS Barnsley Clinical Commissioning Group
FINANCE & PERFORMANCE COMMITTEE held on Thursday 4 November 2021 at
10.30am via Microsoft Teams.**

PRESENT:

Dr John Harban (Chair)	- Elected Member Governing Body - Contracting
Chris Edwards	- Accountable Officer
Roxanna Naylor	- Chief Finance Officer
Jamie Wike	- Chief Operating Officer
Dr Jamie MacInnes	- Elected Member Governing Body
Nigel Bell	- Lay Member Governance

IN ATTENDANCE:

Leanne Whitehead	- Executive Personal Assistant
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APOLOGIES:

Dr Nick Balac	- Chair
Dr Adebowale Adekunle	- Elected Member Governing Body
Jeremy Budd	- Director of Strategic Commissioning and Partnerships
Patrick Otway	- Head of Commissioning (MH, Children, Specialised)

Agenda Item		Action & Deadline
FPC21/142	QUORACY	
	The meeting was declared quorate.	
FPC21/143	DECLARATIONS OF INTEREST, SPONSORSHIP, HOSPITALITY AND GIFTS RELEVANT TO THE AGENDA	
	The Committee noted the declarations of interest report. There were no declarations of interest raised relevant to the agenda.	
FPC21/144	MINUTES OF THE PREVIOUS MEETING HELD ON 7 OCTOBER AND 21 OCTOBER 2021– Approved.	
FPC21/145	MATTERS ARISING REPORT	
	The matters arising report was received and noted and no further updates were given.	
FPC21/146	UPDATE ON RECENT PUBLISHED AND EXPECTED GUIDANCE –	
	The Chief Finance Officer presented the report to members noting that the key points from the H2 – 2021/22 Payment Arrangements	

	<p>and Priorities were shared with the Committee in October 2021 through a slide presentation and links were provided to allow the committee members to review the guidance in full should they so wish.</p> <p>The Committee received and noted the contents of the report.</p>	
FPC21/147	UPDATE ON CONTRACTING CYCLE	
	There was no update available this month.	
FPC21/148	APPROVAL AND OR UPDATE ON PROCUREMENTS	
	<p>The Chief Operating Officer presented the report to members reporting that the standstill period for the procurement of the Brierley Medical Centre service had expired on the 25 October 2021. The CCG could now proceed with the contract award to the Barnsley Healthcare Federation.</p> <p>The Committee received and noted the update.</p>	
FPC21/149	H2 FINANCIAL PLAN	
	<p>The Chief Finance Officer presented slides to members on the H2 financial plan reporting that things were still moving in relation to the overall ICB system plan which will impact on the CCGs position. It was noted that the draft plan had been submitted and only a few minor changes for CCG had been made, the ICS were currently working on the system position which will impact on other organisations, a full report would go to the Governing Body on the 11 November with the final position reported there. The Chief Finance Officer reported the changes in the allocation and the internal adjustments were shared with members.</p> <p>It was reported that BHNFT were to receive £3.1m in order for them to achieve financial balance. £2.679m allocation to Barnsley CCG as a share from the ICS current surplus position and was noted that the governance of this funding was still up for debate and was to be agreed by CFO's at a meeting on the 8 November 2021 to look at the best route to go down.</p> <p>Dr J Harban queried the Trusts position and the Chief Finance Officer reported that a full paper had been received from the trust explaining as to why they were in this position and was noted that within South Yorkshire Barnsley were the only ones declaring an overspend.</p> <p>It was agreed that there was work to do around financial sustainability across the system and there would be some big challenges ahead. It was reported that the Accountable Officer and Chief Finance Officer were due to meet with the Trust to gain a better understanding of these issues and the Chief Finance Officer</p>	

	<p>was also scheduled to have a call with the Local Authority to discuss their position.</p> <p>The Committee were asked to support the final plan going for discussion at Governing Body on the 11 November 2021 and members were all in agreement.</p>	
FPC21/150	INTEGRATED PERFORMANCE REPORT INCLUDING UPDATE FROM CHIEF NURSE ON CHC	
	<p><u>Performance</u></p> <p>The Chief Operating Officer presented the performance section of the report to the Committee reporting that the A&E 4 hour wait target continues to be below and are seeing significant challenges in urgent care with high attendances. Ambulance handover performance continues to be significantly below 2019/20 levels with a worsening position in September. This continues to be expected given the longer waits in A&E and high levels of demand. In terms of planned care the 52 week waits continue to reduce with 18 weeks having a few waits. It was reported that diagnostics were improving but still had some waiting over 6 weeks, the IAPT access target is almost being met and Governing Body had approved additional access funds for this. There were real challenges in cancer targets although lots of plans were being put in place along with activity plans so should expect to see some improvement over the next few months but this was dependent on activity coming through.</p> <p><u>Finance</u></p> <p>The Chief Finance Officer reported that the CCG were continuing to achieve financial balance with pressures and risks continuing in prescribing and CHC. It was reported that there is likely to be more resource coming into the system but the Chief Finance Officer would keep members informed and updated.</p> <p><u>CHC</u></p> <p>The Chief Nurse attended the meeting to update members on the current pressures within Continuing Health Care. A presentation was shared with members which highlighted the high cost care packages and 121 care packages showing costs for Q1 and Q2 over the last 3 years which showed an increase, it was reported that providers were pushing for more 121's for various reasons and they were also being demanded on admission, but the team do review these and reduce them when needed. There had been a decrease in new assessments but increase in spend and lots of work was ongoing with partners around this. The current caseload and reviews for adult CHC was shared and showed that they were now in a better position prior to covid. A number of case examples were shared with members to show the complexities the team were</p>	

	<p>dealing with and members were assured that all care packages were reviewed on a 3 monthly basis. An update was given on children and young people's CHC and IFR noting that following review 6 cases had been closed and funding ceased and that an IFR process was now in place for children and young people.</p> <p>It was reported that issues within CHC was a national issue and not just an issue for Barnsley with market led provision issues and costings. Acute and PICU costs are unpredictable and demand is currently exceeding capacity within SWYPFT, weekly panels are held with weekly updates received from SWYPFT to the team which the team will challenge and change care packages when needed.</p> <p>Conversations were ongoing for neuro rehab as this was a market led provision and pricing and all cases were referred to IFR but noted that some patients have to be placed quickly but would then be reviewed every 3 months.</p> <p>It was reported there had been a 360 audit review and were working through all actions to maintain or reduce costs and all risks were included within the CCG risk register including the national issues around CHC.</p> <p>Dr J MacInnes that as private providers currently provide care could an NHS provider/community provider not provide services. This had been explored in the past and wasn't viable but agreed that as South Yorkshire come together this may be something to look at, at scale to provide and explore again and perhaps start having these conversations at the Chief Nurses meetings.</p> <p>Agreed Actions:</p> <ul style="list-style-type: none"> • Chief Nurse to discuss the possibilities of a South Yorkshire provider the care packages for CHC with other SY Chief Nurses. <p>Note the contents of the report including:</p> <ul style="list-style-type: none"> • Performance to date 2021/22 • projected delivery of all financial duties, predicated on the assumptions outlined in this paper 	
FPC21/151	FULL ASSURANCE FRAMEWORK	
	<p>The Chief Operating Officer presented the report to members noting that there were 6 risks for the committee 5 amber and 1 red risk 3 of which were shared with other committees.</p> <p>The Committee were asked to:</p> <ul style="list-style-type: none"> • Review the risks on the 2020/21 Assurance Framework for which the Finance and Performance Committee is responsible 	

	<ul style="list-style-type: none"> • 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. 	
FPC21/152	FULL RISK REGISTER	
	<p>The Chief Operating Officer presented the full risk register to members and reported that a further update had been received via email for risk 21/02 that morning to members. There were currently 6 red risks on the register for the committee.</p> <p>The Committee were asked:</p> <ul style="list-style-type: none"> • 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 	
FPC21/153	MINUTES OF THE BHNFT CONTRACT EXECUTIVE BOARD – No Minutes Available	
FPC21/154	MINUTES OF THE SWYPFT CONTRACT EXECUTIVE BOARD – No Minutes Available	
FPC21/155	MINUTES OF THE CHILDRENS EXECUTIVE COMMISSIONING GROUP - No Minutes Available	
FPC21/156	MINUTES OF THE ADULTS JOINT COMMISSIONING GROUP – No Minutes Available	
FPC21/157	MANAGEMENT TEAM DECISIONS WITH FINANCIAL IMPLICATIONS	
	<p>The Chief Officer presented the report to members and the Finance & Performance Committee is asked to note the following decisions to commit expenditure taken by Management Team since 24 September 2021:</p> <ul style="list-style-type: none"> • <i>Contract Extension – Place Based Partnership Programme Consultant</i> – SMT approved the extension from the end of October 2021 to 31 March 2022, at a cost of £49,500 +VAT for 2.5 days p/w (possibility of contributions from partners being explored). 	

