

**A meeting of the NHS Barnsley Clinical Commissioning Group Governing Body will be held on Thursday 11 March 2021 at 9.30 am via Microsoft Teams**

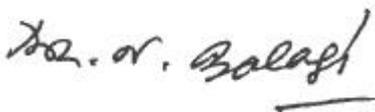
**AGENDA  
(Public)**

<b>1</b>	<b>Session</b>	<b>GB Requested to</b>	<b>Enclosure Lead</b>	<b>Time</b>
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	<b>GB/Pu 21/03/05</b> Nick Balac	9.45 am 5 mins
6	Patient and Public Involvement Activity Report	Assurance	<b>GB/Pu 21/03/06</b> Kirsty Waknell	9.50 am 10 mins
7	Questions from the Public	Information	<b>Verbal</b> Kirsty Waknell	10.00 am 5 mins
8	Minutes of the meeting held on 14 January 2021	Approval	<b>GB/Pu 21/03/08</b> Nick Balac	10.05 am 5 mins
9	Matters Arising Report	Note	<b>GB/Pu 21/03/09</b> Nick Balac	10.10 am 5 mins
	<b>Strategy</b>			
10	Chief Officer's Report	Information	<b>GB/Pu 21/03/10</b> Chris Edwards	10.15 am 10 mins
11	Covid-19 Response and Phase 3 Recovery update	Information & Assurance	<b>GB/Pu 21/03/11</b> Jamie Wike Jeremy Budd	10.25 am 10 mins
12	Assurance Report Transforming Care Update	Information & Assurance	<b>GB/Pu 21/03/12</b> Patrick Otway	10.35 am 10 mins
13	Assurance Report Care Homes - Barnsley Enhanced Health in Care Homes Delivery Plan	Information & Assurance	<b>GB/Pu 21/03/13</b> Jayne Sivakumar	10.45 am 10 mins

14	Assurance Report Out of Area Locked Rehabilitation Provision for Patients		Information & Assurance	<b>GB/Pu 21/03/14</b> Jayne Sivakumar Jo Harrison	10.55 10 mins
<b>Quality and Governance</b>					
15	Quality Highlights Report		Assurance	<b>GB/Pu 21/03/15</b> Jayne Sivakumar	11.05 am 10 mins
16	Children's Services Commissioning Update		Information & Assurance	<b>GB/Pu 21/03/16</b> Patrick Otway	11.15 am 10 mins
17	Risk & Governance Exception Report		Assurance	<b>GB/Pu 21/03/17</b> Richard Walker	11.25 am 10 mins
<b>Finance and Performance</b>					
18	Integrated Performance Report inc QIPP		Assurance and Information	<b>GB/Pu 21/03/18</b> Roxanna Naylor Jamie Wike	11.35 am 15 mins
<b>Committee Reports and Minutes</b>					
19	19.1	Unadopted Minutes of the Audit Committee held on 21 January 2021	Assurance	<b>GB/Pu 21/03/19.1</b> Nigel Bell	11.50 am 5 mins
	19.2	Minutes of the Finance and Performance Committee held on 7 January 2021 and 4 February 2021.	Assurance	<b>GB/Pu 21/03/19.2</b> Nick Balac	
	19.3	Assurance Report Primary Care Commissioning on 28 January 2021 inc. adopted minutes of the meeting on 26 November 2020.	Assurance	<b>GB/Pu 21/03/19.3</b> Chris Millington	
	19.4	Minutes of the Quality and Patient Safety Committee held on 17 December 2021.	Assurance	<b>GB/Pu 21/03/19.4</b> Madhavi Guntamukkala	
	19.5	Assurance Report from the Equality and Engagement Committee held on 25 February 2021.	Assurance	<b>GB/Pu 21/03/19.5</b> Chris Millington	
	19.6	Unadopted Minutes of the Health and Wellbeing Board held on 4 February 2021.	Assurance	<b>GB/Pu 21/03/19.6</b> Nick Balac	
<b>General</b>					
20	Reports Circulated in Advance for Noting:  From the SY&B ICS Collaborative Partnership Board Held on 8 January 2021		Information & Assurance	Nick Balac	11.55 am 5 mins

	<ul style="list-style-type: none"> <li>ICS Chief Executive's Report (Enc B)</li> </ul> <p>From the SY&amp;B ICS Health Executive Group held on 12 January 2021</p> <ul style="list-style-type: none"> <li>SYB ICS CEO Report (Enc B)</li> </ul> <p>From the SY&amp;B ICS Health Executive Group held on 9 February 2021</p> <ul style="list-style-type: none"> <li>SYB ICS CEO Report (Enc B)</li> <li>Sheffield Olympic Legacy Park Update (Enc C)</li> </ul>			
21	<p>Reflection on how well the meeting's business has been conducted:</p> <ul style="list-style-type: none"> <li>Conduct of meetings</li> <li>Any areas for additional assurance</li> <li>Any training needs identified</li> </ul>	Assurance	Nick Balac	
22	<p><b>Date and Time of the Next Meeting:</b></p> <p>Thursday 13 May 2021 at 09.30 am Via Microsoft Teams</p>			Close 12.00 noon

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

11 March 2021

### Declarations of Interests, Gifts, Hospitality and Sponsorship Report

#### PART 1A – SUMMARY REPORT

<b>1.</b>	<b>THIS PAPER IS FOR</b>										
	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="text-align: center;"><i>Decision</i></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><i>Approval</i></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><i>Assurance</i></td> <td style="text-align: center;"><input checked="" type="checkbox"/></td> <td style="text-align: center;"><i>Information</i></td> <td style="text-align: center;"><input 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 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 type="checkbox"/>				
<b>2.</b>	<b>PURPOSE</b>										
	To foresee any potential conflicts of interests relevant to the agenda.										
<b>3.</b>	<b>REPORT OF</b>										
		<b>Name</b>	<b>Designation</b>								
	Executive / Clinical Lead	Richard Walker	Head of Governance & Assurance								
	Author	Paige Dawson	Governance, Risk & Assurance Facilitator								
<b>4.</b>	<b>SUMMARY OF PREVIOUS GOVERNANCE</b>										
	The matters raised in this paper have been subject to prior consideration in the following forums:										
	<b>Group / Committee</b>	<b>Date</b>	<b>Outcome</b>								
	N/A										
<b>5.</b>	<b>EXECUTIVE SUMMARY</b>										
	<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>										

	<b>Type</b>	<b>Description</b>
	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>		
<b>6.</b>	<b>THE GOVERNING BODY IS ASKED TO:</b>	
	<ul style="list-style-type: none"> <li>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.</li> </ul>	
<b>7.</b>	<b>APPENDICES / LINKS TO FURTHER INFORMATION</b>	
	<ul style="list-style-type: none"> <li>Appendix A – Governing Body Members Declaration of Interest Report</li> </ul>	

<b>Agenda time allocation for report:</b>	5 minutes
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**PART 1B – SUPPORTING INFORMATION & ASSURANCE**

<b>1.</b>	<b>Links to Corporate Priorities, GBAF and Risk Register</b>		
	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
<b>2.</b>	<b>Links to statutory duties</b>		
	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)	<input checked="" type="checkbox"/>	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)
<b>3.</b>	<b>Governance Considerations Checklist</b> <i>(these will be especially relevant where a proposal or policy is brought for decision or approval)</i>		
<b>3.1</b>	<b>Clinical Leadership</b>		
	Have GB GPs and / or other appropriate clinicians provided input and leadership?		NA
<b>3.2</b>	<b>Management of Conflicts of Interest (s14O)</b>		
	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
<b>3.3</b>	<b>Discharging functions effectively, efficiently, &amp; economically (s14Q)</b>		
	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
<b>3.4</b>	<b>Improving quality (s14R, s14S)</b>		
	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	<b>Reducing inequalities (s14T)</b>	
	Has an Equality Impact Assessment (EIA) been completed if relevant?	<b>NA</b>
3.6	<b>Public Involvement &amp; Consultation (s14Z2)</b>	
	Has a s14Z2: Patient and Public Participation Form been completed if relevant?	<b>NA</b>
3.7	<b>Data Protection and Data Security</b>	
	Has a Data Protection Impact Assessment (DPIA) been completed if relevant?	<b>NA</b>
3.8	<b>Procurement considerations</b>	
	Have any issues or risks identified been appropriately addressed having taken advice from the procurement Shared Service if appropriate?	<b>NA</b>
	Has a Single Tender Waiver form been completed if appropriate?	<b>NA</b>
3.9	<b>Human Resources</b>	
	Have any significant HR implications been identified and managed appropriately, having taken advice from the HR Lead if appropriate?	<b>NA</b>
3.10	<b>Environmental Sustainability</b>	
	Have any significant (positive or negative) impacts on the environment or the CCG's carbon footprint been identified?	<b>NA</b>

### 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"> <li>• GP Partner at Wombwell Chapelfields Medical Centre</li> </ul>
		<ul style="list-style-type: none"> <li>• The practice is a member of Barnsley Healthcare Federation which may provide services for Barnsley CCG</li> <li>• Clinical sessions with Local Care Direct Wakefield</li> <li>• Clinical sessions at IHeart</li> <li>• Member of the British Medical Association</li> <li>• Member Medical Protection Society</li> </ul>

Name	Current position (s) held in the CCG	Declared Interest
Nick Balac	Chairman	<ul style="list-style-type: none"> <li>• Partner at St Georges Medical Practice (PMS)</li> </ul>
		<ul style="list-style-type: none"> <li>• Practice holds AQP Barnsley Clinical Commissioning Group Vasectomy contract</li> </ul>
		<ul style="list-style-type: none"> <li>• Member of the Royal College of General Practitioners</li> </ul>
		<ul style="list-style-type: none"> <li>• Member of the British Medical Association</li> </ul>
		<ul style="list-style-type: none"> <li>• Member of the Medical Protection Society</li> </ul>
		<ul style="list-style-type: none"> <li>• The practice is a member of Barnsley Healthcare Federation which may provide services for Barnsley CCG</li> </ul>
		<ul style="list-style-type: none"> <li>• Two Partners at St Georges Medical Practice (PMS) are Partners on the Practice Contract at Kingswell Surgery (PMS).</li> </ul>
		<ul style="list-style-type: none"> <li>• Clinical Lead Primary Care South Yorkshire and Bassetlaw ICS (Commissioning).</li> </ul>
Nigel Bell	Lay Member - Governance	<ul style="list-style-type: none"> <li>• Lay Member representing South Yorkshire &amp; Bassetlaw organisations on the Integrated Assurance Committee of South Yorkshire &amp; Bassetlaw Integrated Care System</li> </ul>
Chris Edwards	Chief Officer	<ul style="list-style-type: none"> <li>• Family member employed by Chesterfield Royal</li> <li>• Family member employed by Attain</li> </ul>

Name	Current position (s) held in the CCG	Declared Interest
Madhavi Guntamukkala	Medical Director	<ul style="list-style-type: none"> <li>• Senior GP in a Barnsley Practice (Apollo Court Medical Practice &amp; The grove Medical Practice) Practices provide services under contract to the CCG</li> <li>• The practice is a member of Barnsley Healthcare Federation which may provide services for Barnsley CCG</li> <li>• Spouse – Dr M Vemula is also partner GP at both practices</li> </ul>
John Harban	GP Governing Body Member	<ul style="list-style-type: none"> <li>• GP Partner at Lundwood Medical Centre and The Kakoty Practice, Barnsley</li> </ul>
		<ul style="list-style-type: none"> <li>• AQP contracts with the Barnsley Clinical Commissioning Group to supply Vasectomy, Carpal Tunnels and Nerve Conduction Studies services</li> <li>• Owner/Director Lundwood Surgical Services</li> <li>• Wife is Owner/Director of Lundwood Surgical Services</li> <li>• Member of the Royal College of General Practitioners</li> <li>• Member of the faculty of sports and exercise medicine (Edinburgh)</li> <li>• The practice is a member of Barnsley Healthcare Federation which may provide services for Barnsley CCG</li> <li>• Chair of the Remuneration Committee at Barnsley Healthcare Federation</li> </ul>

Name	Current position (s) held in the CCG	Declared Interest
M Hussain Kadarsha	GP Governing Body Member	<ul style="list-style-type: none"> <li>• GP Partner in Hollygreen Practice</li> </ul>
		<ul style="list-style-type: none"> <li>• GP Partner in Lakeside Surgey, Goldthorpe (Partner in Company Alliance Primary Care LTD)</li> <li>• The practice is a member of Barnsley Healthcare Federation which may provide services to Barnsley CCG</li> <li>• Member of the British Medical Association</li> <li>• Director of YAAOZ Ltd, with wife</li> </ul>
		<ul style="list-style-type: none"> <li>• Malkarsha Properties Ltd (Director)</li> <li>• Partner (share holder) in Primecare LTD – holding the APMs contract for Lakeside Surgery and Goldthorpe</li> </ul>
Jamie MacInnes	Governing Body Member	<ul style="list-style-type: none"> <li>• GP Partner at Dove Valley Practice</li> </ul>
		<ul style="list-style-type: none"> <li>• The practice is a member of Barnsley Healthcare Federation which may provide services for Barnsley CCG</li> </ul>
		<ul style="list-style-type: none"> <li>• Shareholder in GSK</li> </ul>

Name	Current position (s) held in the CCG	Declared Interest
		<ul style="list-style-type: none"> <li>• 3A Honorary Senior Lecturer</li> </ul>
Chris Millington	Lay Member	<ul style="list-style-type: none"> <li>• Partner Governor Barnsley Hospital NHS Foundation Trust (ceased July 2018)</li> <li>• Partner Governor Barnsley Hospital NHS Foundation Trust (since 6 February 2019)</li> </ul>
Roxanna Naylor	Chief Finance Officer	<ul style="list-style-type: none"> <li>• Partner works at NHS Leeds Clinical Commissioning Group.</li> </ul>
Mike Simms	Secondary Care Clinician	<ul style="list-style-type: none"> <li>• Provider of Corporate and Private healthcare and delivering some NHS Contracts.</li> </ul>
Mark Smith	GP Governing Body Member	<ul style="list-style-type: none"> <li>• Senior Partner at Victoria Medical Centre also undertaking training and minor surgery roles.</li> </ul>
		<ul style="list-style-type: none"> <li>• Director of Janark Medical Ltd</li> </ul>
		<ul style="list-style-type: none"> <li>• Practice is a Member of Barnsley Healthcare Federation which may provide services to Barnsley CCG</li> </ul>
Jayne Sivakumar	Chief Nurse	<ul style="list-style-type: none"> <li>• Director of RJS Healthcare Ltd – a healthcare company which receives referrals from healthcare organisations.</li> <li>• Husband is a Consultant Surgeon at the Mid Yorkshire Hospital NHS Foundation Trust.</li> </ul>

In attendance:

Richard Walker	Head of Governance and Assurance	<ul style="list-style-type: none"> <li>• Daughter is employed by Health Education England</li> </ul>
Jamie Wike	Head of Planning, Delivery and Performance	<ul style="list-style-type: none"> <li>• Wife is employed by Barnsley Healthcare Federation as the Lead Social Prescriber</li> </ul>
Jeremy Budd	Director of Commissioning	<ul style="list-style-type: none"> <li>• Director – Your Healthcare CIC (provision of community health services and social care services in SW London)</li> <li>• Director – Barnsley Estates Partnership Limited (LIFT Company for Barnsley)</li> <li>• Director – Barnsley Community Solutions (Tranche 2 ) Limited (LIFT Company for Barnsley)</li> <li>• Director – Barnsley Community Solutions (Tranche 3 ) Limited (LIFT Company for Barnsley)</li> <li>• Director Belenus Ltd (Dormant, non-trading)</li> </ul>

## Governing Body

11 March 2021

### Patient and Public Involvement Activity Report

#### PART 1A – SUMMARY REPORT

<b>1. THIS PAPER IS FOR</b>												
	Decision	<input type="checkbox"/>	Approval	<input type="checkbox"/>	Assurance	<input checked="" type="checkbox"/>	Information	<input type="checkbox"/>				
<b>2. PURPOSE</b>												
	This report outlines the patient and public involvement activity we have carried out to help inform commissioning decisions and service development.											
<b>3. REPORT OF</b>												
	<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 and Engagement</td> </tr> </tbody> </table>				Name	Designation	Executive	Jeremy Budd	Director of Strategic Commissioning and Partnerships	Author	Kirsty Waknell	Head of Communications and Engagement
	Name	Designation										
Executive	Jeremy Budd	Director of Strategic Commissioning and Partnerships										
Author	Kirsty Waknell	Head of Communications and Engagement										
<b>4. SUMMARY OF PREVIOUS GOVERNANCE</b>												
	<table border="1"> <thead> <tr> <th>Group / Committee</th> <th>Date</th> <th>Outcome</th> </tr> </thead> <tbody> <tr> <td>CCG engagement and equality committee</td> <td>25/2/2021</td> <td>Noted</td> </tr> </tbody> </table>			Group / Committee	Date	Outcome	CCG engagement and equality committee	25/2/2021	Noted			
Group / Committee	Date	Outcome										
CCG engagement and equality committee	25/2/2021	Noted										
<b>5. EXECUTIVE SUMMARY</b>												
	<p>This report highlights three areas of work that have taken place to inform our understanding of people's attitudes and experience of life during the pandemic.</p> <p>These now start to focus on findings coming out in relation to the COVID-19 vaccine which will help inform our local approach for the wider roll-out over the coming weeks and months.</p>											
<b>6. THE COMMITTEE IS ASKED TO:</b>												
	<ul style="list-style-type: none"> <li>Note the progress of local involvement activity.</li> </ul>											

<b>Agenda time allocation for report:</b>	5 minutes
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**PART 1B – SUPPORTING INFORMATION & ASSURANCE**

<b>1.</b>	<b>Links to Corporate Priorities, GBAF and Risk Register</b>		
	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:		<i>Provide ref(s) or state N/A</i>
<b>2.</b>	<b>Links to statutory duties</b>		
	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) ✓
	Duty to promote the NHS Constitution (s14P)		Duty to promote the involvement of each patient (s14U) ✓
	Duty to exercise its functions effectively, efficiently and economically (s14Q)	See 3.3	Duty as to patient choice (s14V) ✓
	Duty as to improvement in quality of services (s14R)	✓	Duty as to promoting integration (s14Z1) ✓
	Duty in relation to quality of primary medical services (s14S)	✓	Public involvement and consultation (s14Z2) ✓
<b>3.</b>	<b>Governance Considerations Checklist</b> ( <i>these will be especially relevant where a proposal or policy is brought for decision or approval</i> )		
3.1	<b>Clinical Leadership</b>		
	Have GB GPs and / or other appropriate clinicians provided input and leadership?		<b>Y</b>
3.2	<b>Management of Conflicts of Interest (s14O)</b>		
	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?		<b>NA</b>
3.3	<b>Discharging functions effectively, efficiently, &amp; economically (s14Q)</b>		
	Have any financial implications been considered & discussed with the Finance Team?		<b>NA</b>
	Where relevant has authority to commit expenditure been sought from Management Team (<£100k) or Governing Body (>£100k)?		<b>NA</b>

3.4	<b>Improving quality (s14R, s14S)</b>	
	Has a Quality Impact Assessment (QIA) been completed if relevant?	<b>NA</b>
3.5	<b>Reducing inequalities (s14T)</b>	
	Has an Equality Impact Assessment (EIA) been completed if relevant?	<b>NA</b>
3.6	<b>Public Involvement &amp; Consultation (s14Z2)</b>	
	Has a s14Z2: Patient and Public Participation Form been completed if relevant?	<b>NA</b>
3.7	<b>Data Protection and Data Security</b>	
	Has a Data Protection Impact Assessment (DPIA) been completed if relevant?	<b>NA</b>
3.8	<b>Procurement considerations</b>	
	Have any issues or risks identified been appropriately addressed having taken advice from the procurement Shared Service if appropriate?	<b>NA</b>
	Has a Single Tender Waiver form been completed if appropriate?	<b>NA</b>
3.9	<b>Human Resources</b>	
	Have any significant HR implications been identified and managed appropriately, having taken advice from the HR Lead if appropriate?	<b>NA</b>
3.10	<b>Environmental Sustainability</b>	
	Have any significant (positive or negative) impacts on the environment or the CCG's carbon footprint been identified?	<b>NA</b>

**PART 2 – DETAILED REPORT**

**INTRODUCTION/ BACKGROUND INFORMATION**

**1 Healthwatch Barnsley Survey Results**

Healthwatch Barnsley to shape their next local survey designed to gather insight and feedback from local people about their experiences of life during the pandemic.

Many of the same questions have been used that were included in the original surveys carried out the summer 2020, so it will be possible to compare and contrast the responses received to these as well as collect new insights from those questions included for the first time here.

The Healthwatch Barnsley manager, attended our Equality and Engagement Committee on 25<sup>th</sup> February and presented an overview of the results which can be accessed via the links below.

The findings have been shared as part of the weekly borough wide intelligence reporting and the next step is to collectively look at how we respond to this feedback from the local community and how we use this information to shape our shared decision making and communication and engagement activity going forwards.



what people are telling us - update for



what people are telling us - update for

**2 Healthwatch England Survey Results: What are people telling us about COVID-19 Vaccines**

Healthwatch England ran a survey on people’s attitudes the COVID-19 vaccine. The focus covered:

- Attitudes towards the vaccine
- Access to the vaccine for vulnerable groups
- Logistical access to the vaccine
- Experience of the roll-out

This update is informed by:

- Data from 34 local Healthwatch services across England, providing the feedback of 334 individuals on the COVID-19 vaccine delivery, and
- The views of 2,431 members of the public in polling commissioned by Healthwatch England.

These national results will help inform our local work and will also help us focus in on where we might want to capture more targeted views in Barnsley.



20220216 COVID-19 Intelligence Update.p

3	<p><b>Barnsley Covid Conversations – Feedback from We Are Magpie</b></p> <p>We Are Magpie agency attended our Equality and Engagement Committee on 25<sup>th</sup> February and provided an overview of the feedback they have captured as part of the work they have been doing across the borough to capture feedback from local people about living through the pandemic.</p> <p>We Are Magpie are an agency that has been working with Barnsley Council and partners on a range of things during the pandemic, and specifically in this case they ran a survey to find out people’s behaviours and attitudes to living through the pandemic alongside carrying out a series of online focus sessions.</p> <p>There were questions in there about life in general but also things like testing and the vaccines and the different attitudes to these and the insights gathered are to be shared with all partners to take the learning from this forwards as part of our borough wide awareness raising and communications campaigns.</p>
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**Minutes of the meeting of the Barnsley Clinical Commissioning Group Governing Body (PUBLIC SESSION) held on Thursday 14 January 2021, 9.30 am via Microsoft Teams**

**MEMBERS PRESENT**

Dr Nick Balac	Chairman
Dr Adebowale Adekunle	Member
Nigel Bell	Lay Member for Governance
Chris Edwards	Chief Officer
Madhavi Guntamukkala	Medical Director & Member
Dr John Harban	Member
Dr Hussain Kadarsha	Member
Dr Jamie MacInnes	Member (up to and including minute reference (GB/Pu 21/01/20))
Chris Millington	Lay Member for Patient and Public Engagement & Primary Care Commissioning
Roxanna Naylor	Chief Finance Officer
Mike Simms	Secondary Care Clinician
Dr Mark Smith	Member

**IN ATTENDANCE**

Adrian Bailey	Head of Finance: Statutory Accounts and Financial Reporting
Emma Bates	Commissioning and Transformation Manager
Amanda Capper	Head of Contracting
Jeremy Budd	Director of Strategic Commissioning and Partnerships
Jo Harrison	Specialist Clinical Portfolio Manager (for minute references GB/Pu 21/01/16 and GB/Pu 21/01/17 only)
Lucy Hinchliffe	Commissioning and Transformation Manager (for minute reference GB/Pu 21/01/11 only)
Kay Morgan	Governance and Assurance Manager (Minutes)
Patrick Otway	Head of Commissioning (Mental Health, Children's, and Maternity) (for minute references GB/Pu 21/01/14 and GB/Pu 21/01/15 only)
Leanne Sparks	Commissioning and Transformation Manager
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.

Agenda Item		Action	Deadline
<b>GB/Pu 21/01/01</b>	<b>HOUSEKEEPING</b>		
	Members noted the etiquette for meetings held via Microsoft Teams.		
<b>GB/Pu 21/01/02</b>	<b>QUORACY</b>		
	The meeting was declared quorate.		
<b>GB/Pu 21/01/03</b>	<b>PATIENT STORY</b>		
	<p>The Head of Communications and Engagement provided the Governing Body with a collection of reflections from staff and volunteers during the first month of the Covid-19 vaccination programme. The most consistent message is the gratitude and relief of patients receiving the vaccination and how everyone has pulled together to establish and run the vaccination sites.</p>		
	<p>The following comments were received regarding the Patient Story.</p> <ul style="list-style-type: none"> <li>• The vaccination centres demonstrated the provision of seamless care for patients, no boundaries, with health care professions acting as one team.</li> <li>• A strong common purpose, to vaccinate the population of Barnsley, is evident amongst the Barnsley health and social care partnership and Volunteers.</li> </ul> <p>The Chairman commented that he had received his first vaccination and there was an excellent community atmosphere between staff, volunteers, and patients at the vaccination centre. Every individual staff member from his Practice had volunteered to assist with the Covid vaccination programme. He emphasised that the vaccination is the route out of the Covid-19 pandemic.</p> <p>The Chairman extended his appreciation to the Chief Operating Officer and Chief Executive of the Barnsley Healthcare Federation for logistically establishing the vaccination centers for the people of Barnsley.</p>		
	<b>The Governing Body noted the Patient Story.</b>		

Agenda Item		Action	Deadline
<b>GB/Pu 21/01/04</b>	<b>DECLARATIONS OF INTEREST, SPONSORSHIP, HOSPITALITY AND GIFTS RELEVANT TO THE AGENDA</b>		
	The Governing Body considered the Declarations of Interests Report. No other new declarations were received		
<b>GB/Pu 21/01/05</b>	<b>PATIENT AND PUBLIC INVOLVEMENT ACTIVITY REPORT</b>		
	<p>The Head of Communications and Engagement presented the Patient and Public Involvement Activity Report. The Governing Body was pleased to note that Barnsley CCG had received the top rating possible 'Green Star' for discharging its public involvement duty.</p> <p>The Lay Member for Patient and Public Engagement &amp; Primary Care Commissioning commented that elements of the patient and public involvement activity work and good practice undertaken in Barnsley had been shared with other South Yorkshire and Bassetlaw CCGs.</p>		
	<b>The Governing Body noted the Patient and Public Involvement Activity Report including the positive annual assessment rating and progress of local involvement activity.</b>		
<b>GB/Pu 21/01/06</b>	<b>QUESTIONS FROM THE PUBLIC</b>		
	The Head of Communications and Engagement read out the following questions (together with responses) received from Members of the public. The questions and responses will be saved on the CCG's website alongside the meeting agenda papers and a copy also provided to the person(s) submitting the question(s).		
	<p><b>Question 1</b></p> <p>Governing Body Agenda Item 12 - Home First - Intermediate Care Model: Please can you say how you will advertise your targeted consultation to people? Please can you say who will you target?</p> <p><b>Response</b></p> <p>The ongoing engagement will be with people who are</p>		

Agenda Item		Action	Deadline
	<p>using, or have recently used, the service and their carers or family members. They will be contacted by staff working in the service. This approach has been submitted to and supported by Barnsley Overview and Scrutiny Committee.</p>		
	<p><b>Question 2</b></p> <p>Governing Body Agenda Item 12 Item 14 - Integrated Care - Barnsley Place: Why is there no information for the Barnsley public about Barnsley's Integrated Care arrangements as in other CCG areas across the SYBICS?</p> <p><b>Response</b></p> <p>There is information about each of the place-based partnerships on the ICS website at <a href="https://www.healthandcaredtogethersyb.co.uk/local-plans/Barnsley">https://www.healthandcaredtogethersyb.co.uk/local-plans/Barnsley</a> and regular updates to GB in public session and similarly to the hospital and SWYPFT Boards. The Barnsley Integrated Partnership Group is not a formal decision making group. All commissioning decisions are made by the CCG Governing Body.</p>		
	<p><b>Question 3</b></p> <p>Governing Body Agenda Item 23 - additional documents from the SYBICS: Where are these documents made available for the Barnsley public to access?</p> <p><b>Response</b></p> <p>These documents are made available alongside the Governing Body agenda papers on the GB website at <a href="https://www.barnsleyccg.nhs.uk/about-us/meetings.htm">https://www.barnsleyccg.nhs.uk/about-us/meetings.htm</a></p>		
<p><b>GB/Pu 21/01/07</b></p>	<p><b>MINUTES OF THE MEETING HELD ON 12 NOVEMBER 2020</b></p>		
	<p>The minutes of the Governing Body Extra Ordinary meeting held on 12 November 2020 were verified as a correct record of the proceedings.</p>		
<p><b>GB/Pu 21/01/08</b></p>	<p><b>MATTERS ARISING REPORT</b></p>		
	<p>The Governing Body considered and noted the Matters</p>		

Agenda Item		Action	Deadline
	Arising Report		
<b>STRATEGY</b>			
<b>GB/Pu 21/01/09</b>	<b>CHIEF OFFICER'S REPORT</b>		
	<p>The Chief Officer introduced his report providing the Governing Body including the annual performance assessment of CCGs 2019/20 and the NHSE&amp;I publication Integrating Care Next steps to Building Strong and Effective Integrated Care Systems Across England.</p> <p>Members were advised that further documentation / guidance regarding the Integrating Care Strategy is expected late January or early February 2021, once NHS England has considered all feedback provided in respect of the Strategy. The Integrating Care Strategy will be an iterative process for discussion at Governing Body as to how Barnsley responds to the Strategy. A Governing Body Development session to consider the Strategy is also scheduled for Thursday 28 January 2021.</p> <p>The Governing Body noted the importance of Informing the Barnsley public about progress with the Integrating Care Strategy.</p>		
	<b>The Governing Body noted the report.</b>		
<b>GB/Pu 21/01/10</b>	<b>COVID-19 RESPONSE AND PHASE 3 RECOVERY UPDATE</b>		
	<p>The Chief Operating Officer provided the Governing Body with an update in relation to the CCG's response to the Coronavirus Disease (COVID19) pandemic and details of the reset plans to support recovery in line with national and local priorities. It was noted that as from 5 November 2021 the NHS EPRR (Emergency Preparedness, Resilience and Response) level was increased back to level 4 (national control and command).</p>		
	<p>Discussion took place regarding the following points.</p> <p><b>Operational Priorities for Winter and 2021/22</b></p> <p>Planning for 2021/22</p>		

Agenda Item		Action	Deadline
	<p>The Lay Member for Patient and Public Engagement &amp; Primary Care Commissioning indicate his support in respect of the planning priorities and investment in Primary Care and the focus on improving patient experience, increasing the use of online consultations and expansion of capacity to increase availability of GP appointments.</p> <p>The 2021/22 Financial Framework</p> <p>The Chief Finance Officer commented that whilst the information in the letter from NHSE &amp; I set out the financial framework for 2021/22, guidance has subsequently moved on and advised that the current financial arrangements with providers will continue into the first quarter of 2021/22. The letter does not set out allocation arrangements and this is a difficult situation, there is still lots of guidance to be issued and worked through from a finance perspective.</p> <p>Operational Guidance</p> <p>The Chief Operating Officer highlighted that the latest guidance directs the NHS to continue creating surge capacity to accept and manage priority 1 &amp; priority 2 patients and combine waiting lists across the system to ensure all patients are seen and treated. Priority 3 and priority 4 patients are to be treated where demand can be met. The NHS is to utilise the private sector to meet demand. The NHS must continue to communicate with every patient whose planned care is disrupted.</p>		
	<p><b>Vaccination Programme</b></p> <p>The Chief Operating Officer provided an update regarding the Covid 19 Vaccination Programme in Barnsley.</p> <ul style="list-style-type: none"> <li>• With the rising rates of Covid cases, the latest national directive instructed the vaccination of as many people as possible with a first dose of vaccine to give some protection and maximise protection of others, followed up with a second dose within 12 weeks. The CCG and Barnsley Healthcare Federation are working to this instruction. Some pre booked second dose vaccinations have been given but from 13 January 2021 all people coming to vaccination centres will be for their first dose.</li> <li>• The Government's Vaccination plan includes a range of</li> </ul>		

Agenda Item		Action	Deadline
	<p>delivery models, including large scale vaccination sites. The nearest large vaccination site to Barnsley within a 45 minute drive distance is Manchester.</p> <ul style="list-style-type: none"> <li>Supplies of the Oxford Astra Zeneca vaccine are starting to flow. Practices are working hard to vaccinate all care home residents (with first doses) by 31 January 2020.</li> <li>A regular supply of the Pfizer vaccine is being received at hospital vaccination hubs. All front-line Health and social care workforce will be vaccinated by the 31 January 2021.</li> <li>The three community vaccination hubs based at Apollo Court, Dodworth, Priory Campus, Lundwood and the Goldthorpe Lift Building have made huge progress in vaccinating the over 80 population in Barnsley. Subject to the flow of vaccine being available, the 'housebound' are the next cohort of patients to be vaccinated, with the over 70 population vaccinated by the end of February 2021.</li> </ul>		
	<p>The Chief Officer commented that the vaccination programme demonstrated the resilience of staff and volunteers. However, the vaccination programme will extend well into the Autumn and he had placed a request to access additional staff for Barnsley from the national volunteer workforce resource.</p> <p>The Chairman reiterated that that the Covid vaccination programme is the route to stem the flow of Covid. Primary Care is dealing with its normal daily provision of urgent care and diverting every effort into the mass vaccination of Barnsley people.</p>		
	<p><b>The Governing Body noted the update provided including the progress in implementing the Covid vaccination programme in Barnsley.</b></p>		
<p><b>GB/Pu 21/01/11</b></p>	<p><b>HOME FIRST – A NEW MODEL FOR INTERMEDIATE CARE</b></p>		
	<p>The Commissioning and Transformation Manager introduced a paper to the Governing Body proposing a new model for intermediate care. The new model is a re-provisioning of services to be delivered within current</p>		

Agenda Item		Action	Deadline
	resources focussing on care delivered at home first. It was noted that the clinical leadership and involvement for modelling of the Intermediate care service had remained separate from the procurement process.		
	The Chairman thanked the Commissioning and Transformation Manager and her team for their comprehensive and detailed work on the new model for Intermediate care. It was noted that the proposal had also been presented to and well received by the Patient Council.		
	<p><b>The Governing Body approved:</b></p> <ul style="list-style-type: none"> <li>• <b>the new 'home first' model for intermediate care.</b></li> <li>• <b>Service Specification 1 – Overarching Intermediate Care</b></li> <li>• <b>Service Specification 2 – For the 30 bedded unit</b></li> <li>• <b>Service Specification 3 – GP Medical Oversight</b></li> <li>• <b>The pathways for Discharge to Assess</b></li> </ul>		
<b>GB/Pu 21/01/12</b>	<b>CANCER ASSURANCE REPORT</b>		
	<p>Dr Hussain Kadarsha presented the Cancer Assurance Report to the Governing Body. The reported provided the Governing Body with assurance:</p> <ul style="list-style-type: none"> <li>• about the cancer programme position and update on the cancer priorities within Governing Body Assurance Framework.</li> <li>• that the CCG has a plan in place for managing the impact of Covid-19 on pathways</li> <li>• Regarding the future and current actions being undertaken by the CCG to instil confidence that a third phase NHS response to Covid-19 restoration plan is in place.</li> </ul>		
	<b>The Governing Body noted the Cancer Assurance Report.</b>		
<b>GB/Pu 21/01/13</b>	<b>INTEGRATED CARE AT BARNSLEY PLACE ASSURANCE REPORT</b>		
	The Director of Strategic Commissioning and Partnerships introduced an assurance report to the Governing Body on the development of integrated care at place level, which is priority area 5.2 of the NHS Barnsley CCG Governing Body Assurance Framework 2020-21, together with an update on priority areas of work and principle areas of risk.		

Agenda Item		Action	Deadline
	<p>The Governing Body noted that over the next 12 months, the Barnsley partnership will be focussing on the following objectives:</p> <ol style="list-style-type: none"> <li>1. To deliver the recovery and reset plan that has been collectively developed and agreed</li> <li>2. Delivering the C19 vaccination programme</li> <li>3. To further strengthen the Barnsley Integrated Care Partnership, looking at how the Partnership can make robust collective decisions and effectively manage the Barnsley Pound to deliver the best outcomes for the people of Barnsley</li> <li>4. Working together to fully mobilise the Neighbourhood Teams in localities, building stronger shared leadership arrangements across primary and community care in the first instance whilst also ensuring that our PCN goes from strength to strength</li> <li>5. Supporting the development of the Barnsley HWB initiated Mental Health Partnership, recognising in particular the increasing need being generated as a result of Covid-19 and on-going work to ensure parity of esteem</li> <li>6. Revisiting and further strengthening joint commissioning arrangements between the CCG and the Local Authority, to ensure a one integrated commissioning plan for Barnsley, focussed on the life course – Starting Well, Living Well and Ageing Well</li> <li>7. Having a clear and consistent one voice for Barnsley within our ICS, through the continued development of our Barnsley Integrated Care Partnership governance.</li> </ol>		
	<p>It was noted that mobilisation of integrated multi-disciplinary teams is in progress with a focus on delivering better outcomes for the people of Barnsley. A Care Closer to Home Board has been established and the membership of Board will be expanded to include representation from all partners. The Director of Strategic Commissioning and Partnerships advised that although partner organisations are working closely together to progress integrated care in Barnsley, the current principal threat, due to Covid 19 is the</p>		

Agenda Item		Action	Deadline
	<p>limited capacity across all organisations to undertake transformational change.</p> <p>The Chairman commented that the Health and Well Being Board, Integrated Care Partnership Group and Mental Health Partnership are all meeting regularly to consider wider elements of integrated care and how to work together to make the best use of the Barnsley £.</p>		
	<p><b>The Governing Body noted the Integrated Care at Barnsley Place Assurance Report</b></p> <ul style="list-style-type: none"> <li>• <b>To submit the refreshed Restoration and Recovery Plan (in light of phase 4 letter) to Governing Body on 11 March 2021</b></li> </ul>		
<b>GB/Pu 21/01/14</b>	<b>MATERNITY ASSURANCE REPORT</b>		
	<p>The Head of Commissioning (Mental Health, Children's, and Maternity) presented the Maternity Assurance Report to the Governing Body. It was noted that Barnsley is making good progress in transforming in local maternity services by implementing the recommendations of 'better Births' and performs well against both local and national peers, Barnsley is seen as an exemplar service in respect of the Continuity of Carer models, supporting other Trusts in the region by providing additional support /leadership.</p> <p>The CCG Chief Officer is the senior responsible officer for Maternity Services in South Yorkshire &amp; Bassetlaw and Laura Rumsey (Head of Midwifery/Associate Director of Nursing at Barnsley Hospital NHS Foundation Trust) is also the lead midwife for South Yorkshire &amp; Bassetlaw.</p>		
	<b>The Governing Body noted the Maternity Assurance Report.</b>		
<b>GB/Pu 21/01/15</b>	<b>SUICIDE PREVENTION AND BEREAVEMENT SUPPORT UPDATE</b>		
	<p>The Head of Commissioning (Mental Health, Children's, and Maternity) introduced a Suicide Prevention and Bereavement Support Update to the Governing Body. Two GP Members commented that they were not aware of the totality of services and support available for members of the</p>		

Agenda Item		Action	Deadline
	<p>public. A clear map of available suicide prevention and bereavement support services is required for health and social care professionals and members of the public. Signposting and access to informal support services may prevent people entering more formal services.</p>		
	<p><b>The Governing Body noted the Suicide Prevention and Bereavement Support Update.</b></p> <p><b>Agreed Actions:</b></p> <p><b>To develop information for Primary Care detailing available services re Suicide Prevention and Bereavement support services.</b></p> <p><b>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.</b></p>	<p><b>PO/MS</b></p> <p><b>PO/MS</b></p>	<p><b>11.03.21</b></p> <p><b>11.03.21</b></p>
<b>QUALITY AND GOVERNANCE</b>			
<b>GB/Pu 21/01/16</b>	<b>QUALITY HIGHLIGHTS REPORT</b>		
	<p>The Specialist Clinical Portfolio Manager presented the Quality Highlights Report to the Governing Body.</p> <p>The Chairman referred to the issue regarding ‘Minimising harm due to Covid and patients who had been seen in Primary Care but where referral into secondary care has not been achieved due to services or lists being closed (or unavailable) to new referrals.’ He informed the meeting that Des Breen, the Medical Director for the South Yorkshire and Bassetlaw Integrated Care System (ICS), is leading a piece of work looking at the inconsistencies between providers and within providers in managing referrals. The risk related more to the beginning of Covid and the actual risk is now less than originally assumed. The Governing Body noted that the ‘Minimising HARM’ initiative had initially derived from Barnsley and was adopted by the Cancer Alliance</p> <p>The Chairman requested that the Governing Body receive assurance regarding the ‘red’ rated issue relating to access to out of area locked rehabilitation provision.</p>		

Agenda Item		Action	Deadline
	<p><b>The Governing Body noted the Quality Highlights Report for information and assurance.</b></p> <p><b>Agreed action</b>  <b>To provide assurance Re out of area locked rehabilitation provision for patients to the next meeting of the Governing on 11 March 2021</b></p>	JH (JSiv)	11.03.21
GB/Pu 21/01/17	<b>COVERT ADMINISTRATION OF MEDICINES POLICY</b>		
	The Governing Body received and approved the Covert Administration of Medication for Patients in Care Homes Policy for operational use and publication on the CCG's website.		
GB/Pu 21/01/18	<b>RISK AND GOVERNANCE EXCEPTION REPORT</b>		
	<p>The Head of Governance and Assurance introduced the Risk and Governance Exception Report to the Governing Body. The Governing Body were informed of changes to the Assurance Framework and Risk Register since the report was written.</p> <p>The Finance and Performance Committee had agreed to a reduction in the scores for two risks as follows:</p> <ul style="list-style-type: none"> <li>• Assurance Framework risk reference 6.1 'Financial Balance and Efficiency Plans' reduce score to 3 x 4 = 12</li> <li>• Risk reference Covid risk 4 / 13.31 'QIPP' reduce the score for this risk to 3 x 4 = 12</li> </ul>		
	<p>The Chairman queried the scores for two risks on the Risk Register.</p> <ul style="list-style-type: none"> <li>• Risk reference Covid risk 3 'Flu Season 20/21' The score of 20 for this risk appeared high given that it is January and the flu immunisation programme is coming to an end. It was noted that there was some initial risk relating to the availability of vaccine, but supply of vaccine did flow and there has been a high uptake of the vaccine.</li> <li>• Risk reference 20/02 'Continuing Health Care (CHC).'</li> </ul>		

Agenda Item		Action	Deadline
	<p>The score for this risk is currently 12, the chairman expressed his view that the score for this risk should be higher and will be further reviewed at the Governing Body Development Session on 28 January 2021. It was noted that the Finance and Performance Committee had also highlighted this risk for reassessment following receipt of the CHC Assurance Report.</p>		
	<p><b>The Governing Body:</b></p> <ul style="list-style-type: none"> <li>• Reviewed the Assurance Framework and Risk Register</li> <li>• Noted the new risk in relation to CHC</li> <li>• Noted and approved the reduction in the scores in relation to GBAF risk 6.1 and Corporate Risk Register 13/31 to 3x4=12</li> <li>• Determined that all risks are being appropriately managed</li> <li>• Did not identify any potential new risks or risks for removal</li> <li>• Noted and approved the changes to the Equality and Engagement Committee TOR.</li> </ul> <p><b>Agreed action</b></p> <p>To review risk reference Covid risk 3 'Flu Season 20/21</p>	<p>JW</p>	<p>11.03.21</p>
<p><b>GB/Pu 21/01/19</b></p>	<p><b>HOME WORKING POLICY</b></p>		
	<p>The Head of Governance and Assurance introduced the Home Working Policy to the Governing Body for approval. It was noted that the CCG already includes home working as an option within its Flexible Working Policy. However, it is likely that a number of staff may wish to continue some kind of home working arrangement once the Covid Pandemic emergency has been contained and a return to Hillder House is possible. The Home Working Policy had been developed to provide a more comprehensive and robust framework for considering home working requests than is set out in the existing flexible working policy.</p>		
	<p>The Chairman commented that he supported the Home Working Policy, however home working can have advantages and disadvantages for individuals and the organisation. Home working is good for some individuals. Face to face meetings, generation of ideas and peer support is less with home working and there can be</p>		

Agenda Item		Action	Deadline
	increased professional and social isolation which is a small risk to the organisation. Managers need to bear this in mind when approving individual requests for home working.		
	<b>The Governing Body approved the Home Working Policy</b>		
<b>FINANCE AND PERFORMANCE</b>			
<b>GB/Pu 21/01/20</b>	<b>INTEGRATED PERFORMANCE REPORT</b>		
	<p><b>Finance</b></p> <p>The Chief Finance Officer provided the key headline messages from the month 8 Finance Report. The Governing Body noted that the CCG is on track to deliver its financial duties and achieve a break even position subject to national funding in relation to the hospital discharge programme.</p> <p>The Chief Finance Officer described the following areas which remain a risk in the CCGs financial position:</p> <p>The first relates to the Independent sector and the national reconciliation of activity which potentially may see a defund for Barnsley. However, budgets were set aside to manage this potential risk, and this will probably not pose too much of a significant risk for the CCG.</p> <p>The Primary Care prescribing data continues to show pressures with an overspend position. Nationally the prescribing actual position may be reviewed for the period relating to Month 1-6 and for Barnsley this again may represent a defund of around £300k, but guidance is yet to be issued to confirm if NHSEI are likely to clawback underutilised funding relating to this period..</p> <p>The CCG is working with PCN to claim full value available to Barnsley in relation to the additional roles reimbursement and covid vaccination programme.</p> <p>The Chief Finance Officer advised that she provide a full update regarding the prescribing QIPP to the next meeting of the Governing Body on 11 March 2021.</p> <p>In terms of CHC (Continuing Health Care) pressures continue and the Governing Body is to further consider a</p>		

Agenda Item		Action	Deadline
	<p>CHC assurance report at the Governing Body Development Session on 28 January 2021 to assess the position further.</p> <p>Other efficiencies identified during the planning process are unlikely to deliver and will be met through underspends in budgets. It is therefore expected that this will not cause significant risk to the CCG.</p> <p>The Governing Body noted the Covid-19 Finance Update and available £502k to manage any further costs associated with responding to the pandemic. The CCG Senior Management Team will receive a report re Covid funding including pulse oximetry and release of funding to Primary Care to support the vaccination Programme on 22 January 2021.</p> <p>Dr John Harban queried the replacement of Primary Care laptops which were reassigned to the vaccination centres. It was clarified that new laptops have been ordered for Primary Care to replace the laptops diverted to the vaccination centres. The Chief Operating Officer commented that a balanced view was taken as to how best to use the stock of laptops in Primary Care before reassigning spare laptops to the vaccination centres. Some Practices had not fully deployed their laptops. Stocks of laptops will be further reviewed and deployed as appropriate to maintain services.</p> <p><b>Agreed Action</b>  <b>To review stocks of laptops in Primary Care and deploy as appropriate to ensure services are maintained.</b></p> <p><b>Dr Jamie MacInnes left the meeting (11.56 am)</b></p>	JW	
	<p><b>Performance</b></p> <p>The Chief Operating Officer provided the Governing Body with an overview of the key exceptions to performance indicators. The information provided continued to show the adverse impact of Covid-19 upon delivery of some constitutional standards.</p> <p>Pressures across planned care remain, there had been some improvement but the position is now starting to deteriorate and impacting on referral to treatment times and</p>		

Agenda Item		Action	Deadline
	<p>waiting times for diagnostic waits. Hospitals can only now provide treatment to priority 1 and priority 2 patients.</p> <p>The Secondary Care Clinician referred to cancer waits and commented that from the Cancer Assurance Report received earlier in the meeting, a number of waits related to patient choice, waits for Covid vaccinations or Covid rates to drop rather than lack of capacity at the Hospital.</p> <p>The Chairman concluded the discussion, advising that during the national Covid pandemic crisis local services had coped extremely well. Some people can be anxious about accessing health services during the Covid pandemic.</p>		
	<p><b>The Governing Body noted the contents of the report including:</b></p> <ul style="list-style-type: none"> <li>• <b>Performance to date 2020/21</b></li> <li>• <b>Finance update to Month 8</b></li> </ul>		
<b>COMMITTEE REPORTS AND MINUTES</b>			
<b>GB/Pu 21/01/21</b>	<b>COMMITTEE REPORTS AND MINUTES</b>		
	<p>The Governing Body received and noted the following Committee minutes &amp; assurance reports:</p> <ul style="list-style-type: none"> <li>• Minutes of the Finance and Performance Committee held on 5 November 2020, and 3 December 2020.</li> <li>• Assurance Report from the Primary Care Commissioning held on 26 November 2021.</li> </ul> <p>The Lay Member for Patient and Public Engagement &amp; Primary Care Commissioning informed the Governing Body that James Barker, Chief Executive of the Barnsley Healthcare Federation had given a presentation to the Primary Care Commissioning Committee on the work of the Federation during the Covid Pandemic. A summary of this presentation had also been received by the Patient Council. He further commented that there is an open invitation for members for the public including young adults to join meetings of the Patient Council.</p> <p><b>At this point, the Chairman lost connection to the meeting. The Vice Chair, Lay Member for Patient and</b></p>		

Agenda Item		Action	Deadline
	<p><b>Public Engagement &amp; Primary Care Commissioning chaired the meeting.</b></p> <ul style="list-style-type: none"> <li>Minutes of the Quality and Patient Safety Committee held on 22 October 2020</li> <li>Assurance Report from the Equality and Engagement Committee held on 19 November 2020</li> </ul> <p>The Lay Member for Patient and Public Engagement &amp; Primary Care Commissioning extended his personal appreciation to the Head of Communications and Engagement and Engagement Manager for the CCG's achievement of a green star rating compliance against the NHS Oversight Framework Patient and Community Engagement Indicator for the third year running. The green star rating is the highest rating possible for the oversight framework.</p>		
<p><b>GB/Pu 21/01/22</b></p>	<p><b>REPORTS CIRCULATED IN ADVANCE FOR NOTING</b></p>		
	<p>The Governing Body noted the reports circulated in advance of the meeting:</p> <p>From the SYB Health Executive Group held on 10 November 2020</p> <ul style="list-style-type: none"> <li>SYB ICS CEO Report (Enc B)</li> </ul> <p>From the SYB Health Executive Group held on 8 December 2020</p> <ul style="list-style-type: none"> <li>SYB ICS CE Report (Enc B)</li> </ul>		
<p><b>GB/Pu 21/01/23</b></p>	<p><b>REFLECTION ON HOW WELL THE MEETING'S BUSINESS HAS BEEN CONDUCTED</b></p>		
	<p>The Governing Body agreed that all papers were presented in a timely manner, the quality of papers received was good and no other additional assurances are required.</p> <p>The Chief Operating Officer introduced two new members of staff (in attendance at the meeting) Leanne Sparks and Emma Bates (Commissioning and Transformation Managers) to the Governing Body.</p>		