	<ul style="list-style-type: none"> <i>Greenacres Provision</i> - SMT supported the extension of the Apollo Healthcare contract and agreed to an additional £60k cost for 21/22 to ensure a strong model, which was recognised nationally within guidance as the preferred option, would be implemented by September 22, enhancing the safety of young people whilst on and off site, as well as providing an equitable service and improving the care for all SEND pupils across Barnsley. <p>The Committee received and noted the report.</p>	
FPC21/158	ANY OTHER BUSINESS	
	No items were raised under this heading.	
FPC21/159	AREAS FOR ESCALATION TO GOVERNING BODY	
	H2 Financial position and trust position in private Governing Body.	
FPC21/160	REFLECTION ON HOW THE MEETINGS BUSINESS WAS CONDUCTED	
	The meeting went well, and all relevant business was conducted.	
FPC21/161	DATE AND TIME OF NEXT MEETING	
	Thursday 2 December 2021 at 10.30am via Microsoft Teams.	

**Minutes of the Meeting of the NHS Barnsley Clinical Commissioning Group
FINANCE & PERFORMANCE COMMITTEE held on Thursday 2 December 2021 at
10.30am via Microsoft Teams.**

PRESENT:

Dr Nick Balac (Chair)	- Chair
Dr Adebowale Adekunle	- Elected Member Governing Body
Dr John Harban	- Elected Member Governing Body - Contracting
Chris Edwards	- Accountable Officer
Roxanna Naylor	- Chief Finance Officer
Jamie Wike	- Chief Operating Officer
Dr Jamie MacInnes	- Elected Member Governing Body
Nigel Bell	- Lay Member Governance

IN ATTENDANCE:

Leanne Whitehead	- Executive Personal Assistant
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APOLOGIES:

Jeremy Budd	- Director of Strategic Commissioning and Partnerships
Patrick Otway	- Head of Commissioning (MH, Children, Specialised)

Agenda Item		Action & Deadline
FPC21/162	QUORACY	
	The meeting was declared quorate.	
FPC21/163	DECLARATIONS OF INTEREST, SPONSORSHIP, HOSPITALITY AND GIFTS RELEVANT TO THE AGENDA	
	The Committee noted the declarations of interest report. There were no declarations of interest raised relevant to the agenda.	
FPC21/164	MINUTES OF THE PREVIOUS MEETING HELD 4 NOVEMBER 2021 – Approved as a true record.	
FPC21/165	MATTERS ARISING REPORT	
	FPC21/132 IPR and Update on Prescribing Pressures Meeting with Roxanna Naylor, Nick Balac, John Harban and Chris Lawson re handover linked to prescribing may need to be sooner that Feb/March. FPC21/77 Risk Register	RN/NB/JH

	<p>Update given at May 2021 GB action now complete.</p> <p>FPC18/176 Assurance Framework</p> <p>Funding areas now agreed for CAMHS Chief Operating Officer to ask Head of Commissioning (MH, Children, Specialised) to update the assurance framework for the January committee and GB meetings.</p> <p>The report was received and noted.</p>	JW
FPC21/166	INTEGRATED PERFORMANCE REPORT	
	<p><u>Finance</u></p> <p>The Chief Finance Officer presented the finance section of the report to members reporting that the full forecast would be presented at the January meeting and as of month 8 there were no big risks showing, there were late allocations coming through the system which may give some flexibilities and the Chief Finance Officer was seeking approval from the committee to commence discussions with the Local Authority in relation to the Section 75 agreement. The full budget was outlined in the report and members were fully up to date on this. In depth discussions were had.</p> <p>Agreed Actions:</p> <ul style="list-style-type: none"> • Members asked that a further discussion/see more detail around the Health and Care Plan be had at the January Committee to give members more assurance and better understanding. • Agreed to support the Chief Finance Officer having discussion around the section 75. <p><u>Performance</u></p> <p>The Chief Operating Officer presented the performance section of the report to members noting that urgent care were very challenged and A&E had seen increases above previous levels with 12 hour trolley waits which were very unusual for Barnsley but once explored was due to a patient safety issue. Attendances remain high along with ambulance handover times. In terms of planned care there had been an increase in 18 week waits and 52 weeks were continuing to decrease with small numbers waiting 104 weeks and issues around those were patient choice. The 6 weeks diagnostics performance was decreasing but still had a high number of waits. All cancer targets remain red with 2 weeks waits now in line with the standards. Dr J Harban questioned the number of face to face outpatients were being seen and agreed to share data set on outpatients from the recent Planned Care Board and the Chair asked that comments be fed back to the planned</p>	<p>JW/JB</p> <p>RN</p>

	<p>care board around the knock on effect in Primary Care from non face to face in outpatients.</p> <p>It was reported that plans had been submitted for H2 and work had been undertaken with BHNFT to arrive at a number of assumptions that have been applied to activity trajectories for a number of areas including Elective care/recovery, Emergency Care including A&E and Cancer performance. CCGs have also provided activity trajectories for specific commissioner related metrics, all of which have been collated by the NHSE/I Locality Team for inclusion in a system-level planning submission which was submitted nationally on 16 November 2021. Funding was flowing in to support elective recovery. It was noted that GP streaming would be put in place with 1 GP for 12 hours a day 7 days per week and there were currently 2 locum GP's working those shifts members asked if this was sustainable at that inflated cost and for the financial year yes and would need to look to secure the service going forwards.</p> <p>Agreed Actions:</p> <ul style="list-style-type: none"> • Share outpatients dataset from November Planned Care Board. • Chair asked that comments be fed back to the planned care board around the knock on effect in Primary Care from non face to face in outpatients. <p>Members were asked to note the contents of the report including:</p> <ul style="list-style-type: none"> • Performance to date 2021/22 and assumptions used in the H2 Operational Planning submission • Final budget position for 2021/22 (H1 & H2) • Projected delivery of all financial duties, predicated on the assumptions outlined in this paper 	<p>LW</p> <p>JW</p>
FPC21/167	MANAGEMENT TEAM DECISIONS WITH FINANCIAL IMPLICATIONS	
	<p>The Finance & Performance Committee are asked to note the following decisions to commit expenditure taken by Management Team between 22 October 2021 and 19 November 2021:</p> <ul style="list-style-type: none"> • <i>Telephony</i> - SMT supported a proposal to continue to pay for GP telephony services in LIFT buildings at a total cost of circa £3,000 per month. <p>The Committee received and noted the report.</p>	
FPC21/168	ANY OTHER BUSINESS	
	No items were raised under this heading.	
FPC21/169	AREAS FOR ESCALATION TO GOVERNING BODY	

FPC21/170	REFLECTION ON HOW THE MEETINGS BUSINESS WAS CONDUCTED	
	The meeting went well, and all relevant business was conducted.	
FPC21/171	DATE AND TIME OF NEXT MEETING	
	Thursday 6 January 2022 at 10.30am via Microsoft Teams.	