Agenda Item		Action	Deadline
	<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>		
<p><b>GB/Pu 21/01/24</b></p>	<p><b>DATE AND TIME OF THE NEXT MEETING</b></p>		
	<p>Thursday 11 March 2021 at 09.30 am via Microsoft Teams</p>		

UNADOPTED

**GOVERNING BODY  
(Public session)**

**11 March 2021  
MATTERS ARISING REPORT**

The table below provides an update on actions arising from the previous meeting of the Governing Body (public session) held on 14 January 2021

*Table 1*

Minute Ref	Issue	Action	Outcome/Action
GB/Pu 21/01/13	<p><b>INTEGRATED CARE AT BARNESLEY PLACE ASSURANCE REPORT</b></p> <ul style="list-style-type: none"> <li>To submit the refreshed Restoration and Recovery Plan (in light of phase 4 letter) to Governing Body on 11 March 2021</li> </ul>	JB	This will be completed during March 2021. Delayed due to operational pressures.
GB/Pu 21/01/15	<p><b>SUICIDE PREVENTION AND BEREAVEMENT SUPPORT UPDATE</b></p> <p>To develop information for Primary Care detailing available services re Suicide Prevention and Bereavement support services.</p> <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>	<p>PO MS</p> <p>PO MS</p>	Information sent out the practices on 23/2/21. Exploring possibility of putting MH information on single page on BEST site.
GB/Pu 21/01/16	<p><b>QUALITY HIGHLIGHTS REPORT</b></p> <p>To provide assurance Re out of area locked rehabilitation provision for patients to the next meeting of the Governing on 11 March 2021</p>	JHar (JSiv)	Complete – Agenda item for Governing Body meeting on 11 March 2021

<b>GB/Pu 21/01/18</b>	<b>RISK AND GOVERNANCE EXCEPTION REPORT</b>  To review risk reference Covid risk 3 'Flu Season 20/21	JW	Complete – Risk reviewed and adjusted score recommended by Finance and Performance Committee – See Risk Register Report
<b>GB/Pu 21/01/20</b>	<b>INTEGRATED PERFORMANCE REPORT</b>  To review stocks of laptops in Primary Care and deploy as appropriate to ensure services are maintained.	JW	Complete - Additional IT equipment including laptops have been ordered for GPIT

### 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*

<b>Minute Ref</b>	<b>Issue</b>	<b>Action</b>	<b>Outcome/Actions</b>
<b>GB 19/11/03</b>	<b>PATIENT STORY - YOUNG COMMISSIONERS, OASIS</b>  To consider how the voice of the young commissioners can be involved with the work of the CCG and Health and Wellbeing Board.	<b>NB</b>	<b>IN PROGRESS</b> - Under consideration  Patient Council Member; considering introductions via her contacts.
<b>GB/Pu 20/11/10</b>	<b>COVID-19 RESPONSE AND PHASE 3 RECOVERY UPDATE</b>  To provide feedback on the Recovery and Reset Plan to The Director of Strategic Commissioning and Partnerships	<b>ALL</b>	<b>Complete</b>

**GOVERNING BODY  
Public Session**

**11 March 2021**

**REPORT OF THE CHIEF OFFICER**

**PART 1A – SUMMARY REPORT**

<b>1.</b>	<b>THIS PAPER IS FOR</b>										
	<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"/>				
<b>2.</b>	<b>PURPOSE</b>										
	This report provides the Governing Body with the information regarding the Government White Paper: Working together to improve health and social care for all and NHSEI letter to General Practice Re 'Freeing up practices to support COVID vaccination' letter.										
<b>3.</b>	<b>REPORT OF</b>										
		<b>Name</b>	<b>Designation</b>								
	Executive / Clinical Lead	Chris Edwards	Chief Officer								
	Author	Chris Edwards	Chief Officer								
<b>4.</b>	<b>SUMMARY OF PREVIOUS GOVERNANCE</b>										
	The matters raised in this paper have been subject to prior consideration in the following forums:										
	<b>Group / Committee</b>	<b>Date</b>	<b>Outcome</b>								
	Primary Care Commissioning Committee - Re Freeing up practices to support COVID vaccination'	21.01.21	Approved								
	Management Team - Re Government White Paper	12.02.21	Noted								
<b>5.</b>	<b>EXECUTIVE SUMMARY</b>										
	<p><b>Government White Paper: Working together to improve health and social care for all</b></p> <p>The consultation time frame for the new proposals Integrating Care: Next Steps to Building Strong &amp; Effective Integrated Care Systems Across England closed on Friday 8 January 2021.</p>										

	<p>The Government White Paper (appendix A): Working together to improve health and social care for all was subsequently published on 11 February 2021 followed by Legislating for Integrated Care Systems: five recommendations to Government and Parliament (appendix B).</p> <p>Also attached for further information is:</p> <ul style="list-style-type: none"> <li>• Letter from NHSEI re Integrating Care Next Steps (appendix C)</li> <li>• Frequently asked questions (FAQs) on NHS England and NHS Improvement’s legislative recommendations on ICSs (appendix D)</li> </ul> <p><b>Letter to General Practice re ‘Freeing up practices to support COVID vaccination’ letter’</b></p> <p>On the 9 November 2020 NHSE/I wrote to all CCGs and GPs setting out details of a new General Practice Covid Capacity Expansion Fund. In particular supporting the delivery of the C-19 vaccination model. In Barnsley the allocation equates to £716,000. The Primary Care Commissioning Committee in private session on 21 January 2021 approved payments to Practices from the General Practice Covid Capacity Expansion Fund to support GP Practices to:</p> <ul style="list-style-type: none"> <li>• Contribute to the 7 priority goals set out in the letter and specifically the monitoring and support of oximetry patients and identification of Long Covid patients and referral for support.</li> <li>• Contribute to the current delivery model for COVID Vaccination by supporting the PCN Local Vaccination Service Sites, through booking and contribution of workforce.</li> <li>• Support the delivery of COVID Vaccination at practice level for Care Home residents and staff and for housebound patients.</li> <li>• Support the delivery of COVID Vaccination at practice level through local clinics as this becomes possible through guidance and vaccine availability and supply.</li> </ul>
<p><b>6.</b></p>	<p><b>THE GOVERNING BODY IS ASKED TO:</b></p>
	<ul style="list-style-type: none"> <li>• Note the Report</li> </ul>
<p><b>7.</b></p>	<p><b>APPENDICES / LINKS TO FURTHER INFORMATION</b></p>
	<ul style="list-style-type: none"> <li>• Appendix A – Government White Paper: Working together to improve health and social care for all</li> <li>• Appendix B - Legislating for Integrated Care Systems: five recommendations to Government and Parliament</li> <li>• Appendix C – Letter from NHSEI Integrating Care Next Steps</li> <li>• Appendix D - FAQs on NHS England and NHS Improvement’s legislative recommendations on ICSs</li> <li>• Appendix E – Letter to General Practice re ‘Freeing up practices to support COVID vaccination’ letter’.</li> </ul>

<p><b>Agenda time allocation for report:</b></p>	<p><i>10 minutes</i></p>
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**PART 1B – SUPPORTING INFORMATION & ASSURANCE**

<b>1.</b>	<b>Links to Corporate Priorities, GBAF and Risk Register</b>		
	This report provides assurance against the following corporate priorities on the Governing Body Assurance Framework		
	1.1 Urgent & Emergency Care		6.1 Efficiency Plans
	2.1 Primary Care	✓	7.1 Transforming Care for people with LD
	3.1 Cancer		8.1 Maternity
	4.1 Mental Health		9.1 Digital and Technology
	5.1 Integrated Care @ System		10.1 Compliance with statutory duties
	5.2 Integrated Care @ Place		11.1 Delivery of Enhanced Health in Care Homes
	The report also provides assurance against the following red or amber risks on the Corporate Risk Register:		N/A
<b>2.</b>	<b>Links to statutory duties</b>		
	This report has been prepared with regard to the following CCG statutory duties set out in Chapter A2 of the NHS Act (place ✓ beside all that are relevant):		
	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)	✓	Public involvement and consultation (s14Z2) See 3.6
<b>3.</b>	<b>Governance Considerations Checklist</b> ( <i>these will be especially relevant where a proposal or policy is brought for decision or approval</i> )		
<b>3.1</b>	<b>Clinical Leadership</b>		
	Have GB GPs and / or other appropriate clinicians provided input and leadership?		NA
<b>3.2</b>	<b>Management of Conflicts of Interest (s14O)</b>		
	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
<b>3.3</b>	<b>Discharging functions effectively, efficiently, &amp; economically (s14Q)</b>		
	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	<b>Improving quality (s14R, s14S)</b>	
	Has a Quality Impact Assessment (QIA) been completed if relevant?	<b>NA</b>
	Have any issues or risks identified been appropriately addressed having taken advice from the Chief Nurse (or Deputy) if appropriate?	<b>NA</b>
3.5	<b>Reducing inequalities (s14T)</b>	
	Has an Equality Impact Assessment (EIA) been completed if relevant?	<b>NA</b>
	Have any issues or risks identified been appropriately addressed having taken advice from Equality Diversity & Inclusion Lead if appropriate?	<b>NA</b>
3.6	<b>Public Involvement &amp; Consultation (s14Z2)</b>	
	Has a s14Z2: Patient and Public Participation Form been completed if relevant?	<b>NA</b>
	Have any issues or risks identified been appropriately addressed having taken advice from the Head of Comms & Engagement if appropriate?	<b>NA</b>
3.7	<b>Data Protection and Data Security</b>	
	Has a Data Protection Impact Assessment (DPIA) been completed if relevant?	<b>NA</b>
	Have any issues or risks identified been appropriately addressed having taken advice from the SIRO, IG Lead and / or DPO if appropriate?	<b>NA</b>
3.8	<b>Procurement considerations</b>	
	Have any issues or risks identified been appropriately addressed having taken advice from the procurement Shared Service if appropriate?	<b>NA</b>
	Has a Single Tender Waiver form been completed if appropriate?	<b>NA</b>
	Has a Primary Care Procurement Checklist been completed where GPs, networks or Federations may be a bidder for a procurement opportunity?	<b>NA</b>
3.9	<b>Human Resources</b>	
	Have any significant HR implications been identified and managed appropriately, having taken advice from the HR Lead if appropriate?	<b>NA</b>
3.10	<b>Environmental Sustainability</b>	
	Have any significant (positive or negative) impacts on the environment or the CCG's carbon footprint been identified?	<b>NA</b>



Department  
of Health &  
Social Care

# **Integration and Innovation: working together to improve health and social care for all**

Published 11 February 2021

**The Department of Health and Social Care's legislative proposals for a Health and Care Bill**





# **Integration and Innovation: working together to improve health and social care for all**

Presented to Parliament  
by the Secretary of State for Health and Social Care  
by Command of Her Majesty

February 2021



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# Foreword

We are living through the greatest challenge our health and care system has ever faced. Yet even in crisis conditions, everyone working in our health and care system has continued to deliver excellence. Critically, collaboration across health and social care has accelerated at a pace showing what we can do when we work together, flexibly, adopting new technology focused on the needs of the patient, and set aside bureaucratic rules.

This paper sets out our legislative proposals for a Health and Care Bill. It aims to build on the incredible collaborations we have seen through Covid and shape a system that's better able to serve people in a fast-changing world.

At its heart, however, this Bill is about backing our health and care system and everyone who works in it. Our proposals build on the NHS's own – those in the Long Term Plan. We're also outlining steps to support everyone who works to meet people's health and care needs. Taken together, they will help us build back better after Covid.

First, by removing the barriers that stop the system from being truly integrated. We want to help Integrated Care Systems play a greater role, delivering the best possible care, with different parts of the NHS joining up better; and the NHS and local government forming dynamic partnerships to address some of society's most complex health problems. It will help us deliver our Manifesto Commitments, including 50,000 more nurses and 40 new hospitals.

Second, we will use legislation to remove much of the transactional bureaucracy that has made sensible decision-making harder. The reforms will help enable us to use technology in a modern way, establishing technology as a better platform to support staff and patient care. Our proposals will maintain the distinct responsibilities between those who fund services and those who provide care—which has been a cornerstone of efforts to ensure the best value for taxpayers for over thirty years—but sets out a more joined-up approach built on collaborative relationships, so that more strategic decisions can be taken to shape health and care for the decades to come. It's about population health: using the collective resources of the local system, NHS, local authorities, the voluntary sector and others to improve the health of local areas.

Finally, our proposals will ensure a system that is more accountable and responsive to the people that work in it and the people that use it. Ministers have always been accountable, rightly, for NHS performance. Our proposals will ensure NHS England, in a new combined form, is accountable to Government and the taxpayers that use it while maintaining its clinical and day-to-day operational independence. We will introduce measures to enhance quality and safety in the NHS, including the creation of an independent statutory body to oversee safety investigations. Alongside this we will work with Local Authorities to develop enhanced assurance frameworks for social care, that will support improved outcomes and experiences for people and their families.

These legislative measures are intended to support improvements already under way in the NHS. They should be seen in the context of those broader reforms. And they are by no means the full extent of this government's ambition for the nation's health. We will also bring forward changes in social care, public health and mental health. We also remain

committed to the sustainable improvement of adult social care and will bring forward proposals this year. The targeted public health interventions we have outlined here in relation to obesity and fluoridation, sit alongside our proposals for the future design of the public health system, including the creation of the National Institute for Health Protection (NIHP). We are also bringing forward legislation to bring the Mental Health Act up to date, as set out in our White Paper last month.

As we build back better after Covid-19, these proposals can help us look to the decades ahead with confidence. This is a unique moment when we must continue to build on the audacious legacy that makes the NHS the very best of Britain. We must seize it.

# 1. Executive Summary

- 1.1 We are living through the greatest challenge our health and care system has ever faced. The Coronavirus (Covid-19) pandemic caused an unprecedented external shock, bringing intense pressure that could have been devastating to the system itself and to all of us as individuals. And yet, the extraordinary dedication, care and skill of the people who work in our communities and our hospitals has been unwavering, serving as a reminder once again of just how precious our health and care services are to us all.
- 1.2 This is no ordinary moment. We have seen collaboration across health and social care at a pace and scale unimaginable even a little over a year ago. The NHS and social care providers have delivered outstanding care to those in need while at the same time radically changing ways of working, reducing bureaucracy and becoming more integrated. New teams have been built, adoption of new technology has been accelerated, new working-cultures developed, and new approaches to solving difficult problems pursued. As a result, NHS capacity grew; new hospitals were built in just a matter of days; and new ways of treating patients have become the norm. As we look towards the future and to the recovery of our society, our health and care system will continue to be central to our national wellbeing and prosperity in the years ahead.
- 1.3 In recent years, we have seen our health and care system adapt and evolve to meet the challenges facing health systems around the world. Not only is our population growing in size, people are also living longer but suffering from more long-term conditions. One in three patients admitted to hospital as an emergency has five or more health conditions, up from one in ten a decade ago. While smoking rates may be decreasing; diabetes, obesity, dementia and mental health issues are on the rise. Faced with these challenges, as well as those from Covid-19, the case couldn't be clearer for joining up and integrating care around people rather than around institutional silos – care that focuses not just on treating particular conditions, but also on lifestyles, on healthy behaviours, prevention and helping people live more independent lives for longer. We need the different parts of our health and care system to work together to provide high quality health and care, so that we live longer, healthier, active and more independent lives.
- 1.4 And so, this paper sets out our legislative proposals for a Health and Care Bill. Many of the proposals build on the NHS's recommendations in its [Long Term Plan](#), but they are also founded in the challenge outlined above. There will be those who will say that this is simply the wrong time to make any kind of change in health and social care. Even if it will help the professionals who know best to do their jobs better, unhindered by systems and processes that might slow down or even prevent them from doing their jobs in the way they would want to. The

response to Covid-19 is our current priority but we must also prepare for the recovery of our health and care system and learn lessons from this experience. Our legislative proposals capture the learning from the pandemic and are driven by the context of a post-Covid world, which is now in reach. And they make permanent the innovations that Covid-19 has accelerated and encouraged the system to improvise new and better ways of working. Our proposals will help the NHS and local government in the immediate work of recovery from the pandemic by making joint planning and delivery of services easier, and over the long term by helping to address the needs of everyone, from children to older people, at different stages of their lives.

- 1.5 We have seen the brilliance of our doctors, nurses, carers and other healthcare professionals in providing world-class care to those in need. What has gone unseen by many is that in order to provide this level of care the traditional dividing lines between health professionals have been cast aside to allow unprecedented levels of collaboration.
- 1.6 If we are to improve the lives and life-chances of all in this country, no matter where they are from, their ethnicity or social background we must be ready for whatever may come next.
- 1.7 The response to Covid-19 - led by those who know best - has shown us new ways to deliver care using innovative and creative solutions, exploiting the potential of digital and data, instead of needless bureaucracy. We must not go back to the old ways of working. The gains made through these new approaches must be locked in.
- 1.8 The founding principles of the NHS – taxpayer-funded healthcare available to all, cradle-to-grave, and free at the point of delivery – remain as relevant now as they were in 1948. Local government delivery is also rooted in firm foundations: in serving its residents, with strong local democratic accountability, and expertise in the health, public health and care needs of its populations. To protect these principles, which are so close to all our hearts, we must back those who make them a reality every day of their lives - by building and constantly renewing a culture of collaboration.
- 1.9 Integrating care has meant more people are seeing the benefits of joined up care between GPs, home care and care homes, community health services, hospitals and mental health services. For staff, it has enabled them to work outside of organisational silos, deliver more user-centred and personalised approaches to care, and tackle bureaucracy standing in the way of providing the best care for people. It enables greater ambition on tackling health inequalities and the wider determinants of health – issues which no one part of the system can address alone. It both relies on the power of digital and data to join up care and uses that

power to drive transformation of care. The experience of the pandemic has made the case for integrated care even stronger and has redoubled the government's determination to ensure that public health, social care and healthcare work more closely together in the future than ever before.

- 1.10 High-performing teams and organisations have vibrant cultures that create the conditions for people to perform at their very best. They are collaborative and open organisations, people focussed with processes that support rather than suffocate the efforts of individuals to do good work. And so, this White Paper sets out our proposals for legislation to support and enable the health and care workforce, organisations and wider system to work together to improve, integrate and innovate.
- 1.11 In this paper we refer to health and care partners for brevity's sake, but to be clear, we believe that this means everyone who works tirelessly to deliver high-quality care and support to people all over the country, including NHS organisations, local authorities, voluntary partners and charities.

## **Working together to integrate care**

- 1.12 At the heart of the changes being taken forward by the NHS and its partners, and at the heart of our legislative proposals, is the goal of joined up care for everyone in England. Instead of working independently every part of the NHS, public health and social care system should continue to seek out ways to connect, communicate and collaborate so that the health and care needs of people are met. Healthy, fulfilled, independent and longer lives for the people of England will require health and care services, local government, NHS bodies, and others to work ever more closely together. Different professions, organisations, services and sectors will work with common purpose and in partnership. This will be especially important when we seek to focus on the people and communities that are most in need of support.
- 1.13 There are, then, two forms of integration which will be underpinned by the legislation: integration within the NHS to remove some of the cumbersome boundaries to collaboration and to make working together an organising principle; and greater collaboration between the NHS and local government, as well as wider delivery partners, to deliver improved outcomes to health and wellbeing for local people.
- 1.14 The NHS and local authorities will be given a duty to collaborate with each other. We will also bring forward measures for statutory Integrated Care Systems (ICSs). These will be comprised of an ICS Health and Care Partnership, bringing together the NHS, local government and partners, and an ICS NHS Body. The ICS NHS

body will be responsible for the day to day running of the ICS, while the ICS Health and Care Partnership will bring together systems to support integration and develop a plan to address the systems' health, public health, and social care needs. Both bodies will need to draw on the experience and expertise of front-line staff across health and social care. The legislation will aim to avoid a one-size-fits-all approach but enable flexibility for local areas to determine the best system arrangements for them. A key responsibility for these systems will be to support place-based joint working between the NHS, local government, community health services, and other partners such as the voluntary and community sector. Frequently, place level commissioning within an integrated care system will align geographically to a local authority boundary, and the Better Care Fund (BCF) plan will provide a tool for agreeing priorities. This will be further supported by other measures including improvements in data sharing and enshrining a 'triple aim' for NHS organisations to support better health and wellbeing for everyone, better quality of health services for all, and sustainable use of NHS resources.

## **Reducing bureaucracy**

- 1.15 Stakeholders have said that existing legislation is overly detailed and prescriptive in some areas. We intend to reform the existing legislation to support the workforce by creating the flexibility NHS organisations need – to remove the barriers that prevent them from working together and to enable them to arrange services and provide joined up care in the interests of service users. We will put pragmatism at the heart of the system. Enabling the NHS and local authorities to arrange healthcare services to meet current and future challenges by ensuring that public and taxpayer value – and joined up care – are first and foremost. This will require changes to both competition law as it was applied to the NHS in the Health and Social Care Act 2012 and the system of procurement applied to the NHS by that legislation. These changes will enable the NHS and local authorities to avoid needless bureaucracy in arranging healthcare services while retaining core duties to ensure quality and value. This will be supported by further pragmatic reforms to the tariff and to remove the statutory requirement for Local Education and Training Boards.

## **Improving accountability and enhancing public confidence**

- 1.16 We are also bringing forward several measures to improve accountability in the system in a way that will empower organisations and give the public the confidence that they are receiving the best care from their health and care system, every time they interact with it. The de facto development in recent years of a strongly supportive national NHS body in the form of a merged NHS England and NHS Improvement will be placed on a statutory footing and will be designated as

NHS England. This will be complemented by enhanced powers of direction for the government over the newly merged body which will support great collaboration, information sharing and aligned responsibility and accountability. In addition, we will legislate to further ensure the NHS is able to respond to changes and external challenges with agility as needed. Measures will include reforms to the mandate to NHS England to allow for more flexibility of timing; the power to transfer functions between Arm's Length Bodies and the removal of time limits on Special Health Authorities. An improved level of accountability will also be introduced within social care, with a new assurance framework allowing greater oversight of local authority delivery of care, and improved data collection allowing us to better understand capacity and risk in the social care system. Our measures recognise this, and we therefore plan to introduce greater clarity in the responsibility for workforce planning and a clear line of accountability for service reconfigurations with a power for ministers to determine service reconfigurations earlier in the process than is presently possible.

## **Additional measures**

- 1.17 We also intend to bring forward other measures to support social care, public health and the NHS. These are designed to address specific problems or remove barriers to delivery, maximise opportunities for improvement, and have in most cases been informed by the experience of the pandemic.
- 1.18 These measures are not intended to address all the challenges faced by the health and social care system. The government is undertaking broader reforms to social care and public health which will support the system in helping people to live healthier, more independent lives for longer. In particular, the Department recognises the significant pressures faced by the social care sector and remains committed to reform. We want to ensure that every person receives the care they need and that it is provided with the dignity they deserve. We have committed to bringing forward proposals this year but, in the meantime, our legislative proposals will embed rapid improvements made to the system as it has adapted to challenges arising from Covid-19. Similarly, on public health, our experience of the pandemic underlines the importance of a population health approach, informed by insights from data: preventing disease, protecting people from threats to health, and supporting individuals and communities to improve their health and resilience. The government will publish in due course an update on proposals for the future design of the public health system, which will create strong foundations for the whole system to function at its best. But the measures in this legislation will address issues that require intervention through primary legislation.
- 1.19 In social care, we have set out a number of measures that apply the core themes of these proposals set out above in the specific context of social care. Integration

will be enhanced through the position of social care in the ICS structure, a new standalone legal basis for the Better Care Fund and allowing 'Discharge to Assess' models to be followed. A legal power to make direct payments to providers will reduce bureaucracy in providing future additional support to the sector. Finally, an enhanced assurance framework and improved data collection will improve accountability within the social care sector.

- 1.20 For public health, alongside the population health element of our "triple aim", we intend to bring forward measures to: make it easier to secure rapid change updates in NHS England public health functions; help tackle obesity by introducing further restrictions on the advertising of high fat, salt and sugar foods; as well as a new power for Ministers to alter certain food labelling requirements. In addition, we will be streamlining the process for the fluoridation of water in England by moving responsibilities for doing so from local authorities to central government.
- 1.21 Finally, we plan to bring forward measures that contribute to improved quality and safety in the NHS, including placing the Health Services Safety Investigations Body on a statutory footing; establishing a statutory medical examiners system; and allowing the Medicines and Healthcare products Regulatory Agency to set up national medicines registries. We are also putting in place legislation to enable the implementation of comprehensive reciprocal healthcare agreements with countries around the world.