Adopted

GOVERNING BODY

20 January 2022

PRIMARY CARE COMMISSIONING COMMITTEE HIGHLIGHT REPORT

PART 1A – SUMMARY REPORT

1.	THIS PAPER IS FOR											
	<table border="1"> <tr> <td><i>Decision</i></td> <td><input type="checkbox"/></td> <td><i>Approval</i></td> <td><input type="checkbox"/></td> <td><i>Assurance</i></td> <td><input checked="" type="checkbox"/></td> <td><i>Information</i></td> <td><input checked="" type="checkbox"/></td> </tr> </table>	<i>Decision</i>	<input type="checkbox"/>	<i>Approval</i>	<input type="checkbox"/>	<i>Assurance</i>	<input checked="" type="checkbox"/>	<i>Information</i>	<input checked="" type="checkbox"/>			
<i>Decision</i>	<input type="checkbox"/>	<i>Approval</i>	<input type="checkbox"/>	<i>Assurance</i>	<input checked="" type="checkbox"/>	<i>Information</i>	<input checked="" type="checkbox"/>					
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 25 November 2021.											
3.	REPORT OF											
	<table border="1"> <thead> <tr> <th></th> <th>Name</th> <th>Designation</th> </tr> </thead> <tbody> <tr> <td>Lay Member Lead</td> <td>Chris Millington</td> <td>Chair PCCC</td> </tr> <tr> <td>Author</td> <td>Julie Frampton</td> <td>Head of Primary Care</td> </tr> </tbody> </table>				Name	Designation	Lay Member Lead	Chris Millington	Chair PCCC	Author	Julie Frampton	Head of Primary Care
	Name	Designation										
Lay Member Lead	Chris Millington	Chair PCCC										
Author	Julie Frampton	Head of Primary Care										
4.	SUMMARY OF PREVIOUS GOVERNANCE											
	<p>The matters raised in this paper have been subject to prior consideration in the following forums:</p> <table border="1"> <thead> <tr> <th>Group / Committee</th> <th>Date</th> <th>Outcome</th> </tr> </thead> <tbody> <tr> <td>Primary Care Commissioning Committee (PCCC)</td> <td>25 November 2021</td> <td>Highlights agreed</td> </tr> </tbody> </table>			Group / Committee	Date	Outcome	Primary Care Commissioning Committee (PCCC)	25 November 2021	Highlights agreed			
Group / Committee	Date	Outcome										
Primary Care Commissioning Committee (PCCC)	25 November 2021	Highlights agreed										
5.	EXECUTIVE SUMMARY											
	<p>Since the establishment of the PCT telephony was provided to the LIFT buildings using an onsite telephone system typically providing 150 extensions utilising a 100Mbps data connection and an ISDN30 connection. The data connection was used to allow calls to be passed between all connected sites and remote management of the system. The ISDN30 connection allowed calls to be made and received. The ISDN30 connection allowed up to 30 simultaneous calls to be made. That could be 25 incoming and 5 outbound or any other combination. There was anecdotal evidence that there are busy times when Patients were unable to get through to the practice with the assumption that there were not enough ISDN30 Channels.</p>											

The aim of the telephony project was to transfer the telephony over to the GP practices with the additional benefits of:

- Reducing call costs
- replace the ISDN30 connection which is now at end of life
- improve system support
- Introduce additional features such as call recording
- Allow additional calls to be made at busy times

The current cost to the CCG of providing Telephony per LIFT site is as shown on the table below which is a significant cost per month per site:

Existing Monthly Costs Per Site ex VAT £	
Equipment Maintenance	
Data Connection	
ISDN30 Connection	
Call Charges (6000 minutes at 3p/min)	
Approx. total	1,095.00 /month
Cost per handset	20.00 - 50.00

Future Situation

The project is going to upgrade the existing hardware and re-provide the telephone lines using a modern cloud-based solution utilising the existing data connections to the site. This reduces the line rental and removes all call charges.

Discussions with GP Practices in the LIFT Buildings

The cost of telephony is covered within the practice global sum and all practices outside the LIFT buildings source and pay for their telephony. The Premises Cost Directions also state that telephony is not eligible under the Premises Cost Directions so there is disparity across Barnsley practices. Recently there has been notice of additional funds to support all practices to move to Cloud Based telephony so this will help support a planned second phase of the telephony project to those practices outside LIFT buildings.

When the phone system was installed it was sized to provide 150 extensions within the building. We have discovered that the GP practices only have 13 extensions on average. This makes the average cost per extension very high and is based on a hospital department size rather than GP practice.

During discussions all GP practices felt that absorbing the costs were going to be too expensive and had started to look elsewhere for telephony with other companies that do not have a good record of delivery and on-going support and indeed would charge for every call out to resolve problems and that would be through a remote third party. The additional costs of installing new cabling for every practice would also be costly and, on top, CHP would also levy additional costs for additional data and electrical circuitry. The telephony system would also not properly integrate with existing IT hardware due to the firewalls/encryption and other cyber security protection in place.

Future Costs

The future solution has been adapted to further to reduce the costs. This would involve reducing the size of the data connections and decrease the number telephony channels however it will give some flex to expand should there be a requirement. It would also include the removal of the data connection to the hospital which would be a cost pressure.

This reduces the cost to the GPs to around £15 per core handset. It also pays for:

- the provision of non-core handsets throughout the building benefitting everyone and offering the GPs flexibility
- the current high level of support provided by Active Voice and Data – a local Barnsley Telephony company
- “blue light” availability on all telephony products

GP Monthly Costs Per Site ex VAT	£
Equipment Maintenance and Software Assurance	
Data Connection 10/100	
SIP Telephony Data Centre Connection 15 channels at £9.00 per channel	
Call Charges (6000 minutes at 3p/min)	
Total	385.00/month
Cost per handset	14.81

The only additional cost would be for those practices wanting to have Call Recording which is very expensive and not many of the practices expressed an interest in pursuing this due to the high costs involved.

Given that the reduced costs are a large recurrent cost saving to the CCG, from circa £7000 per month to circa £2700, a request was made to SMT agreed to continue to fund the practices to ensure a resilient package for telephony was in place for all practices. This was supported by SMT and has enable work to progress with these practices in LIFT buildings.

The work with practices outside of LIFT buildings will start to be planned to ensure we can move all practice to modern, resilient telephony systems.

6.	THE GOVERNING BODY IS ASKED TO:
	<ul style="list-style-type: none">• Note the above which is provided for information and assurance.
7.	APPENDICES / LINKS TO FURTHER INFORMATION
	None

Agenda time allocation for report:	<i>10 minutes</i>
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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 (<i>place ✓ beside all that apply</i>):			
	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	
	3.2 Maximising Elective Activity		9.1 Digital and Technology	✓
	4.1 Mental Health		10.1 Compliance with statutory duties	
	5.1 Integrated Care @ System		11.1 Delivery of Enhanced Health in Care Homes	
	5.2 Integrated Care @ Place		12.1 Delivering The Covid Vaccination Programme & Meeting The Needs of Patients with Covid-19	
	5.3 Implementing Population Health Management And Personalised Care			
	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 (<i>place ✓ beside all that are relevant</i>):			
	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 (<i>these will be especially relevant where a proposal or policy is brought for decision or approval</i>)			
3.1	Clinical Leadership			
	Have GB GPs and / or other appropriate clinicians provided input and leadership?			NA
	<i>If relevant provide brief details here OR cross refer to detailed report if used</i>			
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
	<i>If relevant provide brief details here OR cross refer to detailed report if used</i>			

3.3	Discharging functions effectively, efficiently, & economically (s14Q) <table border="1"> <tr> <td data-bbox="284 210 1265 271">Have any financial implications been considered & discussed with the Finance Team?</td> <td data-bbox="1273 210 1401 271">Y</td> </tr> <tr> <td data-bbox="284 277 1265 338">Where relevant has authority to commit expenditure been sought from Management Team (<£100k) or Governing Body (>£100k)?</td> <td data-bbox="1273 277 1401 338">NA</td> </tr> <tr> <td colspan="2" data-bbox="284 344 1401 383"><i>If relevant provide brief details here OR cross refer to detailed report if used</i></td> </tr> </table>	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	<i>If relevant provide brief details here OR cross refer to detailed report if used</i>			
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								
<i>If relevant provide brief details here OR cross refer to detailed report if used</i>									
3.4	Improving quality (s14R, s14S) <table border="1"> <tr> <td data-bbox="284 477 1265 506">Has a Quality Impact Assessment (QIA) been completed if relevant?</td> <td data-bbox="1273 477 1401 506">NA</td> </tr> <tr> <td data-bbox="284 512 1265 573">Have any issues or risks identified been appropriately addressed having taken advice from the Chief Nurse (or Deputy) if appropriate?</td> <td data-bbox="1273 512 1401 573">NA</td> </tr> <tr> <td colspan="2" data-bbox="284 580 1401 618"><i>If relevant provide brief details here OR cross refer to detailed report if used</i></td> </tr> </table>	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	<i>If relevant provide brief details here OR cross refer to detailed report if used</i>			
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								
<i>If relevant provide brief details here OR cross refer to detailed report if used</i>									
3.5	Reducing inequalities (s14T) <table border="1"> <tr> <td data-bbox="284 707 1265 736">Has an Equality Impact Assessment (EIA) been completed if relevant?</td> <td data-bbox="1273 707 1401 736">NA</td> </tr> <tr> <td data-bbox="284 743 1265 804">Have any issues or risks identified been appropriately addressed having taken advice from Equality Diversity & Inclusion Lead if appropriate?</td> <td data-bbox="1273 743 1401 804">NA</td> </tr> <tr> <td colspan="2" data-bbox="284 810 1401 848"><i>If relevant provide brief details here OR cross refer to detailed report if used</i></td> </tr> </table>	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	<i>If relevant provide brief details here OR cross refer to detailed report if used</i>			
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Have any issues or risks identified been appropriately addressed having taken advice from Equality Diversity & Inclusion Lead if appropriate?	NA								
<i>If relevant provide brief details here OR cross refer to detailed report if used</i>									
3.6	Public Involvement & Consultation (s14Z2) <table border="1"> <tr> <td data-bbox="284 938 1265 967">Has a s14Z2: Patient and Public Participation Form been completed if relevant?</td> <td data-bbox="1273 938 1401 967">NA</td> </tr> <tr> <td data-bbox="284 974 1265 1034">Have any issues or risks identified been appropriately addressed having taken advice from the Head of Comms & Engagement if appropriate?</td> <td data-bbox="1273 974 1401 1034">NA</td> </tr> <tr> <td colspan="2" data-bbox="284 1041 1401 1079"><i>If relevant provide brief details here OR cross refer to detailed report if used</i></td> </tr> </table>	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	<i>If relevant provide brief details here OR cross refer to detailed report if used</i>			
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								
<i>If relevant provide brief details here OR cross refer to detailed report if used</i>									
3.7	Data Protection and Data Security <table border="1"> <tr> <td data-bbox="284 1169 1265 1198">Has a Data Protection Impact Assessment (DPIA) been completed if relevant?</td> <td data-bbox="1273 1169 1401 1198">NA</td> </tr> <tr> <td data-bbox="284 1205 1265 1265">Have any issues or risks identified been appropriately addressed having taken advice from the SIRO, IG Lead and / or DPO if appropriate?</td> <td data-bbox="1273 1205 1401 1265">NA</td> </tr> <tr> <td colspan="2" data-bbox="284 1272 1401 1310"><i>If relevant provide brief details here OR cross refer to detailed report if used</i></td> </tr> </table>	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	<i>If relevant provide brief details here OR cross refer to detailed report if used</i>			
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Have any issues or risks identified been appropriately addressed having taken advice from the SIRO, IG Lead and / or DPO if appropriate?	NA								
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3.8	Procurement considerations <table border="1"> <tr> <td data-bbox="284 1400 1265 1460">Have any issues or risks identified been appropriately addressed having taken advice from the procurement Shared Service if appropriate?</td> <td data-bbox="1273 1400 1401 1460">NA</td> </tr> <tr> <td data-bbox="284 1467 1265 1496">Has a Single Tender Waiver form been completed if appropriate?</td> <td data-bbox="1273 1467 1401 1496">NA</td> </tr> <tr> <td data-bbox="284 1503 1265 1563">Has a Primary Care Procurement Checklist been completed where GPs, networks or Federations may be a bidder for a procurement opportunity?</td> <td data-bbox="1273 1503 1401 1563">NA</td> </tr> <tr> <td colspan="2" data-bbox="284 1570 1401 1608"><i>If relevant provide brief details here OR cross refer to detailed report if used</i></td> </tr> </table>	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	<i>If relevant provide brief details here OR cross refer to detailed report if used</i>	
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<i>If relevant provide brief details here OR cross refer to detailed report if used</i>									
3.9	Human Resources <table border="1"> <tr> <td data-bbox="284 1697 1265 1758">Have any significant HR implications been identified and managed appropriately, having taken advice from the HR Lead if appropriate?</td> <td data-bbox="1273 1697 1401 1758">NA</td> </tr> <tr> <td colspan="2" data-bbox="284 1765 1401 1803"><i>If relevant provide brief details here OR cross refer to detailed report if used</i></td> </tr> </table>	Have any significant HR implications been identified and managed appropriately, having taken advice from the HR Lead if appropriate?	NA	<i>If relevant provide brief details here OR cross refer to detailed report if used</i>					
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3.10	Environmental Sustainability <table border="1"> <tr> <td data-bbox="284 1906 1265 1966">Have any significant (positive or negative) impacts on the environment or the CCG's carbon footprint been identified?</td> <td data-bbox="1273 1906 1401 1966">NA</td> </tr> <tr> <td colspan="2" data-bbox="284 1973 1401 2011"><i>If relevant provide brief details here OR cross refer to detailed report if used</i></td> </tr> </table>	Have any significant (positive or negative) impacts on the environment or the CCG's carbon footprint been identified?	NA	<i>If relevant provide brief details here OR cross refer to detailed report if used</i>					
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<i>If relevant provide brief details here OR cross refer to detailed report if used</i>									

**Minutes of the PUBLIC Primary Care Commissioning Committee meeting
held on Thursday, 30 September 2021 at 2.30pm 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 (Chair)	Secondary Care Clinician
Chris Edwards	Chief Officer
Richard Walker	Head of Governance & Assurance

CLINICAL MEMBERS (NON-VOTING)

Dr Nick Balac	Chairman, Barnsley CCG
Dr Madhavi Guntamukkala	Governing Body Member
Dr Mark Smith	Governing Body Member

IN ATTENDANCE:

Terry Hague	Primary Care Transformation Manager
Angela Musgrave	Executive Personal Assistant
Nick Germain	Primary Care Manager, NHSEI
Margaret Lindquist	Board Member, Healthwatch Barnsley
Carrie Abbott	Service Director, Public Health, BMBC
Ruth Simms	Finance Manager

APOLOGIES:

Roxanna Naylor	Chief Finance Officer
Julie Frampton	Head of Primary Care

MEMBERS OF THE PUBLIC:

There were no members of the public present at the meeting.

Agenda Item	Note	Action	Deadline
PCCC 21/09/01	HOUSEKEEPING		
PCCC 21/09/02	WELCOME AND APOLOGIES		
	The Chair welcomed members to the meeting and apologies were noted as above.		
PCCC 21/09/03	QUORACY		
	The meeting was declared quorate.		
PCCC 21/09/04	DECLARATIONS OF INTEREST RELEVANT TO THE AGENDA		
	There were no declarations of interest declared.		

PCCC 21/10/05	MINUTES OF THE LAST MEETING		
	<p>The minutes of the meeting held on 5 August 2021 were verified as a true and correct record of proceedings with the following amendments.</p> <p>Mike Simms Chaired the meeting held on 5 August and was present for the whole meeting; not from agenda item 11 as indicated in the minutes.</p> <p><u>Minute Item 21/08/11 – GP Practice Premises Sale and Return</u></p> <p>The Primary Care Manager, NHSEI raised a concern regarding the wording of the second paragraph relating to the GP practice Premises Sale and Return.</p> <p>The Chairman of the CCG commented that the rules, regulations and implications regarding VAT registration for a GP practice can be very complex.</p> <p>An ambiguity regarding the inclusion of VAT had been identified following PCCC approval of the Sale and Leaseback of premises utilised by Dr Mellor & Partners practice in the March 2021 meeting of the committee. The initial approval had been based on the understanding that there would not be any financial implications. It had then been identified that as the practice were not VAT registered the additional VAT would be a cost to the CCG.</p> <p>NG advised the committee that if information had been known regarding the VAT prior to the initial approval this would not have changed the decision outcome. If the CCG is operating within budget then VAT cost alone would not be a valid reason to reject the sale and return – if the sale and return is deemed necessary for sustainability of services, and CCG expects that services would continue to be required for the population in the area and there are assurances on the state of the building etc, then PCCC would need a strong rationale (other than financial grounds) for rejecting the application.</p> <p>NG also confirmed that a prompt would be included in the sale and return of the GP premises procedure, highlighting the VAT implications of sale and leaseback of GP premises”.</p> <p><i>POST MEETING NOTE – A Sale and lease back application had also been received from Huddersfield Road Surgery and approved by the committee on 28 January 2021. Following further guidance in respect of VAT, it has</i></p>		