## **Next steps**

- 1.22 As we set out in chapter one, legislation is best seen as an enabler of change that is most effective when combined with other reforms and drivers of change within the health and care system. We have seen the NHS adapt in recent years, developing innovations to support more joined up care and to tackle bureaucracy. This provides a foundation to build upon and our aim is to use legislation to provide a supportive framework for health and care organisations to continue to pursue integrated care and other sources of value for service users and taxpayers in a pragmatic manner. As the system emerges from the pandemic, these legislative measures will assist with recovery by bringing organisations together, removing the bureaucratic and legislative barriers between them and enabling the changes and innovations they need to make.
- 1.23 On current timeframes, and subject to Parliamentary business, our plan is that the legislative proposals for health and care reform outlined in this paper will begin to be implemented in 2022. This means they will form a critical part of the recovery process from the pandemic, and so we must ensure that our approach is enabling and flexible. Many of the lessons of the pandemic are clear, but it will take time to fully understand them all. We need to combine the realism required in recognising

we do not know all the answers with the urgency of working to successfully apply the insights we do have as soon as possible. Legislation can only ever be part of the picture, and will need to support and accompany wider reforms in areas such as data and finance, which will play a key role in the years ahead to meet the changing needs of the population, to deal with the challenges caused by the pandemic, and to tackle the health inequalities exposed by Covid-19.

## 2. The role of legislation

- 2.1 In a typical 24-hour period, the NHS in England will see 1 million patients in GP appointments and carry out over 26,000 operations. In the social care system, local authorities are supporting almost 150,000 older people and over 40,000 young people in care homes as well as over 440,000 people in the community. Councils received 1.9m requests for adult social care support in 2019/20 – equivalent to 5,290 requests for support per day. Behind those numbers there are many stories of hope, vulnerability, care and healing; and of health and care services that have empowered and helped people to live fulfilling lives. These stories are the work of the dedicated staff who make our NHS and our care system what it is, and the real experiences of the people behind the statistics.
- 2.2 How many of those health and care staff on that typical day consult, discuss or even think about the legal framework the health and care system operates within? Or how many people are aware of the patchwork of legislation that applies to the NHS and social care system? Hardly any, of course, and there is no reason why they should. The legal framework for the health and care system should be like any operating system – the sort of thing you tend not to notice when it is working well.
- 2.3 It is, however, clear that some elements of the current legal framework need to be improved. The lessons from the pandemic cannot and should not be ignored, we need the right legislative framework to support the recovery by improving outcomes, reducing health inequalities and making best use of limited resources. Society's health and care needs are changing. People are living longer; over the next 20 years the population in England is expected to grow by almost 10%, with the number of people aged 75+ expected to grow by almost 60% - an additional 2.7 million people. New medicines and technologies are being discovered, and more of us are living with long-term conditions such as diabetes or asthma. The proportion of people aged 65+ with four or more diseases is set to almost double by 2035, with around a third of these people having a mental health problem. Covid-19 has exacerbated these trends. Our health and care system will continue to adapt and evolve, as it always has, to meet the challenges of the future and recover from the pandemic. As such, the legislative framework needs to recognise these increasingly complex needs, provide flexibility and support for the health and care system, and ultimately act as a key enabler to support and sustain the process.

**Some of the challenges we face**

- **NHS activity has grown every year since records began** (at an average of 3.3% a year). Over the last 9 years (between 2009/10 and 2018/19) the number of attendances in A&E increased by 4.3 million; the number of GP appointments have risen from 222 million in 1995 to 308 million in 2018/19; and the number of outpatient attendances has increased by almost 36 million since 2009/10.
- **Social care too has seen activity grow.** In 2019/20, there were 1.9 million requests for adult social care support from new clients, an increase of 6% since 2015/16.
- **A growing and ageing population.** Over the next 20 years the population in England is expected to grow by almost 10%. The number of people aged 75+ is expected to grow by almost 60% - an additional 2.7 million people.
- **Growing morbidity and complexity of disease.** Around 20% of our lives are spent in poor health, which has been increasing in recent years and is likely to continue in future. The proportion of people aged 65+ with four or more diseases is set to almost double by 2035, with around a third of these people having a mental health problem.
- **Medical care advancements and technological innovations.** As medical care advances there are more treatments available and more conditions can be treated.
- **Covid-19.** Covid will continue to cause innumerable short, medium and long-term effects to healthcare in the UK and has shone a spotlight on inequalities.

## Achievements

- **Improvements in health outcomes.** Life expectancy at birth in the UK is above the OECD average at 81.4. Death rates from cardiovascular disease have fallen by 60% since 1990 in England, compared to c.50% in the OECD. The UK has the 4th lowest adult diabetes prevalence rate amongst OECD countries.
- **Quality of care improvements.** As of 2020, around 94% of GP practices rated good or outstanding by the Care Quality Commission (CQC), around 82% for NHS mental health core services and 85% of adult social care providers.
- **Safety.** The UK is recognised internationally as a world-leader in driving the patient safety agenda in healthcare.
- **Covid-19 response.** As of 9 February 2021, the UK has vaccinated 12.6 million people. In the early stages of the response, the NHS COVID-19 Data Store was established, which safely brought together accurate, real-time information necessary to inform decisions in response to the current pandemic in England.

- **Building infrastructure for the future.** In October the government announced the creation of 40 hospitals and a further competition for 8 new schemes for competition by 2030.

- 2.4 A great deal of the changes required were captured in the [NHS's recommendations](#) to Government and Parliament for an NHS Bill. These described the legislative changes the NHS needed to help it to deliver the improved outcomes set out in the [NHS Long Term Plan. Both these documents were published with](#) broad support in 2019.
- 2.5 Legislative change can bring real benefits when it helps to remove barriers, provide flexibility and clarify roles. That is precisely what we are seeking to do with these proposals. The measures outlined in this document are designed to make it easier for NHS organisations and their partners to work together to tackle the issues that matter most to the people they serve; to help them move from being 'importers of illness to exporters of health' to quote former Chief Medical Officer Sally Davies<sup>1</sup>. Legislation can help to create the right conditions, but it will be the hard work of the workforce and partners in local places and systems up and down the country that will make the real difference. This does not just apply to legislation for the NHS, and we have sought to develop our legislative proposals with the whole of the health and care system in mind.
- 2.6 A central theme in the NHS's own Long Term Plan is the importance of joint working with colleagues in local government and elsewhere. It is clear that neither the NHS nor local government can address all the challenges facing whole population health on their own. The ambition to reduce inequalities and support people to live longer, healthier and more independent lives will demand bold, joint and cohesive efforts. As well as closer working at a local place and system level, in some cases proportionate national legislative intervention on public health measures must play its part.
- 2.7 We also recognise that the social care system needs reform: this remains a manifesto commitment and the government intends to bring forward separate proposals on social care reform later this year. No one piece of legislation can fix all the challenges facing health and social care – nor should it try – but it will play an important role in meeting the longer-term health and social care challenges we face as a society.
- 2.8 In bringing forward these measures, we are determined to make the changes to legislation the NHS asked for and, given the government's wider responsibilities for public health and social care, we intend to take forward a set of targeted

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<sup>1</sup> Sally C Davies and Jonathan Pearson-Stuttard, *Whose Health Is It, Anyway*, pp7-8.

legislative measures to support social care, public health and safety and quality. These proposals capture the initial learning from the experience of the health and care system in responding to the pandemic and make permanent some of the innovations where Covid-19 has accelerated new and better ways of working. They provide a framework which allows further evolution and will support, harness and sustain the collaboration and integration seen during Covid-19.

- 2.9 Legislation of all kinds needs to be carefully calibrated to make only necessary and proportionate changes. The risk of legislative overreach and of an excessive specification of detail, spelling out the exact conditions under which specific organisations can and cannot work together, can lead to burdensome bureaucracy and confusion for those faced with the task of implementation. As the pandemic has shown, there is a great deal of insight, commitment and innovation in local organisations. We need a legislative framework that builds on the trust we have for those within systems to understand and deliver what their populations need.
- 2.10 Integration is a good example of this: we can legislate to make it easier to integrate care, but it is the hard work of local organisations that make integration a reality. To face the challenges facing the health and care system described above, local authorities, different parts of the NHS – hospitals, primary care, mental health teams and others – and care homes are working together more closely than ever before. In so many areas integration and coordination of services to keep people healthy and out of hospital, is already happening. Even before the pandemic, many local system leaders were seeing huge benefits from joining up across health and local authorities. The NHS and local authorities are working together to make the move from hospital to care settings more seamless for individuals. The NHS and Directors of Public Health are working together to develop more sophisticated approaches to population health management. And local organisations are working together to address the more intractable challenges associated with the wider determinants of health which are best solved when the NHS and local authorities work as a team to support an individual's physical, mental, social and economic needs. It is clear from these examples that the culture of the health and care system is changing and there is a strong recognition across organisations that joined up care and partnership working is critical to ensure better and fairer health for people in England in the years and decades ahead. We will want to engage closely with the system as we develop our implementation plans.

#### The road to better coordination of health and care

- 2014: NHS and local government's national leaders set out a vision of more collaboration in the NHS *Five Year Forward View*

- 2015: 'Vanguards' in 50 areas began to develop and test new models of care
- 2016: NHS and local councils formed Sustainability and Transformation Partnerships covering all of England, to consider local health and care priorities and to plan services together
- 2017: areas refined initial proposals, drawing on conversations with frontline staff, local residents and others in the community
- 2018: some partnerships began to take on more responsibility by becoming 'integrated care systems'
- 2019: NHS Long-Term Plan confirmed that every area will be served by an integrated care system by 2021, with primary and community services funded to do more
- 2020: Building on previous publications for legislative reform, NHS England set out details for how systems will accelerate collaborative ways of working in the future, considering the key components of an effective integrated care system (ICS) and reflecting what a range of local leaders have said about their experiences during the last two years, including the immediate and long-term challenges presented by the Covid-19 pandemic
- 2021: NHS England response to the ICS consultation document and the government brings forward legislative proposals to support integration

2.11 Our proposals will help to create a new framework that builds on the changes already made by the health and care system itself and which will better enable the system to tackle the challenges of the future. Beyond the legislative proposals set out in this document, there are several other ongoing developments and changes to the health and care system – including the development of a data strategy for health and social care, which will capture and build on the lessons of our COVID response and set the direction for data in a post-pandemic system, ensuring that the power of data, used properly, is able to support the transformation of care; financial arrangements to support integration and improvements to public health services – that our proposals are designed to support and to align with. An outward-looking, more connected and integrated health and care system focused on population health, public wellbeing and where technology enabled innovation is possible, and we know it is possible because it is already happening in lots of places. Our proposals are designed to enhance, support, spread and encourage the changes that are already underway to make joined up care a reality for all.

## 3. Our proposals for legislation

- 3.1 Many of the measures we are proposing have been under consideration for some time. In January 2019, the NHS published its [Long Term Plan](#) which set out the priorities for health and care over the next ten years. This plan, developed in partnership with those who know the NHS best – frontline health and social care staff, patients and their families and other experts - suggested targeted legislative proposals that would help to support the implementation of the objectives described in the Long Term Plan.
- 3.2 Following the publication of the Long Term Plan proposals for legislation, the NHS engaged with the public, patients, NHS staff and a broad range of representatives from across the health and social care sectors on possible legislative changes. There were more than 190,000 responses to this engagement exercise and in September 2019, [NHS England published their final recommendations](#). A number of influential organisations and individuals wrote to the government in broad support. These recommendations were supported in a [letter to government](#), including NHS Providers, Unison, the Local Government Association, the Academy of Medical Royal Colleges, National Voices and others.
- 3.3 NHS England’s proposals form the foundation of this Bill. Their recommendations for legislation were designed around three important principles that still stand today: any legislation should solve practical problems; avoid a disruptive top down reorganisation; and have broad consensus within the system. The majority of our proposals either directly implement or build upon NHS England’s recommendations. Where we have built upon NHS England’s proposals this is because we have explored some developments since the original NHS England publication and the experience of Covid-19 suggests there is a case to go further to reach our objective.
- 3.4 In light of this experience of dealing with the pandemic, we have also added some additional proposals in a number of key areas that fall within the broader remit of the Secretary of State for Health and Social Care. These proposals relate to public health, social care and quality and safety matters. These proposals are not intended to add up to a coherent reform package in themselves, rather they represent a specific set of proposals where change to primary legislation is required. But they are intended to complement a much wider package of reforms in social care, public health and mental health. Whilst the majority of these proposals are England only, in some case they would apply to the Devolved Administrations (DAs). We will continue to engage with DAs on all the proposals in this paper. As stated above, it is important that this legislation responds to the NHS’s asks of government, but it is also important that the legislation looks beyond just the NHS, to the whole health and care system, to ensure that

together, the system can deliver improved outcomes for the people who rely on it. Whilst this legislation is not the vehicle for wholesale social care or public health reform, we have sought to use it to address specific problems, where legislative change could be beneficial.

- 3.5 In forming our proposals, we have been able to draw upon the work done by NHS England as part of its Long Term Plan process and upon the insights generated by the extensive engagement that NHS England undertook in formulating its proposals. We have supplemented this with a number of further engagement conversations with stakeholders on both specific issues and on the wider lessons of both the pandemic and the more evolutionary changes experienced by the health and care system in recent years. See Annex C for a list of stakeholders that the Department has been engaging with.
- 3.6 The proposals we have developed can be grouped under the following themes: working together and supporting integration; stripping out needless bureaucracy; enhancing public confidence and accountability; and additional proposals to support social care, public health, and quality and safety. The full detail of these proposals can be found in Annex A. The first three themes directly implement or build on the proposals made by NHS England to government as part of its 2019 engagement exercise on legislative proposals. The final theme includes additional proposals that DHSC consider appropriate to bring forward in this Bill, in light of the experience of the pandemic, and the desire to support the health and care system to recover and reform.

## **Working together and supporting integration**

### **Enabling different parts of the health and care system to work together effectively, in a way that will improve outcomes and address inequalities**

Working together and supporting integration proposals:

1. Integrated Care Systems
2. Duty to Collaborate
3. Triple Aim
4. Foundation Trusts Capital Spend Limits
5. Joint committees

6. Collaborative Commissioning
7. Joint Appointments
8. Patient Choice
9. Data Sharing

- 3.7 Covid-19 has demonstrated the importance of different parts of the health and care system working together in the best interests of the public and patients. This has been something that organisations in the health and care system have been increasingly working towards over the past few years, despite the barriers in legislation which sometimes make it difficult to do so. We propose to implement NHS England's recommendations and legislate to support integration, both within the health service, and between the health service and local government, with its statutory responsibilities for public health and social care.
- 3.8 We want to legislate for **every part of England to be covered by an integrated care system (ICS)**. This builds on the work the system has been doing since the publication of the NHS Long Term Plan, and is in line with NHS England's recommendation in their recent document, formally recognising the need to bring together NHS organisations, local government and wider partners at a system level to deliver more joined up approaches to improving health and care outcomes, coterminous with local authorities.
- 3.9 We intend to establish a statutory ICS in each ICS area. These will be made up of an ICS NHS Body and a separate ICS Health and Care Partnership, bringing together the NHS, local government and partners. The ICS NHS body will be responsible for the day to day running of the ICS, while the ICS Health and Care Partnership will bring together systems to support integration and develop a plan to address the systems' health, public health, and social care needs. Both bodies will need to draw on the experience and expertise of front-line staff across health and social care. ICSs will be accountable for outcomes of the health of the population and we are exploring ways to enhance the role of CQC in reviewing system working
- 3.10 We know from the vanguard ICSs that taking a joined-up, population focused approach means you cannot see the people that services are meant for as just units within the system – their voice and sense of what matters to them becomes really central. That focus won't come through structures alone of course but working with organisations such as Healthwatch there is a real chance to strengthen and assess patient voice at place and system levels, not just as a commentary on services but as a source of genuine co-production.

- 3.11 This will be supported by a broad **duty to collaborate** across the health and care system and a **triple aim duty** on health bodies, including ICSs, as recommended by NHS England. This will require health bodies, including ICSs, to ensure they pursue simultaneously the three aims of better health and wellbeing for everyone, better quality of health services for all individuals, and sustainable use of NHS resources. As an additional safeguard for financial sustainability, we will take a power to impose **capital spending limits on Foundation Trusts**, in line with NHS England’s recommendation. We will implement NHS England’s recommendations to **remove barriers to integration through joint committees, collaborative commissioning approaches and joint appointments**, as well as their recommendation to preserve and strengthen the right to **patient choice** within systems. We will also legislate to ensure more **effective data sharing** across the health and care system, which is critical to effective integration, and will enable the digital transformation of care pathways. Separately set out proposals relating to Adult Social Care also contribute to our ambitions in this area, including reconfirming the legal basis of the Better Care Fund, and changes to the legal functioning of the Better Care Fund, and changes to processes around discharge and assessment.
- 3.12 Further detail on our proposals for integrated care systems is set out at Annex B, encompassing both the legislative and the non-legislative arrangements we intend to put in place. This is one of the most important elements of the legislative proposals, and we have sought to understand the hopes and concerns of a range of stakeholders in framing them. We have been particularly mindful of the importance of places within systems and of the enormous potential for joint working and innovation between local government and health partners that many of the vanguard ICSs have already demonstrated, while also recognising the distinct accountabilities of NHS bodies and local government.

## Reducing bureaucracy

### Turning effective innovations and bureaucracy busting into meaningful improvements for everyone, learning from innovations during Covid-19.

#### Reducing Bureaucracy proposals:

1. Competition
2. Arranging healthcare services
3. National Tariff

#### 4. New Trusts

#### 5. Removing Local Education Training Boards (LETBs)

3.13 In line with NHS England's recommendations, we wish to build greater flexibility into the basis provided by the 2012 legislation, where the current framework fails to enhance and streamline accountability, or necessitates complex or bureaucratic workarounds and makes it difficult for the system to integrate and adapt over time as needed. Covid-19 has presented a unique opportunity and imperative to drive real change in this area, building on the innovation and cultural shift that was already underway in many places. When the pandemic struck, the NHS, the social care sector and partners were quick to cut through some of the bureaucracy that had accumulated over a number of years. Whether it was in relation to data sharing, flexible workforce deployment, decision making / governance, or integrated delivery; in many parts of the country, system leaders responded swiftly to the challenges of the pandemic. Whilst some of these changes are only appropriate as part of an emergency response, others demonstrated how new ways of working could lead to better outcomes in more normal times. We need to build on the trust that we know we can place on frontline staff and their organisations, to enable them to deliver better outcomes and experiences for people that use health and care services.

#### **Busting Bureaucracy: optimising data requests and data sharing**

The pandemic saw the suspension of certain data collection requests from government and national bodies such as NHS England, NHS Digital and the Care Quality Commission. Where data collection was vital to the pandemic response, existing powers were used to publish notices requiring health and care bodies to share data to help manage and control the spread of Covid-19 within local systems. We will build on this approach and make changes to the regulations governing the sharing of data to enable more effective use of data for the benefit of individuals and the health and care system as a whole.

3.14 The Department of Health and Social Care's paper, [Busting bureaucracy: empowering frontline staff by reducing excess bureaucracy in the health and care system in England](#), sets out the government's strategy for reducing excess bureaucracy. These actions are being taken forward through a variety of different projects, some led by the department, some by regulators and some by other bodies across the health and care system. Whilst we can do a lot to reduce bureaucracy through changing processes and culture, the Department's engagement demonstrated that a lot of bureaucracy is also generated by the legislation which in some places is no longer fit for purpose and we therefore want to use this opportunity to amend legislation to resolve these issues.

3.15 In line with the requests made by the NHS, we will use legislation to remove much of the transactional bureaucracy that has made sensible decision-making in the system harder. The NHS should be **free to make decisions on how it organises itself without the involvement of the Competition and Markets Authority (CMA)**. We will also **reform how health care services are arranged by creating a bespoke health services provider selection regime** that will give commissioners greater flexibility in how they arrange services than at present. The NHS have committed to consulting on the new regime. Where procurement processes can add value they will continue, but that will be a decision that the NHS will be able to make for itself. These changes retain a division of responsibility between strategic planning and funding decisions on the one hand, and care delivery on the other, but allow for its operation in a more joined up way. We will preserve the division between funding decisions and provisions of care. These new flexibilities will be **reinforced by changes to the tariff to enable the tariff to work more flexibly within system approaches**; and giving the Secretary of State the **power to create New Trusts to ensure alignment within an integrated system** where that is helpful. In line with the aim of reducing the need for bureaucratic workarounds, and increasing flexibility and adaptability in the system, the government is also proposing an additional measure not put forward by NHS England in their paper: the **removal of Local Education Training Boards (LETBs) from statute** to give Health Education England (HEE) more flexibility to adapt its regional operating model over time. For social care, we also proposed introducing a new legal power to make payments directly to social care providers to remove barriers in making future payments to the sector.

## Enhancing public confidence and accountability

**Ensuring that we have the right framework for national oversight of our health system, that national bodies are streamlined, with clear roles and responsibilities, and that the public and Parliament can hold decision makers to account**

### Ensuring accountability and public confidence proposals:

1. Merging NHS England, Monitor and the NHS Trust Development Authority and Secretary of State powers of direction
2. The NHS Mandate
3. Reconfigurations intervention power
4. Arm's Length Bodies (ALB) Transfer of Functions

## 5. Removing Special Health Authorities Time Limits

## 6. Workforce Accountability

- 3.16 Both the public and Parliament rightly expect to be able to hold decision makers who oversee the health and care system to account. Our legislative proposals focus on ensuring that our accountability arrangements command public confidence, whilst also enabling systems to get on with doing their jobs and making appropriate changes to enable transformation and innovation. This means ensuring that the framework for national oversight of the NHS is fit for purpose now and into the future.
- 3.17** The original set of national NHS bodies has already altered in form and purpose, and in the proposed legislation, we intend to continue the work already undertaken to **formally bring together NHS England and NHS Improvement into a single legal organisation.**
- 3.18 The public largely see the NHS as a single organisation and as local health systems work more closely together, the same needs to happen at a national level. Recognising the evolution of NHS England, we are **also bringing forward a complementary proposal to ensure the Secretary of State for Health and Social Care has appropriate intervention powers** with respect to relevant functions of NHS England. This will support the Secretary of State, when appropriate, to make structured interventions to set clear direction, support system accountability and agility, and also enable the government to support NHS England to align its work effectively with wider priorities for health and social care. This will serve, in turn, to reinforce the accountability to Parliament of the Secretary of State and government for the NHS and the wider health and care system.
- 3.19 Furthermore, the pandemic has highlighted the need to balance national action with local autonomy. The evolution of the system in recent years has led to greater level of responsibility being held by NHS England and NHS Improvement. As Integrated Care Systems are established, we expect more of that responsibility to be held by ICSs themselves. This will be accompanied by measures to strengthen and clarify the role of government and Parliament. The Department will also have a critical role to play in overseeing the health and care system and in ensuring strong alignment and close working between public health, healthcare and social care.
- 3.20 The Department will support the independence and accountability of ICSs, and the Secretary of State for Health and Social Care will have an important role in ensuring that integration across health, public health and social care is working

effectively within these systems. This will be enabled by a **more flexible mandate for NHS England**, which will make it easier for the Secretary of State to set objectives for the body. In addition, when it comes to significant service change, some Parliamentarians have criticised the current system for a lack of accountability and timely access to decision-making for them and the people they represent. We therefore intend to include a provision to allow the Secretary of State to **intervene in local service reconfiguration changes** where required.

- 3.21 We also intend to **legislate to ensure a more agile and flexible framework for national bodies that can adapt over time**. There are no current plans to change or transfer functions of the bodies in the system (with the exception of the changes we are making to merge NHS England and NHS Improvement, and changes arising from the establishment of the National Institute for Health Protection and related reforms to the public health system). Almost half of respondents agreed to this proposal in NHS England's consultation. The government is proposing additional safeguards, which will enable further scrutiny if this power is used. The government is also proposing to bring forward measures to **remove the 3-year time limit for Special Health Authorities from legislation**. Whilst not specifically considered in NHS England's previous recommendations, it is a measure which will support a more flexible framework for national bodies and remove unnecessary limitations from the legislation.
- 3.22 Set out in more detail below, we also intend to legislate to improve accountability in the social care sector. An enhanced assurance framework will provide a greater level of oversight of the delivery of social care by local authorities. At the same time improved data collection will improve insight into the functioning of the sector.
- 3.23 Finally, we are proposing to introduce a Secretary of State duty to publish a report every Parliament which will support **greater clarity around workforce planning responsibilities**, which reflects the concerns raised by the Royal College of Nursing in response to NHS England's publication and will support the aim of greater clarity in how national bodies operate.

## Additional proposals

### Supporting social care, public health and quality and safety

#### Additional proposals:

##### Social Care

##### 1. Assurance

2. Data
3. Direct payments to providers
4. Discharge to assess
5. A standalone power for the Better Care Fund

#### Public health

6. Public Health power of direction
7. Obesity
8. Fluoridation

#### Safety and Quality

10. Health Services Safety Investigations Body (HSSIB)
11. Professional Regulation
12. Medical Examiners
13. Medicines and Healthcare products Regulatory Agency (MHRA) new national (UK wide) medicines registries
14. Hospital food standards
15. Reciprocal healthcare agreements with Rest of World countries

3.24 We have developed an additional series of targeted proposals which will improve social care, public health and quality and safety. These complement the measures we are putting in place in response to the NHS's requests to government. The proposals are not intended to form a coherent reform package in themselves (as stated above, reforms to social care and public health will be dealt with outside this Bill), but are intended to address specific problems or remove barriers to delivery, maximise opportunities for improvement, and have in some cases been informed by the experience of the pandemic.