	<i>been requested and agreed that a clause be included within the contract for the sale and leaseback agreement to state that the landlord will not exercise an option to tax the property for such time it is occupied for the permitted use as a GP practice.</i>		
PCCC 21/09/06	MATTERS ARISING REPORT		
	<p>Members noted the updates provided in the Matters Arising report.</p> <p><u>Minute Item 21/08/10 – CQC Updates</u> Item now complete.</p> <p><u>PCCC 21/08/11 – GP Practice Premises Sale and Return</u> The Primary Care Manager, NHSEI confirmed that to ensure accurate information was provided to CCG colleagues, a prompt would be included in the sale and return of GP premises procedure, highlighting that a GP Practice must be VAT registered.</p>		
STRATEGY, PLANNING, NEEDS ASSESSMENT AND CO-ORDINATION OF PRIMARY CARE			
PCCC 21/09/07	<p>Primary Care Network Update <u>Primary Care Network Workforce Plan</u> The Primary Care Transformation Manager provided members with an update on the Primary Care Network (PCN) workforce submission and PCN Plans for 2021/22 and 2022/23.</p> <p>Following a thorough review by the CCG and PCN Managers, the PCN Workforce Plan and what roles the Additional Roles Reimbursement Scheme (ARRs) would be planned and recruited to for 2021/22 had been submitted to the Workforce Team at NHS England within the deadline. Feedback was currently awaited, and the Committee would be updated when this became available.</p> <p>It was noted that the PCN was also required to update it's ARRs workforce plans for 2022/23 and 2023/24 by the end of October 2021 for CCG review prior to submission to NHS England. PCN Clinical Directors and PCN Managers were currently working on these plans.</p> <p><u>Primary Care Networks – Plans for 2021/22 and 2022/23</u> The CCG had shared with GPs and the PCN the notification received from NHSE regarding the key objectives, service requirements and Impact and Investment fund (IFF) for PCNs.</p>		

	<p>The five areas of focus for PCNs over the coming 18 months were:-</p> <ul style="list-style-type: none"> • Improving prevention and tackling health inequalities in the delivery of primary care • Supporting better patient outcomes in the community through proactive primary care • Supporting improved patient access to primary care services • Delivering better outcomes for patients on medication • Helping create a more sustainable NHS. <p>The PCN Clinical Directors had been asked to support the delivery of these plans. The Primary Care Team had offered support to the PCN Managers and bi-weekly meetings had been arranged.</p> <p>The Primary Care Manager NHSE/I informed that when the plans were initially published, they included funding of £43m nationally for PCN leadership and management. Details of what funding would be received locally and how it was to be distributed was awaited.</p> <p>The Committee: -</p> <ul style="list-style-type: none"> • Noted the submission of the PCN Workforce Plan • Noted the PCN plan requirements for 2021/22 and 2022/23 		
QUALITY AND FINANCE			
PCCC 21/08/08	FINANCE UPDATE		
	<p>The Assistant Finance Manager presented the Finance Report that provided an update of the report.</p> <p>There were two sections to the report:</p> <p><u>Forecast Position 2021/22 – H1 April – September 2021</u></p> <p>The forecast position as at Month 4 reflected a £127k underspend, the majority of which related to underutilisation on 2020/21 accruals.</p> <p>It was reported that in August the CCG was forecasting an underspend of the PCN Additional Roles Reimbursement (ARRS) funding, however following discussions with PCN Managers to discuss their workforce plans it was anticipated that this funding would be fully utilised going forward. An update would be provided on this funding at the next Committee meeting.</p>		

	<p><u>Additional Funding for 2021/22</u></p> <p>Additional allocations received to date, as at month 5, were as follows: -</p> <ul style="list-style-type: none"> • £38k for Online Consultations • £20k Practice Resilience Programme • £69k Primary Care Networks – development and support • £426k Long COVID management of Adults • £131k Primary Care Long COVID Enhanced Service • £30k GP IT Infrastructure and Resilience • The CCG was awaiting allocation confirmation for additional funding in relation to the new Enhanced Service, Weight Management. An update would be provided at the next committee. <p>The Chairman of the CCG assured the Committee that regular meetings were taking place between himself, the Head of Primary Care the Medical Director and the PCN to ensure funding was fully utilised.</p> <p>The Committee: -</p> <ul style="list-style-type: none"> • Noted the contents of the report 		
PCCC 21/09/09	<p>CQC UPDATES</p> <p>There were no CQC updates to report.</p>		
CONTRACT MANAGEMENT			
PCCC 21/09/10	<p>CONTRACTUAL ISSUES REPORT</p> <p>The Primary Care Transformation Manager presented the Contractual Issues Report that provided members with an update on the current contractual issues in relation to primary care contracts.</p> <p><u>Monk Bretton Health Centre</u></p> <p>Barnsley CCG had received an application to vary Monk Bretton Health Centre's PMS contract to add Dr Munir as a new partner from 1 July 2021.</p> <p>As the application required a Contract Variation amendment to the PMS contract, PCCC members were required to approve the amendment.</p> <p>The Primary Care Team and NHSE had carried out all the necessary due diligence checks and it was recommended that the contract variation be approved.</p>		

	<p><u>Woodland Drive Medical Centre Branch Site</u></p> <p>The Primary Care Team had been made aware that appointments were not being delivered by Woodland Drive Medical Centre at their branch site based at The Roundhouse Medical Centre.</p> <p>Further investigation had confirmed that the last regular branch site booking had been made in 2018 and the IT team had confirmed that the rooms had not been indicating any use of IT equipment.</p> <p>Following discussions with the Practice, the Primary Care Team had been informed that the Practice were considering applying to close the branch site. If an application was received, further background work would be carried out and a report brought back to the Committee to consider whether it was appropriate for this to happen.</p> <p>The Lay Member for Governance raised a query regarding the financial status of bookable space not being utilised and whether the space was then categorised as chargeable 'void' space.</p> <p>Action: The Assistant Finance Manager and Primary Care Transformation Manager were asked to investigate this query further and to present a brief assurance report at the next PCCC meeting to ensure funding was being utilised appropriately.</p> <p><u>eDEC Analysis 2020/21</u></p> <p>It was reported that all Barnsley Practices had submitted their mandatory electronic Annual Practice Declaration (eDEC) for 2020/21 in line with the requirements contained in NHSE's Policy and Guidance Manual book of Primary Medical Services.</p> <p>The analysis provided in the report included information on Practice Staff Details, Premises and Equipment, Practice Services, Practice Procedures, Information and Clinical Governance, CQC, General Practice IT and Catchment area.</p> <p>The report provided the Committee with assurance that most practices were meeting requirements with no quality concerns identified. The Primary Care Team would be contacting a small number of Practices to verify the answers provided and to provide support if necessary or ensure an action plan was in place to remedy any issues.</p>	RS/TH	
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	<p>The Committee: -</p> <ul style="list-style-type: none"> • Approved the contract variation for the additional of Dr Munir to the Monk Bretton Health Centre contract. • Noted the issue and work ongoing regarding Woodland Drive Medical Centre branch site. • Noted the analysis of the eDEC submissions and assurance provided. 		
GOVERNANCE, RISK AND ASSURANCE			
<p>PCCC 21/09/11</p>	<p><u>Risk and Governance Report</u></p> <p>The Head of Governance & Assurance presented the risk and Governance report that provided the Committee with:</p> <ul style="list-style-type: none"> • 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 <p><u>Assurance Framework</u></p> <p>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.</p> <p>Both risks had been scored as 'Amber' High Risk and related to:</p> <ul style="list-style-type: none"> • 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. <p><u>Risk Register</u></p> <p>There were currently five risks on the Corporate Risk Register allocated to the PCCC for which the Committee is responsible for managing. Of the five risks, there was one red (extreme) rated risk, one amber risk (high), one yellow risk (moderate) and two green (low) risks.</p> <p>Members were asked to review the risks detailed on Appendix 1 to ensure that the risks were being appropriately managed and scored.</p>		

	<p>The Chairman of the CCG commented regarding risk reference 14/10 Workforce Planning, that following recent discussions around the plan to recruit to additional roles the Head of Primary Care may wish to consider if the score needed to be amended.</p> <p>The Head of Governance & Assurance agreed to liaise with the Head of Primary Care regarding the score for risk reference 14/10 Workforce Planning.</p> <p>The Committee: -</p> <ul style="list-style-type: none"> Reviewed and agreed that the risks were being appropriately managed and scored. 	RW/JF	
OTHER			
PCCC 21/09/12	REFLECTION OF CONDUCT OF THE MEETING The Committee agreed that the meeting had been conducted appropriately.		
PCCC 21/09/13	QUESTIONS FROM MEMBERS OF THE PUBLIC RELEVANT TO THE AGENDA		
	There were no questions received from the members of the public.		
PCCC 21/09/14	ITEMS FOR ESCALATING TO THE GOVERNING BODY There were no items for escalating to the Governing Body.		
PCCC 20/09/15	DATE & TIME OF NEXT MEETING Thursday, 25 November 2021 at 9.30am via MS Teams.		

**Minutes of the NHS Barnsley Clinical Commissioning Group
QUALITY & PATIENT SAFETY COMMITTEE
Thursday 21 October 2021, 13:00pm-16:00pm (Microsoft Teams)**

MEMBERS:

Dr Madhavi Guntamukkala	- Medical Director (Chair)
Jayne Sivakumar	- Chief Nurse (Deputy Chair)
Mike Simms	- Secondary Care Clinician
Dr Mark Smith	Practice Member Representative Contracting Lead from the Governing Body
Chris Millington	- Lay Member for Public and Patient Engagement and Primary Care Commissioning
Jo Harrison	- Specialist Clinical Portfolio Manager
Chris Lawson	- Head of Medicines Optimisation
Dr Adebawale 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
Paige Dawson	- Risk, Governance and Assurance (minutes)
Siobhan Lendzionowski	- Lead Commissioning and Transformation Manager
Sheena Moreton	- Continuing Healthcare Operational Lead

APOLOGIES:

	Note	Action	Deadline
Q&PSC 21/10/01	HOUSEKEEPING		
	The Chair advised that everyone is responsible for their own safety within their environment during the meeting.		
Q&PSC 21/10/02	APOLOGIES, CHANGE TO COMMITTEE MEMBERSHIP & QUORACY		
	There were no apologies. The meeting was declared quorate.		
Q&PSC 21/10/03	PATIENT STORY		
	The Chief Nurse introduced the Patient Story, reflecting the experiences of a man being diagnosed with Prostate Cancer, his journey through treatment, and his aspiration to promote and support other men with early diagnosis and living with prostate cancer. The following comments were received from committee members in respect of the patient story:		

Q&PSC 21/10/04	DECLARATIONS OF INTEREST RELEVANT TO THE AGENDA		
	<p>The Lead Commissioning and Transformation Manager declared that she had a declaration of interest relevant to the agenda holding a contract with Barnsley Healthcare Federation as a vaccination nurse.</p> <p>The Quality Manager highlighted that Dr Sepehri had now resigned from the committee, therefore, to be removed from the report.</p>	PD	October 2021
	<p>Actions agreed: Removal of Dr Sepheri from the register of interests.</p>	PD	October 2021
Q&PSC 21/10/05	MINUTES OF THE MEETING HELD ON 19 August 2021		
	<p>Committee members approved the minutes of the previous meeting held on 19 August 2021 as an accurate record with exception of:</p> <p>Current wording on page 5 states '<i>GP Appointments – All practices in the Primary Care Network (PCN) have now mapped all active appointment slot types to the new set of national appointment categories which will enable reporting at practice level in the coming weeks.</i>'</p> <p>However, for accuracy the minutes need to state the following '<i>all practices in the PCN will have mapped all active appointment slot types to the new set of national appointment categories and are complying with the August 2020 guidance on recording of appointments, which would enable more comprehensive data, which will be included within this report as soon as available.</i>'</p>	JA	October 2021
	<p>Action agreed: Minutes of the meeting on 19 August 2021 to be amended to reflect the wording above.</p>	JA	October 2021
Q&PSC 21/10/06	MATTERS ARISING REPORT		
	<p>The Chair confirmed a number of actions were complete. The following updates were received against outstanding actions:</p> <p>21/08/21 - The Specialist Clinical Portfolio Manager to draft a risk in relation to Mayman Lane service with support from the Head of Governance and Assurance.</p> <p>This action was confirmed as completed and to be discussed later in the agenda under item 21/10/17.</p>		Complete

	<p>21/08/11 - The Chief Nurse to amend the existing Adults CHC risk to reflect the staff vacancy and recruitment difficulty. This action was confirmed as completed.</p> <p>21/08/19 - Risk Ref CCG 13/13 (rated score 10 “high risk”) - YAS to be increased to 15 “extreme”. Risk Ref CCG 20/03 risk rating to remain with amendment to wording Risk Ref CCG 21/01 to be reduced to 12 “high risk” New risk to be added in relation to Mayman Lane service. This action was confirmed as completed.</p> <p>21/08/21 - The Quality Administrator to ask the Head of Optimisation for an update on the D1 Task and Finish Group. This action was confirmed as completed. The Head of Medicines Optimisation confirmed there was still a D1 backlog and will take further with BHNFT.</p> <p>21/06/03 - Chief Nurse to investigate if there are any reasons why ANPs are not able to complete and sign DNACPRs. The Chief Nurse stated that the meeting did not go ahead due to operational issues an email has been sent to Andrea Parkin (BHF) to rearrange.</p> <p>21/06/15 - 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. Further guidance to be gained for clinicians and BCCG website with revised wording along with a supplementary user-friendly guide for Barnsley Patients.</p> <p>21/06/24 - The Chair to meet with Head of Governance and Assurance to discuss how Medical Examiners gain access to read only patient records. The Head of Governance and Assurance to organise a further meeting.</p> <p>21/02/15 - The Head of Medicines Optimisation to draft the risk relating to Denosumab medication provision. The Head of Optimisation to draft the risk.</p> <p>20/12/17 - Tom Davidson (BHNFT) to be invited to a future meeting to present Medway data capability.</p>		<p>Complete</p> <p>Complete</p> <p>Ongoing</p> <p>Ongoing</p> <p>Ongoing</p> <p>Ongoing</p> <p>Ongoing</p>
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	The Chief Nurse confirmed she had contacted Tom Davidson to ask him to attend. The Quality Administrator to email him dates and times of meetings.	JA	Ongoing
QUALITY AND GOVERNANCE			
Q&PSC 21/10/07	QUALITY UPDATE REPORT		
	<p>The Quality Manager took the report as read and presented the following highlights:</p> <p>BHNFT</p> <ul style="list-style-type: none"> • The inclusion of patient experience data including friends and family test results. • Re assurance received in relation to Urology incidents. It was highlighted at the last BHNFT CQB meeting that BHNFT had completed a deep dive review following a number of incidents in Urology. An action was now being progressed to address the issues identified by the review. <p>SWYPFT</p> <ul style="list-style-type: none"> • One minor omission in relation to SWYPFT STEIS incidents data which should state '6'. • Staffing issues within the Neighbourhood Nursing Team were escalated at the last CQB meeting. • Out of area bed usage was also flagged as an issue further discussions with Patrick Otway, (BCCG) were to take place to agree how to take this forward. <p>The Lead Commissioning and Transformation Manager raised a concern regarding CAMHS FFT low number of returns based on the number service users and the percentage of patients who had returned "do not know" answers.</p> <p>It was agreed that further work needed to be completed and issues to be raised with SWYPFT in relation to IAPT data and what it defined as treatment.</p> <p>There followed a discussion about the national care market including care homes, care staffing, workforce retention and provider fees.</p> <p>It was agreed for the Quality Manager to meet with the Specialist Clinical Portfolio Manager and the Chief Nurse to discuss further the detail reporting requirements from SWYPFT and to provide an update at the next SWYPFT Clinical Quality Board (CQB meeting)</p>	HF/JS/JH	January 2022

	Primary Care The Primary Care and Transformation Manager presented the Primary Care Update report highlighting that: <ul style="list-style-type: none"> • GP appointment activity mapping was still underway. • There is an ongoing issue with access in general practice for patients booking appointments. • The CQC process has changed to a monthly review rather than set specific visits. 		
	Actions agreed: Quality Manager to meet with the Specialist Clinical Portfolio Manager and the Chief Nurse to discuss further the detail reporting requirements from SWYPFT and to provide an update at the next SWYPFT Clinical Quality Board (CQB meeting)	HF/JS/JH	January 2022
Q&PSC 21/10/08	INFECTION PREVENTION AND CONTROL CONTRACTING REPORT - SEPTEMBER 2021		
	The Chief Nurse presented the Infection Prevention and Control Contracting Report for assurance and information highlighting: <ul style="list-style-type: none"> • Due to restrictions in relation to the COVID-19 pandemic, routine audits of GP premises and care homes were suspended between 1 April 2020 and 31 March 2021. • The outcome of Care Home and GP audits completed between April 2021 to present. No red flags have come out of any audits to date. <p>The Primary Care and Transformation Manager queried that BHF Highgate Surgery was shown as closed in the report but that is not the case. The Chief Nurse agreed to report this back to Christine Fisher, Infection Prevention Control Lead, BHNFT.</p>	JS	December 2021
	Actions agreed: The Chief Nurse to report the incorrect closure marker against BHF Highgate Surgery to Christine Fisher, Infection Prevention Control Lead, BHNFT.	JS	December 2021
Q&PSC 21/10/09	SAFEGUARDING ADULTS/CHILDREN		
	The Chief Nurse presented the key highlights from Barnsley Safeguarding Partnerships Annual Reports 2020/21 for the for assurance.		