- 3.25 On social care: we intend to bring forward proposals to reflect the themes of supporting integration, reducing bureaucracy and improved accountability in a manner that addresses the specific needs of the social care sector. We will bring forward **measures on system assurance and data**, to ensure that there are appropriate levels of oversight on the provision and commissioning of social care; a payment power, which corrects a limitation in existing legislation preventing the Secretary of State for Health and Social Care making **emergency payments directly to all social care providers**; and proposals that provide greater flexibility as to at what point assessments for care can be made. We will also create a **standalone power for the Better Care Fund**, separating it from the NHS mandate setting process.
- 3.26 On public health we will bring forward measures to: make it easier for the Secretary of State to direct NHS England to **take on specific public health functions**; help **tackle obesity by introducing further restrictions on the advertising of high fat, salt and sugar foods**; as well as a new power for ministers to alter certain **food labelling requirements**. This will ensure consumers can be supported to make more informed, healthier choices about their food and drink purchases. In addition, we will be **streamlining the process for the fluoridation of water** in England by moving the responsibilities for doing so, including consultation responsibilities, from local authorities to central government. These public health measures will complement and augment the efforts of ICSs to make real inroads in improving population health in their areas, helping to tackle inequalities and 'level-up' across communities.
- 3.27 On safety and quality: we will bring forward measures to **put the Healthcare Safety Investigation Branch (HSIB) on a statutory footing**; to enable us to **improve the current regulatory landscape for healthcare professionals** as needed; to **establish a statutory medical examiner system** within the NHS for the purpose of scrutinising all deaths which do not involve a coroner and increase transparency for the bereaved, and to **allow the Medicines and Healthcare products Regulatory Agency (MHRA)** to develop and maintain publicly funded and operated medicine registries so that we can provide patients and their prescribers, as well as regulators and the NHS, with the evidence they need to make evidence-based decisions. We will also be bringing forward measures to enable the Secretary of State to **set requirements in relation to hospital food**. And finally, we will take powers to **implement comprehensive reciprocal healthcare agreements with countries outside the EEA and Switzerland** ('Rest of World countries') – expanding our ability to support the health of our citizens when they travel abroad, subject to bilateral agreements.

## 4. Delivering for patients, citizens and local populations - supporting implementation and innovation

- 4.1 This White Paper represents a significant milestone on the journey towards achieving our objective of supporting everyone to live healthier and fulfilling lives for longer.
- 4.2 For people using the NHS regularly, our proposals will support their GP and healthcare specialists to work together to arrange treatment and interventions that either prevent illness or prevent their conditions deteriorating into acute illness. This population health approach will be informed by better data and understanding of local populations, identifying those who are at risk and who we can impact, with a view to designing a more proactive way of planning and delivering care. It will mean that social care providers can receive emergency financial support when needed to prevent instability in care for the most vulnerable people in our communities. For staff working across the NHS, public health and social care, it should mean that there are fewer bureaucratic hurdles to overcome when they are just trying to do their job. It will support hospitals, GPs, local authorities and voluntary partners to work together to plan how they will address the health needs of their populations in the years ahead, including the use of technology, so that over time the people we care for can live healthier lives for longer. And it will ensure that the quality and safety of care continues to improve, through enhanced use of data, with investigations of things that go wrong so mistakes can be learned from.

“But no one recognises more than does the Government, and certainly no one recognises more than I do, that no legislation, however wisely conceived and however efficiently embodied in an Act of Parliament, can ever give the public a great health service unless the people who administer it want to do it and are enthusiastic in doing it” – Aneurin Bevan, [1946](#)

- 4.3 However, bringing forward legislation is only part of the story. Our proposals are designed to support and accelerate positive changes within the system – its adaptability, collaborative instincts and its ability and determination to always find a way. The measure of the success of legislative change will not be the permanent casting of the system in a single form, but instead the acceleration of its ability to learn, adapt and improve. This will also require the use of non-legislative means, including having the right workforce in place; good leadership at all levels, setting out clear guidance; and getting the incentives and financial flows

right. In order to be successful, our proposals will therefore be supported by an implementation programme that recognises the importance of key non-legislative enablers in facilitating change. We will work closely with the health and care system in developing this implementation programme.

- 4.4 This legislation is not intended to address all the challenges faced by the health and social care system. The government is undertaking broader reforms to social care, public health and mental health which will support the system in helping people to live healthier, more independent lives for longer.
- (a) The Department recognises the significant pressures faced by the social care sector and remains committed to reform. We want to ensure that every person receives the care they need and that it is provided with the dignity they deserve. Our objectives for social care reform are to enable an affordable, high quality and sustainable adult social care system that meets people's needs, whilst supporting health and care to join up services around people. We have committed to bringing forward proposals this year but, in the meantime, our legislative proposals will embed rapid improvements made to the system as it has adapted to challenges arising from Covid-19.
  - (b) Our experience of the pandemic underlines the importance of a population health approach: preventing disease, protecting people from threats to health, and supporting individuals and communities to improve their health and resilience. The government will publish in due course an update on proposals for the future design of the public health system, which will create strong foundations for the whole system to function at its best. These changes are driven by learning from the experiences of Covid-19, but more broadly by the need to ensure we have a public health system fully fit for the future. The factors which prevent poor health are shaped by many different parts of government, public services and the broader health system. So rather than containing health improvement expertise within a single organisation, driving change in the future will mean we need many different organisations to have the capability and responsibility for improving health and preventing ill health.
  - (c) In January, the Department of Health and Social Care and the Ministry of Justice published Reforming the Mental Health Act, a White Paper which responds to the Independent Review of the Act, chaired by Professor Sir Simon Wessely in 2018. This forms our plan to modernise mental health legislation. There is a clear case for modernisation and change. The White Paper sets out our proposals for a substantive programme of legislative reform, taking forward the government's commitment to legislate to give people greater control over their treatment, and ensure they are treated with the dignity and respect they deserve. It also takes forward our commitment to

improve how people with a learning disability and autistic people are treated in law and reduce the reliance on specialist inpatient services for these groups. We want everyone to have the opportunity to live a full and rewarding life in their communities and an end to perpetuated detentions without appropriate therapeutic inputs.

- 4.5 These reforms are not included in our legislative proposals but are part of a wider Departmental strategy.
- 4.6 On current timeframes, and subject to Parliamentary business and successful passage, our plan is that these proposals for health and care reform will start to be implemented in 2022. We will continue to engage with stakeholders across the health and care systems, our Arm's Length Bodies and the Devolved Administrations on the detail of these proposals as they progress. We will also continue to work across government to ensure that the right systems and processes are in place that work for all, recognising the interdependencies between health and other social determinants.

## 5. Annex A: Proposals for legislation

### Working together and supporting integration proposals

- 5.1 These proposals are about enabling different parts of the health and care system to work together effectively, in a way that will improve outcomes and address inequalities. The social care measures reflecting this theme are included as part of our additional proposals.

Working together and supporting integration proposals:

1. Establishing Integrated Care Systems
2. Duty to Collaborate
3. Triple Aim
4. Power over Foundation Trusts Capital Spend Limits
5. Joint committees
6. Collaborative Commissioning
7. Joint Appointments
8. Data Sharing
9. Patient Choice

### Establishing Integrated Care Systems (ICSs) in law

- 5.2 Integrated Care Systems (ICSs) have become an increasingly familiar part of the health and care landscape in recent years. Many of the pioneer ICSs have been highly successful in bringing partners together to improve outcomes for the public, often supporting and supplementing arrangements at place level.
- 5.3 Existing ICS arrangements are based on voluntary arrangements, rather than legislative provision, and are therefore dependent on goodwill and mutual co-operation. There are also legislative constraints on the ability of organisations within an ICS to make decisions jointly. While several systems have found ways to establish effective governance models, there are some obstacles and limitations in the current legal framework which inhibit this. For example, there is no legal basis

at present for Clinical Commissioning Groups (CCGs), NHS trusts and Foundation Trusts (FTs) to form a joint committee to which functions may be delegated, with the power to make decisions on behalf of the organisations within the ICS.

- 5.4 In order for ICSs to progress further, legislative change is now required to give ICSs stronger and more streamlined decision-making authority, and to embed accountability for system performance and delivery into the accountability arrangements of the NHS to government and Parliament.
- 5.5 The legislative provisions that we propose for Integrated Care Systems reflect NHS England's recommendations for change following their recent engagement on ICSs, and are designed to provide a small set of consistent requirements for each system that the partners who make up that system can then supplement with further arrangements and agreements that suit them. The role of ICSs in supporting integration both within the NHS and between the NHS and its partners in local authorities along with further detail on the purpose and governance of Integrated Care Systems is set out at Annex B. In this section we set out the core functions of the ICS along with a number of other provisions designed to support integration across the health and care system.
- 5.6 We are proposing to establish statutory ICSs, made up of an ICS NHS Body and an ICS Health and Care Partnership (together referred to as the ICS), to strengthen the decision-making authority of the system leadership and to embed accountability for system performance into the NHS accountability structure. This dual structure recognises that there are two forms of integration which will be underpinned by the legislation: the integration within the NHS to remove some of the cumbersome barriers to collaboration and to make working together across the NHS an organising principle; and the integration between the NHS and others, principally local authorities, to deliver improved outcomes to health and wellbeing for local people.
- 5.7 The ICS NHS Body will be responsible for:
- Developing a plan to meet the health needs of the population within their defined geography;
  - Developing a capital plan for the NHS providers within their health geography;
  - Securing the provision of health services to meet the needs of the system population.
- 5.8 The ICS NHS Body will model merge some of the functions currently being fulfilled by non-statutory STPs/ICSs with the functions of a CCG. We aim to bring the allocative functions of CCGs into the ICS NHS body so that they can sit alongside

the strategic planning function that we would like the ICS to undertake. This will enhance accountability and allow the members of the ICS to develop integrated and innovative approaches to deliver strategic objectives. Our proposals would also, in line with the approach set out by NHS England, allow for the ICS NHS Body to delegate significantly to place level and to provider collaboratives. To support our ambition for ICSs to also address broader health outcomes - including through improving population health and tackling inequalities - each ICS will also be required to establish an ICS Health and Care Partnership, bringing together health, social care, public health (and potentially representatives from the wider public space where appropriate, such as social care providers or housing providers). This body will be responsible for developing a plan that addresses the wider health, public health, and social care needs of the system – the ICS NHS Body and Local Authorities will have to have regard to that plan when making decisions.

- 5.9 In practice, we recognise that ICSs will have to develop effective and legitimate decision-making processes, and we are giving ICS NHS bodies and ICS Health and Care Partnership the flexibility to develop processes and structures which work most effectively for them. We also know that we need to support staff during organisational change by minimising uncertainty and limiting employment changes. We are therefore seeking to provide stability of employment and will work with NHSE and staff representatives to manage this process.
- 5.10 A key responsibility of the ICS will be working in partnership with other local bodies, both within the health and social care system, and more widely. In order to facilitate this, we will make it easier for organisations to work closely together, for example, through our new proposals for joint committees (see below) and existing collaborative commissioning arrangements (such as s.75 of the NHS Act 2006). This joint approach to working will also be supported by the “triple aim duty” (see the proposal below).
- 5.11 The ICS will also have to work closely with local Health and Wellbeing Boards (HWB) as they have the experience as ‘place-based’ planners, and the ICS NHS Body will be required to have regard to the Joint Strategic Needs Assessments (JSNAs) and Joint Health and Wellbeing Strategies that are being produced at HWB level (and vice-versa). ICSs will also want to think about how they can align their allocation functions with place, for example through joint committees, though we are leaving this to local determination. NHS Trusts and Foundation Trusts (FTs) will remain separate statutory bodies with their functions and duties broadly as they are in the current legislation.
- 5.12 The creation of statutory ICS NHS Bodies will also allow NHS England to have an explicit power to set a financial allocation or other financial objectives at a system

level. There will be a duty placed on the ICS NHS Body to meet the system financial objectives which require financial balance to be delivered. NHS providers within the ICS will retain their current organisational financial statutory duties. The ICS NHS Body will not have the power to direct providers, and providers' relationships with the Care Quality Commission will remain unchanged. However, these arrangements will be supplemented by a new duty to compel providers to have regard to the system financial objectives so both providers and ICS NHS Bodies are mutually invested in achieving financial control at system level.

- 5.13 We know there has been excellent progress in some areas in making a reality of integrated care. We also know that this has sometimes been in spite of the systems we ask people to work within, and that it is far from universally true that integration is proceeding in step with the needs and lives of the people we serve. We have therefore – with the help of NHS England's work following the Long Term Plan – identified several further changes to reinforce or enable integration. Details of the NHS's proposals, which we have bolstered with an additional duty to collaborate, are set out below.

## **Duty to collaborate**

- 5.14 Alongside the creation of statutory ICSs, we intend to introduce a new duty to promote collaboration across the healthcare, public health and social care system. Many existing duties on health and care organisations emphasise the role of the individual organisation and its own interests. We want to rebalance these duties to reflect the need for all health and care organisations to work collaboratively. When collaboration works well it leads to better outcomes for people, for example a successful early intervention can lead to people living independently and in their own homes for longer.
- 5.15 This proposal will place a duty to collaborate on NHS organisations (both ICSs and providers) and local authorities. This policy also provides the Secretary of State for Health and Social Care with the ability to issue guidance as to what delivery of this duty means in practice, in recognition of the fact that collaboration may look very different across different kinds of services.
- 5.16 We intend this collaboration proposal to replace two existing duties to cooperate in legislation to support our wider ICS policy, where we expect local authorities and NHS bodies to work together under one system umbrella.

## **Triple Aim**

- 5.17 To further support integration, we propose to implement NHS England's recommendation for a shared duty that requires NHS organisations that plan

services across a system (ICSs) and nationally (NHS England), and NHS providers of care (NHS Trusts and FTs) to have regard to the 'Triple Aim' of better health and wellbeing for everyone, better quality of health services for all individuals, and sustainable use of NHS resources.

- 5.18 This will support NHS bodies to continue a culture of working together in the best interest of not only their immediate service users and organisations, but of the wider population, and for the ICS as a whole, working together strategically and through its 'place'- based constituents. We hope that the Triple Aim will help align NHS bodies around a common set of objectives, thus supporting the shift towards integrated systems which have strong engagement with their communities.

### **Reserve power over Foundation Trusts Capital Spend Limit**

- 5.19 We are also planning to implement NHS England's recommendation for a reserve power to set a capital spending limit on Foundation Trusts, which will support the third aim of the Triple Aim duty, in relation to sustainable use of NHS resources.
- 5.20 Unlike NHS Trusts, which are set annual capital expenditure limits by NHS Improvement, NHS Foundation Trusts (FTs) currently have additional freedoms to borrow from commercial lenders and spend surpluses on capital projects (e.g. new buildings, equipment or IT). However, capital expenditure by FTs still counts towards DHSC's overall Capital Delegated Expenditure Limit (CDEL).
- 5.21 In recent years, given the restraint on capital expenditure and a growing maintenance backlog, the Department of Health and Social Care has had to restrict capital expenditure by Trusts and temporarily delay capital projects to ensure that it does not breach its CDEL limit. A small number of FTs have previously indicated that they could push ahead with their individual schemes and use their own capital, without full consideration of the overall impact on the ICS and on CDEL as a whole. This could mean that at ICS or national level we may have to pause other schemes which may be strategically more beneficial or clinically required. Dialogue is the first line of defence and remediation locally and nationally, but a targeted reserve power is required as a last resort to protect the system and ensure the most sustainable use of NHS resources.
- 5.22 As we embed a new capital regime where Integrated Care Systems (ICS) are allocated a system-wide capital limit, and have duties placed upon them to create a capital plan, we are seeking powers in the Bill to be able to set legally-binding Capital Departmental Expenditure Limits (CDEL) for individual, named Foundation Trusts (FTs), where they are not working effectively to prioritise capital expenditure within their ICS, and risk breaching either system or national CDEL limits.

- 5.23 This is not a general power to direct all FTs on capital spending and is not intended to erode FT autonomy, but it is designed to be used in targeted ways to support the work of ICSs.

## **Joint Committees**

- 5.24 As NHS England set out in their engagement document, legislation does not currently allow NHS providers (NHS trusts and foundation trusts) and CCGs (which will become part of ICSs) to take joint decisions, either through a joint committee or committees-in-common, or for local authorities and other providers of NHS care to be involved in such partnership arrangements. Furthermore, Foundation Trust boards and individual directors have a duty to act with a view to promoting the success of their organisation. This creates an unhelpful barrier to joint working, and commissioners and providers currently have to use workarounds with complex governance arrangements in order to jointly discuss integrated care, incurring legal risk and administrative cost.
- 5.25 Our ICS NHS body provisions go most of the way to increasing the ease with which providers and commissioners could establish joint working arrangements and support the effective implementation of integrated care. We consider, nonetheless, that NHS England's recommendation to allow ICSs and NHS providers to create joint committees would be a useful addition, removing unnecessary barriers to joined-up decision making.
- 5.26 We are therefore proposing to create provisions relating to the formation and governance of these joint committees and the decisions that could be appropriately delegated to them; and separately, allowing NHS providers to form their own joint committees. Both types of joint committees could include representation from other bodies such as primary care networks, GP practices, community health providers, local authorities or the voluntary sector.

## **Collaborative Commissioning**

- 5.27 We want to support the health and care system to work collaboratively and flexibly across different footprints. Many local areas have been exploring ways of working more collaboratively and are seeking to align decisions and pool budgets between CCGs and NHS England, across CCGs, and between CCGs and local authorities (LAs).
- 5.28 Existing NHS legislative mechanisms make it difficult to do this, forcing local systems to adopt complex workarounds to be able to make lawful decisions across a wider population footprint. In practice, these arrangements can be cumbersome, difficult to manage and can slow decision-making processes. We intend to

implement NHS England's recommendation to change the underpinning NHS legislation to remove these barriers and streamline and strengthen the governance for this type of decision-making.

5.29 These proposals will:

- Give NHS England the ability to joint commission its direct commissioning functions with more than one ICS Board, allowing services to be arranged for their combined populations.
- Allow ICSs to enter into collaborative arrangements for the exercise of functions that are delegated to them, enabling a "double-delegation".
- Allow groups of ICSs to use joint and lead commissioner arrangements to make decisions and pool funds across all their functions (and not just commissioning functions).
- Enable a greater range of delegation options for section 7A public health services, including the ability for onward delegation of the function into collaborative arrangements, such as a section 75 partnership arrangement; and
- Enable NHS England to delegate or transfer the commissioning of certain specialised services to ICSs singly or jointly, or for NHS England to jointly commission these services with ICSs if these functions are considered suitable for delegation or joint commissioning subject to certain safeguards. Specialised commissioning policy and service specifications will continue to be led at a national level ensuring patients have equal access to services across the country.

## **Joint Appointments**

5.30 To support closer working between actors in the health and care system, greater clarity is needed to enable joint appointments across different organisations.

5.31 Joint appointments of executive directors can help to foster joint decision making, enhance local leadership and improve the delivery of integrated care. They can also help to reduce management costs and engender a culture of collective responsibility across organisations.

5.32 In line with NHS England's recommendation, we are proposing to introduce a specific power to issue guidance on joint appointments between NHS Bodies; NHS Bodies and local authorities; and NHS Bodies and Combined Authorities. This will aid the development and delivery of integrated care and will ensure that there is a clear set of criteria for organisations to consider when making joint appointments.

- 5.33 NHS England will need to keep the guidance under review, and if substantial changes to it are considered, they will need to consult appropriate organisations before the revision is published.

## Data Sharing

5.34 Building on the successful data sharing in response to Covid-19, we want to ensure that health and care organisations use data, when they can do so and with appropriate safeguards, for the benefit of individuals and the wider health and social care system. The forthcoming Data Strategy for Health and Care will set out a range of proposals to address structural, cultural/behavioural and legislative barriers to data sharing and a more flexible legislative framework to improve data access and interoperability, including enabling the safe sharing of data in support of individual care, population health and the effective functioning of the system. As part of this work, we are exploring where achieving these objectives may require primary legislation. This includes proposals to:

- require health and adult social care organisations to share anonymised information that they hold where such sharing would benefit the health and social care system.
- introduce powers for the Secretary of State for Health and Social Care to require data from all registered adult social care providers about all services they provide, whether funded by local authorities or privately by individuals (discussed further in the Adult Social Care proposals); and require data from private providers of health care.
- make changes to NHS Digital's legal framework to introduce a duty on NHS Digital to have regard to the benefit to the health and social care system of sharing data that it holds when exercising its functions; and clarify the purposes for which it can use data.
- introduce a power for the Secretary of State for Health and Social Care to mandate standards for how data is collected and stored, so that data flows through the system in a usable way, and that when it is accessed/provided (for whatever purpose), it is in a standard form, both readable by, and consistently meaningful to the user/recipient.

The measures in this Bill will help NHS organisations join up, to provide better care for the public and to plan services. None of the measures here will erode the protection of personal information.

## Patient Choice

- 5.35 Integrated services provide an opportunity to offer joined up care to all and provide clear information on the choices people have in how and where their care is delivered. A patient's right to choose where and who will provide their health and care needs will be preserved and strengthened in the new system arrangements.
- 5.36 The NHS's Long-Term Plan (LTP) makes specific proposals to strengthen patient choice and control. The LTP states that the ability of patients to choose where they have their treatment remains a powerful tool for delivering improved waiting times and patient experiences of care. The LTP also states that the NHS will continue to provide patients with a wide choice of options for quick elective care, including making use of available Independent Sector capacity. The protections and rights in relation to patient choice and the Any Qualified Provider (AQP) requirements are fundamentally set out in the current legislation.
- 5.37 As part of the wider package of changes to the arrangement of healthcare services, we propose to repeal section 75 of the Health and Social Care Act 2012 Act including the Procurement, Patient Choice and Competition Regulations 2013 and replace the powers in primary legislation under which they are made with a new provider selection regime. Under the new model, bodies that arrange NHS Services as the decision-making bodies will be required to protect, promote and facilitate patient choice with respect to services or treatment. We also want to make clearer the rules, circumstances and processes around the operation of Any Qualified Provider (AQP).
- 5.38 We will take forward the NHS's recommended approach by retaining existing patient choice rights and protections and bolstering the process for AQP arrangements. In addition, ICSs can be powerful drivers of patient centred approaches that provide greater choice and control to patients by transforming services around the specific needs of their populations.
- 5.39 We will also work closely with the NHS to reduce the health inequalities currently experienced in the area of choice, by helping to increase clarity and awareness of patient choice rights within systems and of the range of choices available.

## Reducing bureaucracy proposals

- 5.40 These proposals focus on stripping out needless bureaucracy, turning effective innovations and bureaucracy busting into meaningful improvements for everyone, learning from the innovations during Covid-19.

Reducing Bureaucracy proposals:

1. Competition
2. Arranging healthcare services
3. National Tariff
4. New Trusts
5. Removing Local Education Training Boards (LETBs)

5.41 The Department's recent [Busting Bureaucracy](#) exercise showed how bureaucracy can act as a barrier to the frontline when delivering care. We want to remove those barriers and use our legislation to give people in the system the flexibility to work together to improve services for everyone. We also want to remove parts of the legislation which no longer reflect the current ways of working and have necessitated complex and often bureaucratic workarounds, and made it difficult for the system to adapt over time as needed. The social care measures reflecting this theme are included as part of our additional proposals set out below.

## Competition

5.42 Whilst competition can drive service improvement, it has in some cases hindered integration between providers. Currently, the Competition and Markets Authority (CMA) have specific powers to review mergers involving Foundation Trusts (FT). It has become clear that the CMA is not the right body to review NHS mergers. In line with NHS England's recommendations, we intend to remove these powers and allow NHS England, as overseer of the system, to ensure that decisions can always be made in the best interests of patients. The CMA's jurisdiction over mergers is UK-wide, so we are working with the devolved administrations to ensure there would be no unintended consequences of these proposals.

5.43 Building on the experience of the last few years, we now want to take forward proposals to legislate to clarify the central role of collaboration in driving performance and quality in the system, rather than competition. The proposals are to:

- Remove the CMA function to review mergers involving NHS foundation trusts. The CMA's jurisdiction in relation to transactions involving non-NHS bodies (e.g. between an NHS Trust/FT and private enterprise) and other health matters (e.g. drug pricing) would be unchanged.
- Remove NHS Improvement's specific competition functions and its general duty to prevent anti-competitive behaviour.

- Remove the need for NHS England to refer contested licence conditions or National Tariff provisions to the CMA.

5.44 Alongside the role of competition in driving service improvement, it is also right that (as the newly merged body) NHS England's main role is on supporting improvements in health outcomes, the quality of care and use of NHS resources.

## **Arranging healthcare services**

5.45 The NHS has sent us a clear message that the current regime for arranging healthcare services is not working. It is confusing, overly bureaucratic and does not support the integration and efficient arrangement of services in the best interest of patients.

5.46 In line with the requests made by NHS England, which garnered strong support from the wider system, we will use legislation to remove much of the transactional bureaucracy that has made sensible decision-making and collaboration in the system harder. We will reform the approach to arranging healthcare services and create a bespoke regime that will give commissioners more discretion over when to use procurement processes to arrange services than at present, with proportionate checks and balances. Where competitive processes can add value they should continue, but that will be a decision that the NHS will be able to make for itself.

5.47 The reforms within these legislative proposals will remove the current procurement rules which apply for NHS and public health commissioners when arranging healthcare services. They will do this by creating the powers to remove the commissioning of these services from the scope of the Public Contracts Regulations 2015, as well as repealing Section 75 of the Health and Social Care Act 2012 and the Procurement, Patient Choice and Competition Regulations 2013.

5.48 The powers within the Bill are intended to enable us to develop a new provider selection regime which will provide a framework for NHS bodies and local authorities to follow when deciding who should provide healthcare services. The provider selection regime will be informed by NHS England's public consultation, and aims to enable collaboration and collective decision-making, recognising that competition is not the only way of driving service improvement, reduce bureaucracy on commissioners and providers alike, and eliminate the need for competitive tendering where it adds limited or no value. Commissioners will be under duties to act in the best interests of patients, taxpayers, and the local population when making decisions about arranging healthcare services.