	It was also highlighted that for adults, two case study videos are available to watch in relation to 'cuckooing' and 'making safeguarding personal' respectively.		
Q&PSC 21/10/10	SPECIALIST CLINICAL PORTFOLIO QUALITY AND FINANCE HIGHLIGHT REPORT		
	<p>The Specialist Clinical Portfolio Manager presented the Specialist Clinical Portfolio Activity and Spend for information and assurance.</p> <p>In summary the total number of active cases has reduced from 34 in August 2021 to 16 currently. This is mainly due to the data cleansing exercise which, has been carried out and also discussions about children not eligible for funding but were still being funded.</p> <p>The committee thanked the Specialist Clinical Portfolio Manager and Team.</p>		
Q&PSC 21/10/11	ADULT CONTINUING HEALTHCARE UPDATE		
	<p>The Operational Lead for Continuing Healthcare (CHC) gave a verbal update on adult Continuing Healthcare for assurance highlighting:</p> <ul style="list-style-type: none"> • 389 patients were currently funded via CHC. • At present there are 20 outstanding reviews to undertake but all are on track. • In comparison to April 2021 where 40.9% of reviews were outstanding. Now there are only 5.14%. • There are no patients awaiting care packages to be allocated. <p>The committee thanked the CHC team for all their extra hard work over the past 6 months.</p>		
Q&PSC 21/10/12	PATIENT EXPERIENCE 2021/22 QTR2 REPORT		
	<p>The Quality Manager presented the patient experience report for assurance and information.</p> <p>The report encompasses formal complaints, relating to the CCG and its providers. It also includes data on concerns received by the CCG that are of interest or importance that require an investigation but where the complainant is content for the issue to be dealt with informally or referred onto a provider.</p> <p>It was noted that there had been few formal complaints made about the CCG in the quarter but a high volume of contacts received regarding access to GP appointments.</p>		

	<p>Dan Jarvis, MP has raised with the CCG that he has received a high number of contacts from his constituents in relation to waiting times for GP appointments and the method by which they had to book them.</p> <p>The Quality Manager confirmed that learning which had been identified from complaints had been actioned and systems within the Quality Team have been strengthened to track actions through to completion</p> <p>The Specialist Clinical Portfolio Manager left the meeting at 3.20pm.</p>		
Q&PSC 21/10/13	BARNSELY HOSPICE CQC ACTION PLAN		
	<p>The Chief Nurse reported on the Barnsley Hospice CQC action plan for information and assurance.</p> <p>The Committee was reminded that the Hospice currently carried an Inadequate CQC rating. The Hospice has submitted its improvement plans to the CQC in the timescale required by the CQC.</p> <p>Julie Ferry, Chief Executive at Barnsley Hospice left on 13 October 2021 and Martine Tune, previously Deputy Chief Nurse at Barnsley Clinical Commissioning Group has replaced her.</p> <p>The Chief Nurse confirmed that she will be meeting with Martine Tune regularly to discuss the progress of the action plans and a range of as KPIs</p> <p>It was noted that feedback from the new Chief Executive indicates that the medical, nursing and therapy staff are very patient focussed and a real asset to the organisation.</p>		
Q&PSC 21/10/14	BHNFT SENTINEL STROKE NATIONAL AUDIT PROGRAMME (SSNAP) DATA		
	<p>The Chair gave a verbal update on BHNFT Sentinel Stroke National Audit Programme (SSNAP) data for assurance.</p> <p>Chief Nurse and Medical Director met with BHNFT colleagues on 1 October 2021 to discuss the notification letter received from the National SSNAP Lead advising the Trust as an outlier.</p> <p>At the meeting the Trust provided background information and updates on the action plan implemented.</p>		

	<p>The committee were assured there has been no lapses in patient care since.</p> <p>It was agreed by the committee that a piece of work needed to be undertaken to ensure patients are seeking help at the right time.</p>		
Q&PSC 21/10/15	MINIMISING HARM UPDATE		
	<p>The Lead Commissioning and Transformation Manager presented the agenda item for information and assurance.</p> <p>It was highlighted that Barnsley Hospital NHS Foundation Trust has been working through an Oncology Provision improvement project with Weston Park Hospital for the past 2 years but due to the pandemic this project was paused. Over the past 8 months the project has restarted. The aim of this work is to repatriate all Breast patients to have systematic anti-cancer therapy (SACT) treatment delivered 'closer to home'. This is predominantly for chemotherapy.</p> <p>It was discussed at length the potential risks to the Barnsley population including:</p> <ul style="list-style-type: none"> • There has been no wider discussion with patient, carers and external groups about the change and the implications • The Barnsley Oversight and Scrutiny Committee (OSC) has not been sighted on this potential change • No consideration has been given to having at least 1-2 oncologists at each location rather than having only the hubs • This change will withdraw all face to face appointments currently being held at BHNFT <p>It was agreed for a risk to be drafted and brought back to the committee for approval in relation to Oncology Provision</p> <p>The Lead Commissioning and Transformation Manager left the meeting at 3.40pm.</p>	SL/RW	December 2021
	<p>Action agreed:</p> <p>The Lead Commissioning and Transformation Manager to draft a risk and bring back to the committee for approval in relation to Oncology Provision</p>	SL/RW	December 2021

Q&PSC 21/10/16	LYMPHOEDEMA SERVICE		
	<p>The Chief Nurse gave a verbal update about the recent cessation of the Lymphoedema Service operated by Barnsley Hospice for cancer patients. The Committee was informed that the CCG is liaising with SWYPFT for them to provide the service but this will take 4-6 weeks to implement. Therefore, to ensure clinical oversight and continuity of care, the CCG has put an in-house nursing service in place to support via the Medicines Management Team.</p> <p>The Chief Nurse left the meeting at 2.45pm.</p>		
Q&PSC 21/10/17	RISK REGISTER AND ASSURANCE FRAMEWORK (STANDING ITEM)		
	<p>The Head of Governance and Assurance presented the Risk Register highlighting six risks which have been escalated to the Assurance Framework as a gap in control against one or more risks in the Assurance Framework.</p> <ul style="list-style-type: none"> • Ref CCG 14/15 – Discharge medication risks. • Ref CCG 19/05 - End of Life care services. • Ref CCG 20/03 - BCCG Adult CHC backlog of reviews. • Ref CCG 21/02 – commissioning for complex cases • Ref CCG 21/03 – finance CHC • Ref CCG 13/13 – YAS <p>The committee approved a new risk that had been drafted in relation to the Mayman Lane Supported Living Scheme. Risk to be added to the master risk register and scored '9', amber rated.</p> <p>It was also agreed for a new risk to be drafted in relation to Intermediate Care.</p>	<p>RW</p> <p>RW/JS/ HF</p>	<p>December 2021</p> <p>December 2021</p>
	<p>Actions agreed:</p> <p>The committee approved a new risk that had been drafted in relation to the Mayman Lane Supported Living Scheme. Risk to be added to the master risk register and scored '9', amber rated.</p> <p>It was also agreed for a new risk to be drafted in relation to Intermediate Care.</p> <p>The Head of Governance and Assurance left the meeting at 3.45pm.</p>	<p>RW</p> <p>RW/JS/ HF</p>	<p>December 2021</p> <p>December 2021</p>
COMMITTEE REPORTS AND MINUTES			
Q&PSC 21/10/18	MINUTES OF JULY, AUGUST AND SEPTEMBER PRESCRIBING COMMITTEE		

	The Chair asked committee members for any questions in relation to the committee reports. No comments were made.		
Q&PSC 21/10/19	MINUTES OF AUGUST 2021 PRIMARY CARE QUALITY & COST EFFECTIVE PRESCRIBING GROUP MEETING		
	The Chair asked committee members for any questions in relation to the committee reports. No comments were raised.		
Q&PSC 21/10/20	CLINICAL QUALITY BOARDS <ul style="list-style-type: none"> • BHNFT – MINUTES 01 JULY 2021 • SWYPFT – MINUTES 29 JULY 2021 		
	The Chair presented the minutes for information and assurance. No comments were raised.		
Q&PSC 21/10/21	MINUTES OF JULY 2021 PRIMARY CARE QUALITY IMPROVEMENT GROUP		
	The Primary Care and Transformation Manager presented the minutes for information and assurance. No comments were raised.		
Q&PSC 21/10/22	ANY OTHER BUSINESS		
	No items were raised.		
Q&PSC 21/10/23	AREAS FOR ESCALATION TO THE GOVERNING BODY via the QUALITY HIGHLIGHT REPORT		
	Items for escalation are: <ul style="list-style-type: none"> • Infection Prevention and Control Contracting report April - September 2021 • Safeguarding Annual Reports • Barnsley Hospice Update • Lymphoedema Service • Patient Experience Report Qtr 2 Report 2021/22 • BHNFT Sentinel Stroke National Audit Programme (SSNAP) Data • Oncology Provision 		
Q&PSC 21/10/24	REFLECTION ON HOW WELL THE MEETING'S BUSINESS HAS BEEN CONDUCTED		
	Members agreed that it had been a good informative meeting.		
Q&PSC 21/10/25	DATE AND TIME OF NEXT MEETING 16 December 2021, 1pm via MS Teams		

GOVERNING BODY

20 January 2022

EQUALITY & ENGAGEMENT COMMITTEE SUMMARY REPORT

PART 1A – SUMMARY REPORT

1.	THIS PAPER IS FOR																
	<i>Decision</i>	<input type="checkbox"/>	<i>Approval</i>	<input type="checkbox"/>	<i>Assurance</i>	<input checked="" type="checkbox"/>	<i>Information</i>	<input type="checkbox"/>									
2.	PURPOSE																
	<p>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.</p>																
3.	REPORT OF																
	<table border="1" style="width: 100%; border-collapse: collapse; margin-top: 10px;"> <tr style="background-color: #d9e1f2;"> <th style="width: 35%;"></th> <th style="width: 35%;">Name</th> <th style="width: 30%;">Designation</th> </tr> <tr> <td>Executive / Clinical Lead</td> <td>Chris Millington</td> <td>Lay Member</td> </tr> <tr> <td>Author</td> <td>Carol Williams</td> <td>Project Coordinator</td> </tr> </table>									Name	Designation	Executive / Clinical Lead	Chris Millington	Lay Member	Author	Carol Williams	Project Coordinator
	Name	Designation															
Executive / Clinical Lead	Chris Millington	Lay Member															
Author	Carol Williams	Project Coordinator															
4.	SUMMARY OF PREVIOUS GOVERNANCE																
	<p>The matters raised in this paper have been subject to prior consideration in the following forums:</p> <table border="1" style="width: 100%; border-collapse: collapse; margin-top: 10px;"> <tr style="background-color: #d9e1f2;"> <th style="width: 45%;">Group / Committee</th> <th style="width: 15%;">Date</th> <th style="width: 40%;">Outcome</th> </tr> <tr> <td style="height: 20px;"></td> <td></td> <td></td> </tr> </table>								Group / Committee	Date	Outcome						
Group / Committee	Date	Outcome															
5.	EXECUTIVE SUMMARY																
	<p>Committee members agreed to highlight the following from the 18 November 2021 equality & engagement committee meeting:</p> <ul style="list-style-type: none"> The equality impact assessment toolkit has had a new section added to assess health inequalities. 																
6.	THE GOVERNING BODY / COMMITTEE IS ASKED TO:																
	<ul style="list-style-type: none"> Note the contents of this report for information and assurance. 																

7.	APPENDICES / LINKS TO FURTHER INFORMATION
	<ul style="list-style-type: none">○ Appendix A – Adopted Equality & Engagement Minutes 12 August 2021 (seen by committee September 2021)

Agenda time allocation for report:	5 Minutes
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ADOPTED 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 Adebawale Adekunle (AA)	Elected Governing Body Member, CCG

IN ATTENDANCE:

Ellie Roche (ER)	Senior HR & OD Advisor
Emma Bradshaw (EB)	Engagement Manager, CCG
Roya Pourali (RP)	Equality, Diversity, Inclusion, BHNFT
Angela Musgrave	Exec PA, 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		
	<p>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.</p> <p>Apologies were received as above.</p>		

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		
	<p>The Committee considered the declarations of interest report. There were no new declarations of interest relevant to the agenda.</p> <p>The Chair noted she was not included on the declarations of interest report and confirmed she did not have anything to declare.</p> <p>Action: Declarations of Interest report to be updated to include the Deputy Chief Nurse, CCG.</p> <p>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.</p>	MT	
EEC 21/08/04	MINUTES OF THE PREVIOUS MEETING HELD ON 20 MAY 2021		
	<p>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.</p> <p>Action: KW to tweak the wording relating to minute item 21/05/09 for accuracy.</p>	KW	
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
	<p>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.</p> <p>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.</p> <p>The procurement proposal approach had been received and approved by the Overview and Scrutiny Committee.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p>		
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
	<p>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.</p> <p>It was noted that across SY&B similar conversations had not yet taken place.</p> <p>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.</p> <p>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.</p>		
EEC 21/08/08	MINUTES OF THE PATIENT COUNCIL MEETINGS HELD IN JUNE AND JULY 2021		
	<p>The Patient Council minutes were shared for information (May meeting was cancelled).</p> <p><u>Patient Council Minutes – 30 June 2021</u> 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.</p> <p>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.</p> <p>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.</p>		

Agenda Item	Note	Action	Deadline
	<p><u>Patient Council – 28 July 2021</u> EB provided a verbal update on the Patient Council meeting held on 28 July 2021.</p> <p>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.</p> <p>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.</p> <p>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.</p>		
QUALITY GOVERNANCE			
EEC 21/08/09	CCG Risk Register and Assurance Framework		
	<p>The Committee reviewed the CCG Risk Register and Assurance Framework.</p> <p>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.</p> <p>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:</p> <ul style="list-style-type: none"> • 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 		

Agenda Item	Note	Action	Deadline
	<p>embedded across the CCG there is a risk that the CCG will fail to discharge its statutory duties as an employer and will not adequately consider issues of equality within the services we commission.</p> <p>The Committee reviewed and were assured that the risks were being appropriately managed and scored.</p> <p>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.</p> <p>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 be able to carry out their function. The CCG were currently looking at multiple ways of engaging with the wider membership.</p> <p>Action: RW agreed to discuss this issue with the Chairman of the CCG.</p> <p>Action: KW agreed to provide wording for consideration on the risk register.</p> <p>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</p> <p>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.</p> <p>ER was in conversation with ES regarding the possibility of replicating this at Barnsley CCG.</p> <p>Action: ER agreed to discuss this in more details with ES.</p>	<p>RW</p> <p>KW</p> <p>ER/ES</p>	

Agenda Item	Note	Action	Deadline
EQUALITY			
EEC 21/08/10	EQUALITY OBJECTIVES ACTION PLAN 2019 – 2021 PERFORMANCE		
	<p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>Action: KW to discuss further with colleagues and the SMT.</p>	KW	
GENERAL			
EEC 21/08/11	HR Policies		
	<p>The Committee was asked to approve the proposed changes to the following policies as summarised below:</p> <ul style="list-style-type: none"> • Relocation Policy • Service Award Policy • Whistleblowing policy <p>RW informed the Committee that the HR team continually reviewed and captured any changes in legislation relating</p>		

Agenda Item	Note	Action	Deadline
	<p>to HR policies and procedures. These changes were shared with the CCG, Counter Fraud and staff for comments or feedback.</p> <p>All three policies detailed above had gone through this process and had been circulated with the meeting papers for Committee to approve the changes.</p> <p>As the Committee was not quorate it was agreed to circulate the policies to full Committee members requesting approval of the changes.</p> <p>Action: RW to circulate the policies to all Committee members for virtual approval.</p> <p>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.</p> <p><u>Post Meeting Note:</u> The HR policies had been circulated to all Committee members and virtual approval had been received from all members.</p>	RW	
EEC 21/08/12	REVIEW OF COMMITTEE WORKPLAN		
	RW shared the Committee Workplan with members for information.		
EEC 21/08/13	ANY OTHER BUSINESS		
	<p><u>CCG Staff Survey</u></p> <p>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.</p> <p>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.</p> <p><u>Colin Brotherton-Barnett</u></p> <p>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</p>		

Agenda Item	Note	Action	Deadline
	<p>conversations with people less onerous.</p> <p>The Committee welcomed Roya Pourali to the meeting. Roya was the Equality, Diversity & Inclusion Lead at Barnsley Hospital and would be taking over from Colin.</p>		
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.		