- 5.49 We anticipate that there will continue to be an important role for voluntary and independent sector providers, but we want to ensure that, where there is no value in running a competitive procurement process, services can be arranged with the most appropriate provider. The NHS will continue to be free at the point of care and our proposals seek to ensure that where a service can only be provided by an NHS provider e.g. A&E provision, that this process is as streamlined as possible.
- 5.50 These reforms will only apply to the arrangement of healthcare services – including public health services whether commissioned solely by a local authority or jointly by the local authority and NHS as part of a S75 agreement. The procurement of non-clinical services, such as professional services or clinical consumables, will remain subject to Cabinet Office public procurement rules.

## **National Tariff**

- 5.51 The legislation for the National Tariff allows a substantial degree of flexibility, in what is a complex area – but it was in part designed to further implement a system of ‘payment by results’ or payment by activity, as part of the wider 2012 Act reforms, and in some respects its provisions may not always best facilitate new payment approaches to support collaboration or support the use of digital tech and services in the provision of care. As we move towards a system of ICSs focused on population health, we want to ensure that the payment system supports that direction of travel.
- 5.52 The set of proposals relating to the National Tariff are intended to implement NHS England’s recommendations and update the legislative requirements to reflect and support the drive towards greater integration in healthcare; make adjustments that remove barriers to desired pricing approaches; and simplify and streamline the pricing process. Experiences during the pandemic have also demonstrated the positive impact that financial frameworks can have on facilitating joint working.
- 5.53 We will take forward NHS England’s proposals on the National Tariff, by amending the legislation to enable the National Tariff to support the right financial framework for integration whilst maintaining the financial rigour and benchmarking that tariff offers. This includes:
- Where NHS England specifies a service in the National Tariff, then the national price set for that service may be either a fixed amount or a price described as a formula.
  - NHS England could amend one or more provisions of the National Tariff during the period which it has effect, with appropriate safeguards.

- Remove the requirement for providers to apply to NHS Improvement for local modifications to tariff prices.
- NHS England should be able to include provisions in the National Tariff on pricing of NHS public health services where exercising public health functions delegated by the Secretary of State.

## **New Trusts**

- 5.54 We are not seeking to significantly alter the provider landscape; however, NHS England's recommendations to government included a provision to allow the creation of new trusts for the purposes of providing integrated care. We agree that there may be merit in creating a new trust to provide integrated care, and there may also be other circumstances when the Secretary of State may want to create a new trust. Consequently, we intend to allow the creation of new NHS trusts with the overriding objective of ensuring the health system is structured to deliver the best outcomes for whole population health and respond to emerging priorities. This is in line with our overarching aim to ensure the system is flexible and adaptable into the future, and wherever possible avoids the need for complex workarounds to deliver system priorities.
- 5.55 We are therefore bringing forward measures that will enable ICSs to apply to the Secretary of State to create a new trust. Any new trust will be subject to appropriate engagement and consultation. This process will be set out in guidance.

## **Removing Local Education Training Boards (LETBs)**

- 5.56 The collaborative working between Health Education England (HEE), NHS England and NHS Improvement and the Department on the development of the [NHS People Plan](#) has shown the need for a flexible and future-proofed regional workforce operating model.
- 5.57 In light of this work, we have reviewed the role of Local Education and Training Boards. These were originally established in 2012 as statutory sub-committees of HEE to perform HEE's functions at local and regional level by ensuring effective regional planning systems for the planning and delivery of education and training. In addition, LETBs had a direct role in commissioning the education and training required at local level, a role which has diminished following the 2017 education funding reforms. However, LETB functions are restricted by legislation which has limited their scope to adapt and interact with the regional directorates of NHS England and Improvement and the newly established non-statutory Regional

Workforce and People Boards (which now provide an architecture consistently across England for oversight of Workforce, Education and Training).

- 5.58 We are proposing to amend the Care Act 2014 (which sets out the functions and constitution of HEE and LETBs) to remove LETBs from statute. We believe removing LETBs from statute with their functions continuing to be undertaken by HEE (and reporting to the HEE Board) will provide HEE with the flexibility to adapt its regional operating model over time. Accompanied with our proposal for the Secretary of State for Health and Social Care to take a statutory duty to publish a document outlining the workforce planning and supply system at national, regional and local level, this measure will provide clarity over responsibilities.
- 5.59 While LETBs operate only in England, we will work with devolved administrations should this proposal have any UK-wide impact.
- 5.60 This proposal was not directly recommended by NHS England, but it flows as a consequence of the changes being recommended by NHS England to encourage more system working, and fits with our plans to ensure the legislative framework is not overly rigid or restrictive, and can adapt over time as needed.

## **Ensuring accountability and enhancing public confidence proposals**

- 5.61 These proposals focus on enhancing public confidence by ensuring that we have the right framework for oversight of our health system, that national bodies are streamlined, with clear roles and responsibilities, and that the public and Parliament can hold decision makers to account.

### Ensuring accountability and enhancing public confidence proposals

1. Merging NHS England, Monitor and the NHS Trust Development Authority and Secretary of State powers of direction
2. The NHS Mandate
3. Reconfigurations intervention power
4. Arm's Length Bodies (ALB) Transfer of Functions
5. Removing Special Health Authorities Time Limits
6. Workforce Accountability

## **Merging NHS England, Monitor and NHS Trust Development Authority and Secretary of State powers of direction**

- 5.62 In their recommendations to Government, NHS England recommended that NHS England and NHS Improvement should be permitted to merge fully, as requested by both their boards and strongly supported in the engagement responses.
- 5.63 As NHS Improvement currently consists of the NHS Trust Development Authority (NHS TDA) and Monitor, we are proposing to formally transfer their functions to NHS England and abolish Monitor and the NHS TDA.
- 5.64 Over the last two years, we have seen NHS England and NHS Improvement come together to work effectively as a single organisation. We have seen clear benefits from them working in practice as one organisation providing national leadership: speaking with one voice, setting clearer and more consistent expectations for providers, commissioners and local health systems; removing unnecessary duplication; using collective resources more efficiently and effectively to support local health systems and ultimately making better use of public money.
- 5.65 Despite the success of NHS England and NHS Improvement's joint working programme, there are limits to how far they can fully collaborate under the current legislation. For example, both organisations have separately been assigned some distinctive and non-shareable functions in legislation – they are currently required to have separate Boards, Chairs, CEOs and non-executive directors and still consist of three separate employers. Despite the efforts of both organisations to find practical arrangements and 'work-arounds', these restrictions and governance arrangements prevent the organisations from fully operating as one single organisation.
- 5.66 The public largely see the NHS as single organization and as local health systems work more closely together, the same needs to happen at a national level.
- 5.67 By bringing forward this proposal to formally bring NHS England and NHS Improvement together, we will remove these remaining bureaucratic and legislative barriers, enabling the organisation to legally come together as one to provide unified national leadership for the NHS.
- 5.68 As a newly public merged body, NHS England will, of course, remain answerable to the Secretary of State for Health and Social Care and Parliament for all aspects of NHS performance, finance and care transformation. However, the NHS England of 2022 will combine NHS England itself with Monitor and the NHS Trust

Development Authority, each of which currently have different accountabilities. Recognising this evolution, we are bringing forward a complementary proposal to ensure the Secretary of State has appropriate intervention powers with respect to NHS England. This will maintain clinical and day to day operational independence for the NHS but will support accountability by allowing the Secretary of State for Health and Social Care to formally direct NHS England in relation to relevant functions. This will support system accountability and agility, and also enable the Government to support NHS England to align its work effectively with wider priorities for health and social care. This will serve, in turn, to reinforce the accountability of the Secretary of State and Government for the NHS and the wider health and care system.

- 5.69 The public and patients need to know that when issues arise, and when people need answers to their concerns, there are systems in place to address the issues at the appropriate level. That is likely to almost always be done within systems rather than at a national level. However, there will be occasions when it will be necessary for national leadership and for NHS England to set direction. Equally, there will be occasions when it is appropriate for ministers to take more oversight in relation to NHS England, and these proposed powers would structure such interventions and ensure Ministers are accountable for them.
- 5.70 It will also support the Secretary of State to set clear direction in a more agile way, and to do so formally alongside the strong and effective informal arrangements for working together that have evolved between the Department and NHS England in recent years.
- 5.71 These powers will not allow Secretary of State to direct local NHS organisations directly nor will they allow the Secretary of State to intervene in individual clinical decisions. They will also not undermine the established NICE process and guidance for treatments and medicines.

## **The NHS Mandate**

- 5.72 Each year the Government publishes the NHS mandate, a document which sets out the objectives which NHS England should seek to achieve. The NHS mandate is intended to set strategic direction for the NHS by setting out the top priorities that the Government expects NHS England to focus on delivering. These objectives are carried through to NHS England's planning guidance.
- 5.73 When NHS England, Monitor and the NHS Trust Development Authority are legally merged, the current statutory mandate to NHS England will cover the whole of the combined organisation.

- 5.74 At present, the process for setting, publishing and replacing the mandate is linked to the financial cycle and takes place annually. Before the start of each financial year, the Secretary of State for Health and Social Care must publish and lay before Parliament the NHS mandate. However, this annual cycle has become problematic as it does not align with timescales for other strategic decisions that should influence and align with the mandate's content. For example, by the time the mandate is published alongside the new financial year, the NHS has completed its annual planning round and local organisations have signed off plans for the coming year.
- 5.75 To allow the mandate to set direction over a longer term and in a more strategic way than currently permitted by the annual cycle, we are proposing to replace the current legislative requirement to have a new mandate each year with a new requirement to always have a mandate in place. It will also provide the flexibility for the mandate to be replaced to respond to changing strategic needs, emerging evidence on deliverability or appropriateness of objectives, or external events, rather than having to wait until the next annual opportunity.
- 5.76 This proposal will remove the duty to set NHS England's capital and revenue resource limits in the mandate itself. Instead, these limits will continue to be set within the annual financial directions that are routinely published, and which will, in future, also be laid in Parliament. The direction set in the mandate will continue to be closely aligned to the capital and resource spending limits set through financial directions. The Secretary of State will retain their duty to consult NHS England before setting a mandate.
- 5.77 Additional consequential changes will also be made to the current legal provisions on integration (the Better Care Fund) which currently rely on the NHS mandate. These provisions will be recreated as a standalone power so that they will continue to meet the policy intention for the Better Care Fund even where mandates are not replaced annually.
- 5.78 This proposal will not impact on Parliament's ability to scrutinise the mandate – each new mandate will continue to be laid in Parliament by the Secretary of State and will be published. NHS mandate requirements will also continue to be underpinned by negative resolution regulations, providing further opportunity for Parliament to engage with the content of the mandate. Furthermore, the existing duty for the Secretary of State to consult NHS England, Healthwatch England, and any other persons they consider appropriate before setting objectives in a mandate, will also remain in place. Healthwatch England's involvement ensures that all NHS mandates are informed by the needs of patients and the public.

## Reconfigurations intervention power

- 5.79 Reconfigurations involve changing the way NHS services are delivered to patients, such as the closure of several stroke units being replaced with a single centralised hyper acute unit.
- 5.80 Most service changes happen locally by consent – planned reconfigurations are developed at local or regional levels by commissioners. The current system for reconfigurations works well for most service changes, and so this will remain in place for the majority of day-to-day transactions.
- 5.81 Where it does not work well, however, is in cases which are a significant cause for public concern or are particularly complex. Inevitably some can be more controversial and can lead to difficult – even intractable – debate and processes that stretch on for years.
- 5.82 The Secretary of State is currently only able to intervene in such cases upon receiving a local authority referral and may commission the Independent Reconfiguration Panel to provide recommendations. After receiving these, the Secretary of State will communicate his final decision. Whilst this can help with difficult cases, referrals can often come very late in the process. This can lead to difficult debates and lengthy processes, meaning a long and arduous journey to a decision being made and local areas and their democratic representatives are left in limbo. This leaves ministers in the position of having to account for service changes in Parliament without having been meaningfully engaged on them themselves. In the context of Covid-19, the situation on reconfigurations (especially temporary ones) is integral to understanding both system resilience and the strengths and weaknesses of recovery plans.
- 5.83 We are therefore proposing to broaden the scope for potential ministerial intervention in reconfigurations, creating a clear line of accountability, by allowing the Secretary of State to intervene at any point of the reconfiguration process. The Secretary of State will be required to seek appropriate advice in advance of their decision, including in relation to value for money, and subsequently publish it in a transparent manner.
- 5.84 To support this intervention power, we will introduce a new process for reconfiguration that will enable the Secretary of State to intervene earlier and enable speedier local decision-making. We will issue statutory guidance on how this process will work as well as removing the current local authority referral process to avoid creating any conflicts of interest. We will publish further details of proposed arrangements in due course. This would mean that we expect the Independent Reconfiguration Panel to be replaced by new arrangements. Since its establishment in 2003, the Independent Reconfiguration Panel has provided

advice to the Secretary of State on over 80 cases and we will learn from the work of the IRP as we develop processes that build on lessons and principles for achieving successful service change.

- 5.85 We do not anticipate this power being used with great frequency but where there are issues that Ministers have concluded need to be pressed to a resolution, this will provide a means of doing so.

## **Arm's Length Bodies (ALB) Transfer of Functions Power**

- 5.86 Looking beyond just NHS England, to the wider national landscape, we have seen the Department's Arm's Length Bodies, with all their differing functions and operations, respond rapidly to the Covid-19 pandemic and demonstrating immense flexibility. From the outset, core activities were streamlined whilst new Covid-19 related work programs were implemented. We have seen our ALBs working more closely together in collaborative ways in order to support and improve people's health and care.
- 5.87 It is important that when needed, we can support our ALBs to work flexibly, make it easier for them to respond to future challenges, and provide clarity about who is responsible and accountable for various functions. Therefore, we are proposing to create a power in primary legislation for the Secretary of State for Health and Social Care to transfer functions to and from specified ALBs. This mechanism will allow us to review where functions are best delivered in order to support a more flexible, adaptive and responsive system. In cases where an ALB becomes redundant as a result of transfer of its functions, this power will also include the ability to abolish that ALB. The power to transfer functions and the power to abolish an ALB will be only be exercisable via a Statutory Instrument (SI), following formal consultation. Devolved administrations will also be consulted from the outset so that provision can be made for their approval of any transfer of functions that are operative within their nations.
- 5.88 In the responses to NHS England's engagement exercise, stakeholders sought further detail and clarity about how the power could be used. This power is designed to provide greater resilience to future system stresses, and to support and foster the flexibility that ALBs have shown in dealing with the pandemic. It will allow the system to adapt and shift to changes in priorities and focus over time, rather than having to introduce complex and bureaucratic workarounds (as we have seen between NHS England and NHS Improvement, for example).
- 5.89 There is no immediate plan to use this power. Use of this power will be subject to a full, open and transparent process throughout. Before it can be used, a formal consultation will be required. The Secretary of State will also need to consider any

recommendations made by Parliamentary Committees, and both Houses of Parliament would need to approve the proposal. This process will ensure that the ALBs, the wider health and care system, and Parliament will have the opportunity to scrutinise any plans for its use, and to ensure that any movement of functions is right for the health and care system and the public.

## **Special Health Authorities Time Limits**

- 5.90 We greatly value our Special Health Authorities (SpHAs) and the work that they do. There are currently five SpHAs, each with their own distinct and important roles. These are the NHS Business Services Authority (NHSBSA), the NHS Trust Development Authority (TDA), NHS Blood and Transplant (NHSBT), NHS Resolution (NHSR) and the NHS Counter Fraud Authority (NHSCFA).
- 5.91 Currently, existing legislation sets an automatic expiry date on SpHAs set up after 2012, which requires us to formally extend their existence every three years. This is a time consuming and bureaucratic process that creates unnecessary administration costs for the SpHAs and the department.
- 5.92 This proposal will remove the three-year time limit on all SpHAs. Not only is this time limit unnecessary as the functions of the SpHAs are enduring, it is also inconsistent as the time limits only currently impact one SpHA, the Counter Fraud Authority (CFA); and any future SpHAs that come into being would also be subject to the time limit legislation. By removing this time limit, we are ensuring all SpHAs are treated equally in legislation and removing the bureaucratic, time consuming and duplicative process.

## **Workforce Accountability**

- 5.93 The Department is proposing to create a duty for the Secretary of State for Health and Social Care to publish a document, once every five years, which sets out roles and responsibilities for workforce planning and supply in England. This document would:
- cover the NHS including primary, secondary, community care and where sections of the workforce are shared between health and social care e.g. registered nurses, and health and public health e.g. doctors and other regulated healthcare professions.
  - describe the workforce planning and supply system including the roles of DHSC and its Arm's Length Bodies, NHS bodies and others and how they work together.
  - not give any bodies additional functions to those they already have in statute,

- be co-produced with (at a minimum) Health Education England and NHS England.

5.94 The purpose of this document is to set out in one document the current roles and responsibilities in order to provide greater transparency.

## **Additional proposals**

5.95 The remaining proposals are designed to support social care, public health and safety and quality.

### Social care

1. Data
2. Assurance
3. Direct payments to providers
4. Discharge to assess
5. A standalone power for the Better Care Fund

### Public health

6. Public Health power of direction
7. Obesity
8. Fluoridation

### Safety and Quality

9. Health Services Safety Investigations Body (HSSIB)
10. Professional Regulation
11. Medical Examiners
12. Medicines and Healthcare products Regulatory Agency (MHRA) new national (UK-wide) medicines registries
13. Hospital food standards
14. Reciprocal healthcare agreements with Rest of World countries

## **Social Care**

- 5.96 We are proposing a number of specific and targeted social care changes which address the key themes of the Bill. Our proposed legislative measures encourage joined up care for everyone by ensuring local government and social care stakeholders are at the heart of our ICS proposals, and by amending the legal framework to enable person-centred approaches to hospital discharge. A new power for the Secretary of State to make payments directly to adult social care providers, will remove a bureaucratic barrier to delivering support to the sector in exceptional circumstances like those we have seen in the last year. Finally, we want to increase accountability in the delivery of social care through an enhanced assurance framework examining the performance of local authorities, and a new power to collect data from providers.
- 5.97 These measures embed improvements that have been made to the system as it has adapted to address needs arising from Covid 19. They will grant us a greater ability to respond flexibly to the needs of the sector while adapting and developing existing practice in a way that does not place undue burden on local authorities or social care providers. The Bill will also serve as a platform for detailed policy design in collaboration with stakeholders as we move forward on wider reforms for the sector.
- 5.98 The legislative measures in the Bill are just one element of a wider programme of positive reform for the adult social care sector. We remain committed to sustainable improvement of the adult social care system and will bring forward wider social care reform, with proposals to be published this year.

## **Integrated Care Systems and Adult Social Care (ASC)**

- 5.99 ICS legislation will complement and reinvigorate place-based structures for integration between the NHS and Social Care, such as Health and Well-Being Boards, the Better Care Fund and pooled budget arrangements. The ICS Health and Care Partnership will be a springboard for bringing together health, local authorities and partners, to address the health, social care, and public health needs at a system level, and to support closer integration and collaborative working between health and social care. We will support this by published guidance that will offer support for how ICS Health and Care Partnerships can be used to align operating practices and culture with the legislative framework to ensure ICSs deliver for the ASC sector.
- 5.100 We will also create a more clearly defined role for Social Care within the structure of an Integrated Care System NHS Board. This will give ASC a greater voice in NHS planning and allocation.

- 5.101 We also recognise the importance of bringing together ICSs and Health and Wellbeing Boards (HWB) as complimentary bodies at system and place level. ICS NHS Bodies and Health and Care Partnerships will have formal duties to have regard to HWB plans, and we will continue to support and prioritise meaningful integration that makes patient and user journey's smoother.
- 5.102 Putting ICSs on a statutory basis will also act as a foundation for future work to shape ICSs as they develop, to ensure that they effectively promote integration between health and care at place level, as well as improving integration within the NHS. The active involvement of the sector in this work going forwards will be hugely important in ensuring that ICSs deliver for adult social care.

### **Improve the quality and availability of data across the Health and Social Care Sector**

- 5.103 We need to make changes to the data we collect and the frequency with which we collect it; not just for central government assurance and oversight, (further detail is provided on this below), but so that local authorities, providers and consumers can access the data they need, while minimising the burden on data providers. Building on improvements made by existing tools such as the capacity tracker implemented during the pandemic and an increased ability to gather data from social care providers (for both local authority and privately funded care), we will remedy gaps in available data to help us understand capacity and risk in the system. This will enable the Department to better understand the system to inform future policy developments and ultimately help facilitate the care of individuals across the care system. Unlike the NHS, adult social care is not one national system. Many bodies currently collect information but there is little standardisation in how data are collated, shared and used. Data should flow better to cover the whole sector, and this represents a first step towards development of a more integrated data system.
- 5.104 One such gap in our existing data from local authorities is around services provided to those who self-fund their care. By collecting data from social care providers on the services they offer we will be able to better understand this aspect of the system. Data on hours of care services provided and their cost per person, together with data on financial flows, will show how money flows to providers and workforce. With client level data, we can make links with health data and use it to improve our understanding of the lifetime cost of care. This will also support improved cooperation and joint decision-making between health and social care partners in delivering shared outcomes.
- 5.105 With more and better data, we can plan the future care of our population and will have the potential to generate significant health benefits such as increased independence, improved quality of care, higher patient satisfaction and more

efficient use of funding. Improved data on the sector workforce can also benefit recruitment, retention and equality policies.

- 5.106 We want high quality data, collected to agreed high standards and that meets the needs of all users. Through technology and data strategies, and through the Data Alliance Partnership, we are working to ensure the most efficient methods of data collection, improvement in the interoperability of systems will mean that data will be able to be collected through provider systems, reducing reporting burdens by extracting from existing data sets and sharing with multiple users. By maximising the use of technology and using data intelligently, we will support commissioning and delivery of high-quality services.

### **A new assurance framework for social care**

- 5.107 Demographic change has resulted in more people turning to social care and we expect this trend to continue for the foreseeable future. Local authorities are at the forefront of our response to this challenge, and we welcome their commitment to providing high quality outcomes as envisaged through the Care Act 2014, placing an emphasis on personalisation, choice and early intervention.
- 5.108 As social care affects a greater number of people at some point during their lives, accountability for services becomes increasingly important for both national and local government. It is therefore only reasonable for Government to want to ensure the ASC system is delivering the right kind of care, and the best outcomes, with the resources available. We also want to be able to readily identify best practice across the system, building on existing sector-led support and improvement programmes. To achieve this, we want to work with local authorities and the sector to enhance existing assurance frameworks that will support our drive to improve the outcomes and experience of people and their families in accessing high quality care and support, regardless of where they live. To support these goals, we propose to introduce through the Health and Care Bill, a new duty for the Care Quality Commission to assess local authorities' delivery of their adult social care duties. Linked to this new duty we also propose to introduce a power for the Secretary of State to intervene where, following assessment under the new CQC duty, it is considered that a local authority is failing to meet their duties. Any intervention by the Secretary of State would be proportionate to the issues identified and taken as a final step in exceptional circumstances when help and support options have been exhausted. Our plan is to secure these provisions in primary legislation at a high-level, prior to working with government partners and the sector on detailed system design and practice, providing a long-term basis of consistent oversight with the goal of reducing variation in the quality of care.
- 5.109 We understand that these proposals come following an extraordinarily challenging year for adult social care, which is why our initial focus will be to improve the

quality, timeliness and accessibility of adult social care data, with the assessment and intervention elements to be introduced over time as the final element of the assurance framework.

### **Provide a power for the Secretary of State for Health and Social Care to make payments directly to providers**

- 5.110 The Coronavirus pandemic has demonstrated the need for speed and flexibility in providing support to the social care sector. Coronavirus has also clearly demonstrated how unforeseen and quickly changing circumstances may require fast intervention. We are therefore legislating to amend the Health and Social Care Act 2008 to expand the powers of the Secretary of State for Health and Social Care, which currently allows the Secretary of State to make payments to not-for-profit bodies engaged in the provision of health or social care services in England. The Bill will widen this to allow direct payments to be made to any bodies which are engaged in the provision of social care services in England.
- 5.111 The Bill will not prescribe in what circumstances the power can be used, or how it should be provided. Instead, this power will act as a legal foundation for future policy proposals.
- 5.112 The type of payment will be determined on a case-by-case basis. However, we are clear that this power will not be used to amend or replace the existing system of funding adult social care, where funding for state provision is provided via local authorities, largely through local income, and supplemented by government grant funding. Instead, it will only be used in exceptional circumstances.

### **Discharge to assess**

- 5.113 We will bring forward measures to update approaches to hospital discharge to help facilitate smooth discharge, by putting in place a legal framework for a 'Discharge to Assess' model, whereby NHS continuing healthcare (CHC) and NHS Funded Nursing Care (FNC) assessments, and Care Act assessments, can take place after an individual has been discharged from acute care. This will replace the existing legal requirement for all assessments to take place prior to discharge.
- 5.114 This change will help to embed good practice guidelines which have been followed over the past few years. Providing a legal framework for this model allows for the safe discharge of individuals into an environment familiar to them, enabling a more appropriate and accurate evaluation of an individual's care and support needs. Discharge to Assess will not change the thresholds of eligibility for CHC or support through the Care Act or increase financial burdens on local authorities.

5.115 As a requirement to assess prior to discharge is removed, the system of discharge notices, and associated financial penalties, will no longer be required, and will also be removed by this legislation.

### **A standalone power for the Better Care Fund**

5.116 As set out above, legislation will be amending the process for setting the NHS mandate so that it is no longer set on a rolling annual basis. Currently the allocation of the Better Care fund is tied to this annual process. As such, we will be creating a standalone legislative power to support the Better Care Fund and separate it from the mandate setting process.

5.117 This will be a technical change, and will not have any impact on the function, purpose or policy intention for the fund.

### **Proposals relating to public health**

5.118 Alongside the Government's proposals for the future design of the public health system, including the creation of the National Institute for Health Protection (NIHP) and the closure of Public Health England, we are bringing forward a range of targeted proposals in primary legislation relating to public health. Taken together, the proposals will strengthen local public health systems, improve joint working on population health through ICSs, reinforce the role of local authorities as champions of health in local communities, strengthen the NHS's public health responsibilities, strengthen the role of the Department of Health and Social Care in health improvement, and drive more joint working across government on prevention.

5.119 We are also taking measures to intervene in one of the biggest health problems this country faces: obesity; recognising that there is an opportunity to help people make better informed food choices and to help them improve their health.

5.120 Fluoride is a naturally occurring substance that has been shown to improve oral health. We will work to streamline the process for initiating proposals for new schemes for fluoridation of water in England by moving the responsibilities for doing so from local authorities to central government.

### **Public Health power of direction**

5.121 Under existing legislation in section 7A of the 2006 Act, the Secretary of State for Health and Social Care can make arrangements for his public health functions to be exercised by other bodies including NHS England. Currently, this delegation is made by agreement by way of the '[NHS Public Health Functions Agreement](#)' which is made annually between the Secretary of State and NHS England for

commissioning a range of public health services, often referred to as 'section 7A services'.

- 5.122 Under this agreement, NHS England currently commissions a range of services which include national immunisation programmes; national population screening programmes; child health information services; public health services for adults and children in secure and detained settings in England; and sexual assault services (sexual assault referral centres).
- 5.123 The annual NHS Public Health Functions Agreement process is seen as a helpful mechanism for collaborative working; adding value to the health service and providing a framework for delegating delivery of key programmes. However, the Secretary of State cannot require NHS England to take the delegated function. This limits his options to deliver better care and value for patients and the taxpayer in a timely manner.
- 5.124 As such, our proposal is to create a power for the Secretary of State for Health and Social Care to require NHS England to discharge public health functions delegated by the Secretary of State alongside the existing section 7A provisions (which will be retained as they have application to a wider range of bodies and, in general, are an effective mechanism in most circumstances).
- 5.125 In common with the proposed power of direction in respect of NHS England's other functions, this includes scope to direct as to how those delegated functions are to be exercised.
- 5.126 During the pandemic we have seen the increased need to ensure join up between our NHS and public health sectors. By having this power, we will enhance the ability to facilitate urgent updates or rapid service change when needed.

## **Obesity**

- 5.127 Obesity is one of the biggest health problems this country faces. The number of children admitted to hospital for obesity and related conditions has quadrupled in the last decade. Individuals who are obese in their early years are more likely to become obese adults, putting them at a higher risk of ill-health, such as heart disease, type 2 diabetes, several types of cancer and fatty liver disease, and premature death. Evidence also shows that people living with obesity are significantly more likely to become seriously ill and be admitted to intensive care with Covid-19 compared to those with a healthy weight. The need to act now and tackle obesity is clear.
- 5.128 Building on the Government's obesity strategy, [Tackling obesity: empowering adults and children to live healthier lives](#), we want to help people make better

informed food choices and to help them improve their own health. We are making several changes to legislation to support the government's ambitions to halve childhood obesity by 2030, to reduce the number of adults living with obesity and to reduce health inequalities.

- 5.129 We are proposing to amend section 16 of the Food Safety Act 1990 to give ministers the power to amend the EU Food Information to Consumers (2011/1169) regulations that have been transposed into UK law. This will allow ministers to introduce new strengthened labelling requirements that best meet the needs of the consumer to make more informed, healthier choices subject to approval by Parliament.
- 5.130 This power will enable the swift introduction of key obesity strategy policies such as changes to our front-of-pack nutrition labelling scheme and mandatory alcohol calorie labelling, following consultation. We are considering the impact of this clause with the devolved administrations and will continue to engage them on our current and any future policy proposals.
- 5.131 It is the government's intention to introduce further advertising restrictions to prohibit advertisements for products high in fat, sugar or salt (HFSS) being shown on TV before 9pm. In November and December 2020, we consulted on how to go further and implement an online restriction for HFSS advertisements. Depending on the outcome of this consultation, it is our intention to take forward further online advertising restrictions simultaneously in this legislation.

## **Water Fluoridation**

- 5.132 Water Fluoridation is clinically proven to improve oral health and reduce oral health inequalities. It has a protective effect which reduces the impact of a high sugar diet or poor oral hygiene. Around 10% of the population of England currently receive fluoridated water. In the most deprived areas fluoridation of water has been shown to reduce tooth decay in 5-year olds by a third.
- 5.133 Since 2013, local authorities have had the power to propose, and consult on, new fluoridation schemes, variations to existing schemes, and to terminate existing schemes. The Secretary of State for Health and Social Care has responsibility for approving any proposals submitted by local authorities. Local authorities have reported several difficulties with this process including the fact that local authority boundaries are not co-terminous with water flows, which requires the involvement of several authorities in these schemes, in a way which is complex and burdensome. In addition, local authorities are responsible for the oversight of

revenue and costs associated with new proposals, including feasibility studies and consultations, while having no direct financial benefit from any gains in oral health.

- 5.134 In light of these challenges, we are proposing to give Secretary of State for Health and Social Care the power to directly introduce, vary or terminate water fluoridation schemes. The Secretary of State for Health and Social Care already has the existing power to decide on whether proposals for water fluoridation should be approved and responsibility for the administration of schemes.
- 5.135 This removes the burden from local authorities and will allow the Department of Health and Social Care to streamline processes and take responsibility for proposing any new fluoridation schemes, which will continue to be subject to public consultation. Central government will also become responsible for the associated work, such as the cost of consultations, feasibility studies, and the capital and revenue costs associated with any new and existing schemes.
- 5.136 As is the case now, once a scheme is agreed, the agreements held with the water companies will continue to be held centrally.

### **Proposals relating to safety and quality**

- 5.137 The government recognises that any health and care reforms must have safety and quality at their core. Legislative changes to wider structures should enhance and support improvements in these areas. The government is therefore proposing to take the opportunity of legislation to bring forward a range of proposals to support and enhance safety and quality in the provision of healthcare services.
- 5.138 The quality and safety measures in the Bill are about transparency and accountability to the public and patient. They build on work of recent years that now needs urgent legislative underpinning to ensure this openness and accountability is embedded into the structure and culture of the NHS via the establishment of an independent Health Services Safety Investigations Body. This will be complemented by proposals on professional regulation, which seek powers to make it easier to ensure that professions protected in law are the right ones and that the level of regulatory oversight is proportionate to the risks to the public, now and in the future. We are introducing a medical examiner system for the purpose of scrutinising all deaths which do not involve a coroner. This will improve the accuracy of cause of death and mortality statistics; increase transparency for the bereaved; and help deter criminal activity and poor practice. We are also proposing to allow the MHRA to develop and maintain publicly funded and operated medicine registries and to work with the NHS to populate and maintain them where there is a clear patient safety or other important clinical interest.

5.139 Taken together, this much needed package of improvements will bolster safety and quality in the NHS, ensuring that patients can have confidence that the care they receive is of the highest quality; that the professions they receive it from are regulated well; that all deaths are scrutinised in as transparent a manner as possible; and that we have the best data available about the medicines they are prescribed.

### **Health Service Safety Investigations Body**

5.140 The Health Service Safety Investigations (HSSI) Bill was introduced in October 2019. We are intending to bring the provisions from the HSSI Bill into the Health and Care Bill.

5.141 Our provisions propose the establishment of a new independent body, the Health Services Safety Investigations Body (HSSIB) to investigate incidents which have or may have implications for the safety of patients in the NHS. This body will be established as an Executive Non-Departmental Public Body with powers to investigate the most serious patient safety risks to support system learning. Independence as a concept is fundamentally important to HSSIB as it will be a crucial way of ensuring that patients, families and staff have trust in its processes and judgements. Investigation reports will make recommendations and require organisations to publicly respond to these measures, within a specified timescale.

5.142 This proposal will:

- prohibit disclosure of information held by the HSSIB in connection with its investigatory function save in limited circumstances set out in the Bill. The aim is to create a 'safe space' whereby participants can provide information to the HSSIB for the purposes of an investigation in confidence and therefore feel able to speak openly and candidly with the HSSIB.
- encourage the spread of a culture of learning within the NHS through promoting better standards for local investigations and improving their quality and effectiveness. To this end the HSSIB will provide advice, guidance and training to organisations.

5.143 The Health Service Safety Investigations Body (the HSSIB) will continue the work of the Healthcare Safety Investigations Branch (HSIB) which became operational in April 2017 as part of NHS Improvement, to conduct high-level investigations into patient safety incidents in the NHS.

5.144 We are responding to concerns raised during the HSSI Bill's first Parliamentary Passage and plan to amend the Bill provision to extend HSSIB's remit to cover healthcare provided in and by the independent sector.

- 5.145 In addition, we are also introducing a power to enable the Secretary of State for Health and Social Care to require the HSSIB to investigate particular qualifying incidents or groups of qualifying incidents.
- 5.146 We will also be including a regulation-making power allowing Secretary of State to set out additional circumstances when the prohibition on disclosure (safe space) does not apply.
- 5.147 The devolved administrations have previously been involved in policy discussions prior to introduction in October 2019, and we will continue to engage with them on any proposed amendments as this work progresses further.

### **Professional regulation**

- 5.148 Professional regulation assures the public that those providing healthcare are qualified, capable and competent to provide safe and effective care. When healthcare professionals do not meet these standards, professional regulators must act to protect the public.
- 5.149 The UK model of professional regulation for healthcare professionals has become increasingly rigid, complex and needs to change to better protect patients, support the provision of health services, and help the workforce better meet current and future challenges.
- 5.150 The proposed powers will make it easier to ensure that professions protected in law are the right ones and that the level of regulatory oversight is proportionate to the risks to the public, now and in the future. This is not about deregulation – we expect the vast majority of professionals such as doctors, nurses, dentists and paramedics will always be subject to statutory regulation. But this recognises that over time and with changing technology the risk profile of a given profession may change and while regulation may be necessary now to protect the public, this may not be the case in the future.
- 5.151 These proposals form part of a wider programme to create a more flexible and proportionate professional regulatory framework that is better able to protect patients and the public. This will enable regulators to ensure that the processes that professionals have to go through to join and stay on a register are proportionate to assure public safety and are not overly bureaucratic.
- 5.152 This reform programme is being taken forward on a four-country basis and we are continuing to engage with the devolved administrations as we take this work forward. We are aiming to consult on our broader reform proposals, which will be delivered through secondary legislation, shortly.

5.153 At present, section 60 of the Health Act 1999 provides powers to make a large number of changes to the professional regulatory landscape through secondary legislation. The proposals in the Health Bill for additional powers will widen the scope of section 60 and enable the Secretary of State for Health and Social Care to make further reforms to ensure the professional regulation system delivers public protection in a modern and effective way and, that professions are regulated in the most appropriate and cost effective manner.

5.154 The proposal includes:

(a) the power to remove a profession from regulation.

- Statutory regulation should only be used where it is necessary for public protection. The level of regulatory oversight for each profession should be proportionate to the activity carried out and the risks to patients, service users and the public.
- The landscape of the health and social care workforce is not static, and risks will change over time as practices, technology and roles develop. While statutory regulation may be necessary now for a certain profession, over time the risk profile may change, such that statutory regulation is no longer necessary.
- A provision to enable the removal of a profession from statutory regulation through secondary legislation will make it easier to ensure that the protections and regulatory barriers that are in place remain proportionate for all health and care professions.

(b) the power to abolish an individual health and care professional regulator.

- There is inevitable duplication in having nine regulatory bodies (10 including Social Work England) performing similar functions in relation to different professions. A reduction in the number of regulators would deliver public protection in a more consistent way, while also delivering financial and efficiency savings. Powers under section 60 already allow for the creation of new regulators through secondary legislation. However, it is not possible to use these powers to close a regulator.

5.155 This change would allow the Secretary of State to exercise this power and enable Parliament to abolish a regulator using secondary legislation, where its regulatory functions have been merged into or subsumed by another body or bodies, or where the professions that it regulates are removed from regulation.

5.156 Reducing the number of regulators is consistent with proposals set out in the July 2019 [Government response](#) to the [Promoting professionalism, reforming regulation](#) consultation. The Secretary of State for Health and Social Care committed to reviewing the number of health and care professional regulators in the November 2020 [Busting Bureaucracy](#) policy paper.

(c) The power to remove restrictions regarding the power to delegate functions through legislation

- Regulators are currently restricted from delegating to another body some of their core functions. This includes the keeping of a register of persons permitted to practise; determining standards of education and training for admission to practise; giving advice about standards of conduct and performance; and administering procedures relating to misconduct and unfitness to practise.
- The removal of these restrictions would enable a single regulator to take on the role of providing a function across some or all regulators. This would enable one regulator to run the registration function on behalf of others to provide a single process for all registrants to follow, which could reduce duplication and costs for registrants. This will help to deliver public protection in a more consistent fashion and may also increase efficiency. Where a function is delegated, the delegating regulator would retain responsibility for that function.

(d) Clarifying the scope of section 60 to include senior NHS managers and leaders and other groups of workers

- Clarifying the definition of professions covered by Section 60 to include senior managers and leaders and other groups of workers would enable us to extend regulation to those groups in the future. We will continue to ensure that regulation is only used where public protection cannot be assured in other ways, such as through employer oversight.
- The [2019 Kark Review](#) of the fit and proper persons test recommended putting in place stronger measures to ensure that NHS senior managers and leaders have the right skills, behaviours and competencies and that those who are unsuitable to work in such roles are unable to do so. However, the Kark Review stopped short of recommending full statutory regulation and NHS Improvement is currently considering how best to achieve this through non-statutory means.
- While there are no plans at this stage to statutorily regulate senior NHS managers and leaders, clarifying the scope of professions who can be

regulated using the powers in Section 60 of the Health Act 1999 to include these groups would enable this to be brought forward in the future, if further measures are needed following those currently being proposed by NHS England/Improvement to address the concerns raised in the Kark Review.

### **Medical examiners**

- 5.157 Previously included in the above mentioned HSSI Bill, with this proposal we plan to amend existing legislation to establish a statutory medical examiner system within the NHS for the purpose of scrutinising all deaths which do not involve a coroner. We support the recommendations of a number of inquiries, including the Shipman Inquiry, to create a new rigorous and unified system of death certification in England.
- 5.158 This proposal will amend the Coroners and Justice Act 2009 to allow for NHS bodies, rather than local authorities, to appoint Medical Examiners. Once in place, we want to ensure that every death in England and Wales is scrutinised, either by a coroner or a medical examiner. The medical examiner system will improve the accuracy of the cause of death and subsequently mortality statistics and will increase transparency for the bereaved and help deter criminal activity and poor practice.

### **Medicines and Healthcare products Regulatory Agency (MHRA) new national medicines registries**

- 5.159 Medicines registries can consolidate prescribing data for specific medicines with data from clinical care and other social administrative databases and can be further developed to capture more detailed and bespoke data on the cohorts of patients receiving these medicines. The data captured in a specific medicine registry can help support the safe use of the medicine.
- 5.160 The aim is to enable the establishment and operation of a comprehensive medicine information system, including data collection from private providers, which will support UK wide medicine registries. Medicine registries have the potential to be an important tool to support improving post-market surveillance of the use of medicines and help ensure consistent implementation of the highest standards of care.
- 5.161 This proposal will allow the MHRA to develop and maintain publicly funded and operated medicine registries so that we can provide patients and their prescribers, as well as regulators and the NHS, with the evidence they need to make evidence-based decisions.

- 5.162 The MHRA can already request for marketing authorization holders (for example, a pharmaceutical firm which sells a medicine in the UK) to capture data to address specific gaps in knowledge regarding the use, safety and effectiveness of medicines.
- 5.163 However, the registries created and controlled by marketing authorization holders have not always delivered the required evidence in reasonable time frames. There is an opportunity to capitalise on the increasing volume of data routinely captured and linked across the healthcare system to build high quality sustainable registries that can deliver for all patients. These legislative changes will allow the MHRA to set up registries themselves, and work with NHS to populate and maintain them where there is a clear patient safety or other important clinical interest. Registries would be established for a medicine where the public need is clear and the benefits of a publicly held national registry that can access routinely collected data where it is available are required. For example, where we know risks of a medicine can result in serious adverse health outcomes and consistent adherence to risk minimisation measures is critical, or where there are substantive unknowns about the safety or effectiveness of a medicine in a population and urgent evidence is required to support safe access to it.
- 5.164 Where a safety issue has led to the introduction of measures to minimise risk to patients, statutory registries with mandated inclusion of data will facilitate the early identification and investigation of potential non-compliance so that additional action can be taken by regulators in conjunction with health service providers at a national, local, or individual patient level. Registries will help understand the impact of changes in risk minimisation measures on the health of patients and help us to understand how to ensure regulatory actions taken to support patient safety and clinical effectiveness are as effective as possible. Registries will also provide an opportunity for patients to actively contribute information on their experiences with specific medicines bringing focus to the safety and clinical effectiveness issues that impact most on their lives.

### **Hospital food standards**

- 5.165 The Independent Review of NHS Hospital Food published on the 26th October 2020 recommended for improved NHS food and drink standards for patients, staff and visitors to be put on a statutory footing. We support this recommendation and believe that putting hospital food standards on a statutory footing will deliver for the first time, mandatory minimum standards for the provision of good hydration and nutrition in the NHS.
- 5.166 Adopting statutory standards will also provide NHS hospital staff with improved access to healthier options and instil greater confidence in the public that the NHS

is committed to deliver appropriate levels of nutrition and hydration, as well as good quality food.

- 5.167 We propose to grant the Secretary of State for Health and Social Care powers to adopt secondary legislation that will implement the national standards for food across the NHS.

### **Reciprocal healthcare agreements with Rest of World countries**

- 5.168 The UK has multiple reciprocal healthcare agreements with countries outside the EEA and Switzerland ('Rest of World countries'), such as Australia and New Zealand. However, without financial reimbursement or data sharing mechanisms, these agreements are limited in scope and reach.
- 5.169 In line with the Government's Global Britain strategy, looking to invest and strengthen the UK's relationships with countries across the globe and strengthen international healthcare cooperation, the proposed legislation will enable the government to implement more comprehensive reciprocal healthcare agreements with Rest of World countries subject to negotiations. Under the current legislation, the UK is limited to implementing such arrangements with the EU, EEA, EFTA blocs or their Member States. This would offer the opportunity to strengthen existing agreements with Rest of World countries and agree new reciprocal healthcare arrangements with Rest of World countries of strategic importance.
- 5.170 Comprehensive reciprocal healthcare agreements with Rest of World countries could make healthcare more accessible for UK residents when they travel abroad for tourism or short-term business purposes and support individuals with long-term conditions who usually pay higher travel insurance premia or face difficulties in getting comprehensive insurance cover. They can also foster closer collaboration on healthcare with our international partners, supporting improved health outcomes for all.
- 5.171 In addition to supporting people access necessary healthcare, the proposed legislation will enable other advantages for agreements with Rest of World countries:
- The introduction of a reimbursement mechanism means that healthcare costs could be covered, so that no healthcare system will be left worse-off.
  - The exchange of data between countries for the purposes of reimbursement will allow for constant monitoring and evaluation of the cost-effectiveness of these agreements over time.

- The responsibility for paying healthcare charges will lie with governments, thus guaranteeing income for the NHS while eliminating most of the financial burden for the traveller.

5.172 The scope for any new agreements will be agreed across relevant government departments and will be tailored to meet our national interest with input from the devolved administrations as well as relevant operational partners.

## 6. Annex B: Integration, partnerships and accountability

### Working together

- 6.1 Healthy, fulfilled, independent and longer lives for the people of England will require health and care services, local government, NHS bodies, and others to work ever more closely together. Different professions, organisations, services and sectors will work with common purpose and in partnership. This will be especially important when we seek to focus on the people and communities that are most in need of support.
- 6.2 In many ways, the professionals are ahead of the organisations. Multi-disciplinary working has been a recognised part of good care for many years now. But the organisations are catching up. We have seen real advances in recent years in forms of joint working, with a great deal of commitment in parts of local government and the NHS to developing broadly-based 'integrated care systems', many of which are now starting to make a real difference.
- 6.3 One of the most impressive and heartening features of the work to develop integrated care systems has been the emphasis on shared purpose over structures and titles. We are very mindful that any statutory framework for integrated care should preserve, spread and enhance this feature. The point was summed up with great clarity in the recent consultation on integrated care issued by NHS England which set out the following four purposes for systems:
- (a) Improving population health and healthcare;
  - (b) Tackling unequal outcomes and access;
  - (c) Enhancing productivity and value for money; and
  - (d) Helping the NHS to support broader social and economic development.
- 6.4 These purposes provide both a formidable challenge and an excellent basis for collaborative working. Much of this work is happening at the level of 'place'.

### The primacy of place

- 6.5 Many people who are making integration happen emphasise the importance of 'place' (which is most usually aligned with either CCG or local authority

boundaries) in the joining up of services to support people to live well. The most successful integrated care systems have often concentrated on developing the places within their wider geography to thrive and to find shared priorities to work on. Many provider organisations and groupings of organisations such as primary care networks look to their 'place' as their primary focus.

- 6.6 Places vary by population and geography, and they also vary in the history and strength of the connections between the key agencies that make joined up services and improvement to outcomes happen. It is vital that we recognise this as it gives us both assets and challenges: we must not damage the former in tackling the latter (as can happen when reform is attempted). This has led us – building on the experience of those making integrated care happen - to think hard about the right balance between what needs to be prescribed by legislation and other means and what should rightly be left to local and system level decisions.

## **Two forms of integration**

- 6.7 The increased importance of integration within health and social care, is, of course, driven by the vital importance of arranging care around people and the complete picture of their health and care needs, as well as the wider demographic imperatives of getting ahead of the curve on prevention and of supporting people with multiple health and care needs (especially in later life and especially in disadvantaged communities). It is also, as the third of the purposes set out by NHS England notes, about ensuring that we get the best possible value for money for the people we serve – the patients, service users and taxpayers of England.
- 6.8 As is described elsewhere in this paper, we intend to introduce legislation that removes the needless bureaucracy that has grown up around the commissioning framework for the NHS. This will allow the NHS to shift away from an adversarial and transactional system centred on contracting and activity payments to one that is far more collaborative and dedicated to tackling shared problems. While NHS provider organisations will retain their current structures and governance, they will be expected to work in close partnership with other providers and with commissioners or budget holders to improve outcomes and value. This is what the best organisations already do, and the work of early wave integrated care systems in recent years has shown how a collaborative approach can work well - even in a framework that was not specifically designed to support it.
- 6.9 There are, then, two forms of integration which will be underpinned by the legislation: the integration within the NHS to remove some of the cumbersome boundaries to collaboration and to make working together an organising principle; and the integration between the NHS and others, (principally local authorities), to deliver improved outcomes to health and wellbeing for local people.

- 6.10 This adds complexity and will require thoughtful handling within systems with respect to governance and accountability; but we need both forms of integration if we are to achieve the improvements in outcomes that we seek. A more internally collaborative NHS will be a better, more coherent partner for local government and others. A wider partnership that includes local government and which enables a shift towards population health will deliver health, care and economic benefits and contribute to the levelling up agenda as well.
- 6.11 There is an important difference between the NHS and local government: each has a distinct line of accountability. Local government is, of course, held to account by local people and their elected representatives. NHS services and organisations are scrutinised by local authority overview and scrutiny committees and work with them closely on a number of issues – but their primary form of democratic accountability is (via NHS England) to national government and ultimately to Parliament. This will be important to recognise and reflect in the legislation but, as the pioneer ICSs have shown, it is no barrier to shared purpose, shared leadership and the pursuit of outcomes and service integration to improve the lives of local people.

## **The role of legislation**

- 6.12 The purpose of legislation in this context is to create an enabling framework for local partners to either build upon existing partnerships at place and system levels or, where these partnerships are yet to form in earnest, to begin the work of aligning services and decision making in the interests of local people.
- 6.13 The three factors that frame our proposed approach are:
- (a) The importance of shared purpose within places and systems;
  - (b) The recognition of variation – some of it warranted – of form and in the potential balance of responsibilities between places and the systems they are part of;
  - (c) The reality of differential accountabilities, including the responsibility of local authorities to their elected members and the need for NHS bodies to be able to account for NHS spend and healthcare delivery and outcomes.
- 6.14 Legislation in this context needs to be used in a targeted way and in conjunction with a great deal of local and system level freedom to make arrangements that work for all partners. We will not, for example, be making any legislative provision about arrangements at place level- though we will be expecting NHSE to work with ICS NHS bodies on different models for place-based arrangements.

- 6.15 NHS England's November consultation on integrated care generated a large number of responses from individuals and key organisations. It concluded that the government should bring forward legislation to underpin ICSs; that the legislation should allow a significant degree of local flexibility; and should not undermine effective place-based arrangements. It also recommended that ICSs should be underpinned by both an NHS ICS statutory body, with stronger responsibilities for commissioning primary medical, dental, ophthalmology and pharmaceutical services, and a wider statutory health and care partnership.
- 6.16 Having considered the response to the NHS England consultation, the government has concluded that the allocative functions of CCGs should be held by a system level body responsible for integrated care - what we are calling an ICS NHS Body.
- 6.17 Many of the responses served to reinforce the importance of the key factors for framing legislation set out above. As the response from The King's Fund noted 'We also recognise that there is a careful balance to be struck between using legislation to clarify and improve accountability and transparency, while also creating the flexibilities to allow systems to develop the arrangements best suited to their local contexts and population needs. Difficult trade-offs will be involved in resolving some of the issues we have highlighted in this section and we do not underestimate the complex nature of the decisions involved in doing so'.
- 6.18 These considerations have led us to the following model:
- (a) Place based arrangements between local authorities, the NHS and between providers of health and care services are at the core of integration and should be left to local organisations to arrange. We expect local areas to develop models to best meet their local circumstances. We would expect NHS England and other bodies to provide support and guidance, building on the insights already gained from the early wave ICSs. The statutory integrated care system (ICS) will also work to support places within its boundaries to integrate services and improve outcomes – recognising that different places will be at different stages of development and face different issues.
  - (b) Health and Wellbeing Boards will remain in place and will continue to have an important responsibility at place level to bring local partners together, as well as developing the Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy, which both HWBs and ICSs will have to have regard to. We will support HWBs and ICSs, including with guidance, to work together closely to complement each other's roles, and to share learning and expertise.
  - (c) A statutory ICS will be formed in each ICS area. These will be made up of a statutory ICS NHS body and a separate statutory ICS Health and Care Partnership, bringing together the NHS, local G

- (d) government and partners e.g. community health providers. We would expect the public name of each ICS NHS Body to reflect its geographical location – for example, NHS Nottinghamshire or NHS North West London.
- (e) The ICS NHS Body will take on the commissioning functions of the CCGs and some of those of NHS England within its boundaries, as well as CCG's responsibilities in relation to Oversight and Scrutiny Committees. It will not have the power to direct providers, and providers' relationships with CQC will remain unchanged.
- (f) Each ICS NHS body will have a unitary board, and this will be directly accountable for NHS spend and performance within the system, with its Chief Executive becoming the Accounting Officer for the NHS money allocated to the NHS ICS Body. The board will, as a minimum, include a chair, the CEO, and representatives from NHS trusts, general practice, and local authorities, and others determined locally for example community health services (CHS) trusts and Mental Health Trusts, and non-executives. ICSs will also need to ensure they have appropriate clinical advice when making decisions. NHSE will publish further guidance on how Boards should be constituted, including how chairs and representatives should be appointed.
- (g) The ICS NHS body will be responsible for the day to day running of the ICS, and NHS planning and allocation decisions. It will be responsible for:
  - developing a plan to address the health needs of the system;
  - setting out the strategic direction for the system; and
  - explaining the plans for both capital and revenue spending for the NHS bodies in the system.

6.19 Discussions with a number of stakeholders including the Local Government Association has led us to the conclusion that there is a strong case for the governance arrangements for an ICS to include an ICS Health and Care Partnership made up of a wider group of organisations than the ICS NHS Body. This Partnership would be tasked with promoting partnership arrangements, and developing a plan to address the health, social care and public health needs of their system. Each ICS NHS Body and local authority would have to have regard to this plan. The Health and Care Partnership will be promoting collaboration and it would not impose arrangements that are binding on either party, given this would cut across existing local authority and NHS accountabilities.

6.20 Members of the ICS Health and Care Partnership could be drawn from a number of sources including Health and Wellbeing Boards within the system, partner

organisations with an interest in health and care (including Healthwatch, voluntary and independent sector partners and social care providers), and organisations with a wider interest in local priorities (such as housing providers). Our intention is to specify that an ICS should set up a Partnership and invite participants, but we do not intend to specify membership or detail functions for the ICS Health and Care Partnership - local areas can appoint members and delegate functions to it as they think appropriate.

- 6.21 The ICS Health and Care Partnership could also be used by NHS and Local Authority Partners as a forum for agreeing co-ordinated action and alignment of funding on key issues, and this may be particularly useful in the early stages of ICS formation. We will, working with NHSE and the LGA, also issue guidance to support ICSs in establishing these bodies. This, along with the flexibilities at place level, will allow systems to decide how much or how little to do at these different levels and will also potentially allow them to vary these arrangements over time as the system matures and adapts. We know that this element of flexibility has been of value to the early wave ICSs where there are many (and different) examples of partnership boards and of arrangements at place level. In many cases, partnership boards have served as a way to identify, develop and drive shared priorities and projects between local government and NHS partners.
- 6.22 Taken together, we think these arrangements provide the right balance between recognising the distinctive accountabilities and responsibilities of the NHS, local authorities and other partners while also strongly encouraging areas to go further in developing joint working and decision-making arrangements that deepen and improve over time in the interests of local people.

## 7. Annex C: Stakeholder Engagement

7.1 Despite the unprecedented context under which we have developed this paper, we have still managed to engage with a range of stakeholders from across the health and care system, both through roundtables and smaller discussions.

7.2 We would like to extend our sincere thanks to the following organisations for discussing the themes and proposals at the centre of this paper with us.

- Academy of Medical Royal Colleges
- Age UK & Care Support Alliance
- Alzheimer's Society
- Association of Directors of Adult Social Services (ADASS)
- Association of Directors of Public Health
- Association of Pharmacy Technicians
- British Medical Association
- Care England
- Care Providers Alliance
- Care Quality Commission
- Care UK
- Carers UK
- Centre for Ageing Better
- Centre for Mental Health
- Faculty of Public Health
- Health Education England
- Health Foundation
- Healthcare Safety Investigation Branch

- Healthwatch England
- Independent Healthcare Provider Network
- Institute for Government
- International Longevity Centre UK
- Learning Disability England
- Local Government and Social Care Ombudsman
- Local Government Association
- National Association of Primary Care
- National Care Forum
- National Data Guardian
- National Voices
- NHS Assembly
- NHS Blood and Transplant
- NHS Business Services Authority
- NHS Clinical Commissioners
- NHS Confederation
- NHS Digital
- NHS Employers
- NHS England
- NHS Improvement
- NHS Providers
- NHS Resolution
- National Institute for Health and Care Excellence

- Nuffield Trust
- Policy Exchange
- Public Health England
- Royal College of General Practitioners
- Royal College of Nursing
- Royal Pharmaceutical Society
- Social Care Institute for Excellence
- Skills for Care
- SOLACE
- The King's Fund
- The Patients Association
- Think Local Act Personal
- UK Home Care Association
- UNISON



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# Legislating for Integrated Care Systems: five recommendations to Government and Parliament

February 2021

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# 1. Introduction and summary

1. Following the publication of the NHS Long Term Plan, and informed by a major public engagement exercise, in October 2019 NHS England and Improvement (NHSE/I) made a number of recommendations to Government for targeted reform of NHS primary legislation. These were widely supported within the NHS, by our partners and by Parliament's cross-party Health and Social Care Committee.
2. We subsequently heard a growing desire – particularly from NHS leaders - to strengthen our original legislative proposals specifically in relation to Integrated Care Systems (ICSs), following enhanced experiences of system working during the NHS's successful response to the coronavirus pandemic. We worked up further legislative options in *Integrating Care – the Next Steps*, published in November 2020. These were rooted within the much wider context of how ICS are continuing to develop in practice – for example through partnerships at place level, the development of Primary Care Networks (PCNs) and emerging provider collaboratives. Our ICS plans have been the product of several years of extensive co-production and discussion with stakeholders. They built on a widespread consensus in favour of greater partnership working and closer integration of planning and service delivery between NHS organisations, local councils and other important partners such as the voluntary sector.
3. Our engagement attracted a significant response. Bringing together the NHS and local government and wider stakeholder views gathered through this latest engagement exercise, we now make five specific recommendations to Government on the narrow question of how to legislate for ICSs. The Government has now agreed to legislate to give effect to our proposals. Separately we will continue to engage widely on the development of ICSs.
4. A minority of respondents sought an extension which would have prevented NHS's own views being offered in a sufficiently timely way to inform and influence the Government's thinking about a prospective NHS Bill.
5. A number of responses were concerned with ensuring the NHS continues to operate as a public service. NHSE/I's wider set of proposals for legislative reform, published in October 2019, already included (i) abolishing Section 75 of the Health and Social Care Act 2012, (ii) removing the Competition and Markets Authority functions created by that Act, and (iii) developing a bespoke NHS regime to replace current procurement requirements. During this most recent engagement exercise we heard impatience about how and when they will be implemented. Today NHSE/I is also publishing, earlier than originally planned, our draft proposals for selecting NHS providers and we invite responses by 7 April 2021: <https://www.engage.england.nhs.uk/consultation/nhs-provider-selection-regime>.

**Legislative recommendation 1: The Government should set out at the earliest opportunity how it intends to progress the NHS’s own proposals for legislative change.**

6. We asked if now was the right time to seek to put ICSs on a stronger statutory footing. From the NHS, the response was a clear yes. We saw a marked absence of support for sticking to the October 2019 legislative proposal for ICS to be voluntary committees.
7. Responses to this and the other questions were nuanced and qualified. The message we received was proceed, but carefully. At the same time as supporting the aim of a more collaborative system, think tanks such as the Nuffield Trust and the Health Foundation observed that over many decades, successive different Governments had oversold the scale of the likely potential benefits of NHS legislative changes, and not paid sufficient attention to mitigating the potential risks of local disruption and staff uncertainty. In line with this, we heard strong support for our proposed transitional employment commitment for all staff working below board level who are affected by the legislative changes – including, but not limited to, CCGs.
8. We heard a strong appetite for ICSs to integrate care and improve population health, in line with the wider vision we described – at the same time, we also heard an equally clear desire for legislative underpinnings to be as short, simple, and enabling as possible. Legislation should be carefully designed to recognise the heterogeneity of ICSs – what works best in a large ICS like North East and North Cumbria is not the same as what works best in Dorset ICS. The more extensive the legislative provisions, the more disruptive they are likely to prove. We also heard that over-specifying arrangements at a whole ICS level is likely to undermine the importance of place-based arrangements.

**Legislative recommendation 2: ICSs should be put on a clear statutory footing, but with minimum national legislative provision and prescription, and maximum local operational flexibility. Legislation should not dictate place-based arrangements.**

9. We put forward two alternative statutory models. The first model was a mandatory statutory committee. The second model was to repurpose CCGs as the statutory local NHS ICS body, with revised governance arrangements – we indicated this was our preferred model.
10. There was, on balance, agreement – particularly from NHS organisations. This included the NHS Confederation and NHS Clinical Commissioners, who felt that this supported a clearer and more collaborative model of decision-making and accountability within the NHS. NHS Providers supported the overall direction of travel, but did not express a preference between the options.
11. There was also support for the first model. Without disagreeing that the NHS would benefit from the second model, many respondents, including the Local Government Association (LGA), local authority leaders, and the voluntary community and social enterprise (VCSE) sector, questioned whether an NHS statutory body, with its clear national NHS and political accountability requirements, could also cover the entirety of the health and care system, given the separate statutory functions, funding and political accountability of local

government, as well as the need for enhanced community voice. They argued that the functions and statutory accountabilities of the NHS body needed different governance from that of the vital partnership between the NHS and local government.

12. The LGA went further and argued that the choice between the first and second models was not an either/or – and that a separate statutory body should bring together the NHS statutory body with local government in a partnership of equals. We assess that this view best represents the overall balance of opinion. Strongest support exists for progressing both models in combination, ahead of the second model alone (our original stated preference) or the first model alone.
13. Each system is different and each should be free to establish its own best way of satisfying statutory partnership requirements. We heard – and agree – that statute should not cut across the ability for the NHS and its partners to choose to continue existing models for partnership working across ICSs, for example to take account the role of the mayor of Greater Manchester as part of the agreed devolution arrangements.

**Legislative recommendation 3: ICSs should be underpinned by an NHS ICS statutory body *and* a wider statutory health and care partnership. Explicit provision should also be made for requirements about transparency.**

14. Some national representative organisations sought a guaranteed seat for their own constituencies on the board of the ICS. We also heard the need to ensure effective governance for NHS statutory functions and accountabilities and how this is different from inclusive engagement of partners.
15. Many respondents with a clinical or professional interest asked the NHS to provide clarity on how the voice of clinical and professional leaders would be reflected in every system, including a role for GPs through primary care networks at place and system level. We agree that clinical leadership is fundamental to the success of ICSs. We commit to producing national guidance on this later in the year, working with all interested organisations.
16. We also heard exactly the same challenge in relation to creating deeper partnerships with patients and local communities, in order to personalise care and tackle health inequalities. Chapters 1 and 2 of the NHS Long Term Plan directly address these issues and we recommit to continuing to achieve their implementation. Our October 2019 legislative proposals also included a commitment of community engagement for NHS organisations, linked to the new triple aim.

**Legislative recommendation 4: There should be maximum local flexibility as to how an ICS health and care partnership is constituted, for example using existing arrangements such as existing ICS partnership boards or health and wellbeing boards where these work well.**

**The composition of the board of the NHS ICS body must be sufficiently streamlined to support effective decision-making. It must be able to take account of local circumstances as well as statutory national guidance. Legislation should be broadly permissive, mandating only that the members of the NHS ICS Board must include a chair and CEO and as a minimum also draw**

**representation from (i) NHS trusts and Foundation Trusts, (ii) general practice, and (iii) a local authority. As with CCGs now, NHSE/I should approve all ICS constitutions in line with national statutory guidance.**

17. We sought views on transferring or delegating NHSE commissioning functions to the new ICS statutory body. Many Local Medical Committees (LMCs) and PCNs sought a clear public commitment on primary care budget protection. Some primary care respondents were concerned that the arrangements could involve moving away from national contractual arrangements. We reaffirm our continued commitment to national contractual arrangements across the primary care contractor professions and also to the primary and community services funding guarantee – alongside the mental health investment standard – in the NHS Long Term Plan. Some GPs were concerned about the loss of the GP membership model, whilst others welcomed the clearer focus placed on the role that general practice plays in integrating care at neighbourhood level through PCN development.

18. We also heard clear support for moving commissioning and planning functions closer to the populations they serve.

**Legislative recommendation 5: Provisions should enable the transfer of primary medical, dental, ophthalmology and pharmaceutical services by NHS England to the NHS ICS body. Provision should also enable the transfer or delegation by NHS England of appropriate specialised and public health services we currently commission. And at the same time, NHS England should also retain the ability to specify national standards or requirements for NHS ICSs in relation to any of these existing direct commissioning functions.**

## 2. How we involved and engaged stakeholders

19. The *Integrating Care* paper was not the beginning of our engagement and it will not be the end. It built on more than four years of incremental policy co-design: with people who use and work in our services, with system leaders, with key partners such as local government and the voluntary sector, and with organisations that represent all of these interests nationally and locally. During this time, NHSE/I established regular working groups and one-off sessions with system leaders from across the NHS, Local Government, independent and voluntary sectors.
20. Written engagement on the paper's specific policy and legislative proposals closed on 8 January 2021. 7,167 individuals, or organisations representing different parts of the health and social care system, responded in writing. Specifically, there were:
- 6,769 responses, mostly to our online survey, clearly setting out a position of agreement or disagreement on our proposals
  - 5,171 of these responses predominantly were concerned with ensuring the NHS continues to operate as a public service
  - 85% of NHS organisations – NHS trusts, FTs, ICSs, STPs and commissioners – clearly expressed support for giving ICSs a statutory footing
  - further substantive written responses from organisations and individuals providing detailed feedback and
  - 27 responses from LMCs concerned about timing and the impact on General Practice.
21. NHSE/I ran more than 30 online sessions to discuss the work with interested stakeholders from November 2020 to January 2021 and the implications of the document's proposals. This included:
- discussing proposals with the [NHS Assembly](#), whose co-chairs jointly authored a Health Service Journal article welcoming the proposals
  - virtual sessions with executive and clinical leaders from every ICS and sustainability and transformation partnership (STP)
  - bespoke sessions with clinical commissioners, staff representative groups including GPs and allied health professionals, local government officers and councillors, and local Healthwatch and meetings with smaller community and voluntary sector organisations
  - presenting the work at pre-existing meetings of networks of various organisations' executive groups or networks, including the NHS Confederation and NHS Providers, the Shelford Group, the LGA, Society of Local Authority Chief Executives (SOLACE), and NHSE's VCSE Health and Wellbeing Alliance

- meetings with the medical Royal Colleges, trade unions and other clinical and professional leaders; as well as a national session with local Healthwatch Groups, and two sessions with local community and voluntary organisations, arranged in partnership with the National Association for Voluntary and Community Action (NAVCA).

22. We supplemented these larger sessions with smaller-scale, meetings with interested organisations and individuals: to understand their priorities, to hear any questions or practical suggestions, and to test the feeling from potentially affected colleagues and networks. A partial list of many organisations and networks who attended sessions, helped to arrange conversations for us with their members, or gave advice to us directly is published alongside this document.

23. We thank all organisations and individuals who have taken time to provide feedback to this engagement. The volume of response and level of engagement, at a time of significant pressure, demonstrates the importance people attach to getting legislative arrangements right and learning lessons from the past. The strength of feeling of respondents expressed in this document as statistics are based on the denominator of those who clearly expressed a view.

24. We have reflected carefully on what we have heard. A number of stakeholders raised specific policy questions that were not obviously matters for primary legislation. Engagement on many of those issues will continue through the various regular forums. Whilst this document is only focused on the legislative aspects of ICSs, many of the priorities and suggestions raised in the events and meetings will directly inform policy guidance that NHSE/I will publish in 2021/22.

# 3. Legislating for Integrated Care Systems

## A statutory basis for Integrated Care Systems?

25. The first question on which we sought views was whether now is the time to move ICSs on to a statutory footing. A range of organisations responded to this question. 5,171 came via our online survey from people identifying as members of the public or patients concerned about “privatisation” of the NHS in some way. These comments were identified as a response to a national campaign group and involved speculation about the creation of statutory ICSs, including:
- concern about “collaboration” and contracting with independent sector providers;
  - the need to ensure private companies do not sit on ICS boards, directing decisions for their own benefit;
  - the need to ensure ICSs themselves are public bodies;
  - concerns about the future of a publicly funded NHS; and
  - the need to avoid poor purchasing practice similar to those highlighted in the media about Government procurement of Personal Protective Equipment (PPE).
26. We welcome support for the NHS to remain a universal national healthcare system free at the point of delivery. We propose that NHS ICS bodies should be statutory public NHS bodies; not private entities. The NHS ICS body should be an evolution of existing CCGs, retaining many of the responsibilities and functions, but working across a bigger footprint, allowing a greater role for both NHS statutory providers and local authorities in how NHS services are arranged and delivered.
27. Our wider legislative proposals set out in October 2019 included:
- rebalancing the focus on competition between NHS organisations by reducing the Competition and Markets Authority’s role in the NHS and abolishing Monitor’s role and functions in relation to enforcing competition;
  - simplifying procurement rules by scrapping section 75 of the 2012 Act and removing the commissioning of NHS healthcare services from the jurisdiction of the Public Contracts Regulations 2015;
  - providing increased flexibilities on tariff;
  - reintroducing the ability to establish new NHS trusts to support the creation of public sector integrated care providers;
  - ensuring a more coordinated approach to planning capital investment, through the possibility of introducing FT capital spend limits;

- the ability to establish decision-making joint committees of commissioners and NHS providers and between NHS providers;
- enabling collaborative commissioning between NHS bodies – it is currently easier in legislative terms for NHS bodies and local authorities to work together than for NHS bodies themselves to do so;
- a new “triple aim” duty for all NHS organisations of ‘better health for the whole population, better quality care for all patients and sustainable services for the taxpayer; and
- merging NHS England and NHS Improvement – formalising the work already done to bring the organisations together.

28. During this most recent engagement exercise we heard impatience to learn more about how and when they will be implemented, and the response to our previous recommendation that the Department of Health and Social Care (DHSC) may wish to undertake a review to clarify workforce accountabilities and responsibilities.

**Legislative recommendation 1: The Government should set out at the earliest opportunity how it intends to progress the NHS’s own proposals for legislative change.**

29. Today NHSE/I is also publishing, earlier than originally planned, our draft proposals for selecting NHS providers and we invite responses by 7 April 2021: <https://www.engage.england.nhs.uk/consultation/nhs-provider-selection-regime>.

30. The remainder of this document presents the breakdown of those who stated a clear opinion on each of the questions via our online survey, but with the Keep our NHS Public (KONP) campaign clearly captured separately.

Survey question	1,747 unique responses (KONP responses: 5,155)
1	Do you agree that giving ICSs a statutory footing from 2022, alongside other legislative proposals, provides the right foundation for the NHS over the next decade?

31. Of the unique and clearly identifiable responses received 49.2% agreed or strongly agreed with our proposals, with 43% disagreeing or strongly disagreeing. 7.8% of respondents were neutral towards the proposal.

32. Overall, there was a high level of support from most representative bodies that it is right to now consider establishing ICSs in statute. For example:

- *“We support the spirit and ambition set out in these proposals. To date, progress in joining up local services has often been achieved via workarounds to the current legislative framework, many of which are inherently complex and bureaucratic, and can lead to duplication and protracted decision-making processes. We have long argued that legislative changes will eventually be needed to re-establish coherence between local practice and the statutory framework.”* (Kings Fund)

- *“Yes. Overall there is agreement across our membership that systems becoming statutory is necessary to address the limitations of the existing legislative framework and to embed collaboration and integration into the NHS architecture. The successes of recent years in developing collaboration and system working risk plateauing without the proposed legislation, and there is much more that systems wish to achieve together. Of the two options, there was broad support across our membership for option two.”* (The NHS Confederation)
- *“The Academy and its member organisations strongly support the direct of travel towards greater integration of care systems. We have consistently believed that healthcare is better delivered through a collaborative approach and with systems working together rather than in competition with each other. There is broad consensus that giving ICSs a statutory footing from 2022, alongside other legislative proposals, provides the right foundation for the NHS over the next decade.”* (The Academy of Medical Royal Colleges)
- *“Overall, there is a range of views among trust leaders as to whether or not ICSs should be placed on a formal statutory basis, although we note that the number of trust leaders open to this option seems to be increasing and recent engagement suggests a majority would favour an appropriate statutory underpinning subject to agreement on aspects of the ‘plumbing and wiring.’ The diversity of views reflects the diversity of experience, population need and local structure currently supporting system working across the country – and different interpretations of the core purpose of the ICS.”* (NHS Providers)
- *We support the view of the majority of our members and agree that option 2 is a positive step forward for the next phase of integrated care. However, in agreeing this position – we have some significant concerns that must be addressed to avoid any negative impact on CCG transition and therefore ICS establishment. These focus on the interpretation and enactment of what is outlined in option 2.”* (NHS Clinical Commissioners)
- *Overall, we agree that putting ICSs on a statutory footing from 2022 would provide a positive basis for a wide range of long-term developments, and that your second option would provide greater clarity than the first. We also support in principle the proposed permissive approach to local governance arrangements, within a clear overarching framework. NHSE/I would, however, have an important responsibility to maintain an overview of the effectiveness, appropriateness and transparency of locally-determined governance systems.*(The Richmond Group of Charities)
- *“As the BMA has argued previously, the lack of statutory footing for ICSs has severely limited their accountability and transparency and, in so doing, has reduced confidence in them as nascent institutions. We believe that enshrining ICSs in statute would, in part, help to resolve these issues, particularly in respect of ICSs’ transparency and their accountability to clinicians, patients, and the public. [...] We endorse neither option set out in the consultation for the future of CCGs. Instead, we call for positive elements of CCGs to be retained in any new model. This includes their vital function in ensuring accountability to clinicians and patients, their invaluable local*

*knowledge, their role in providing a strong clinical voice, and their skill and experience in commissioning services.” (The British Medical Association)*

33. There were a number of caveats associated with support for the intention, including requests for more clarity on the role of local government, the voluntary sector and patients:

- *“We support the direction of travel of the proposals towards joining up health and care support around the individual, based on collaboration between organisations, and where decision-making is at the most local level. [...] It is essential that there is local government representation on ICS boards, whatever legal structure it takes. In our view, the ICS as currently proposed will be an NHS body with local government representation, not a partnership of equals across the whole system. (LGA)*
- *“ICSs cannot both be at the same time a statutory corporate NHS body, and a true and equal partnership with non-NHS bodies. Our NHS colleagues explained clearly and convincingly to us that NHS organisations in a system (both commissioners and providers) need to be brought together in order to deal with unhelpful competition, inefficiencies and obstacles to better service integration. In our view, it is therefore probably advantageous to enable this 'NHS internal' integration. Our hope would be that the NHS would therefore also become easier to partner-up with, easier to hold to account and easier to engage with (in fact, whether VCSE organisations or other external partners report that the NHS is in fact now easier to work with, should be used as a benchmark for whether any legislative change has been a success). But we also think there is a need for creating powerful partnerships that local authorities with their various functions can be members of- and not just through social care: this needs to include public health, housing, children's services, education, and so on.” (National Voices)*
- *UNISON does not have a definitive position on whether and how integrated care systems (ICSs) should be enshrined in legislation [...] However, UNISON does believe that enshrining ICSs in legislation is more likely to head off some of the problems that staff, unions and patient/public groups experienced with the development of sustainability and transformation partnerships (STPs).” (UNISON)*

34. Responses to this and the other questions were nuanced and qualified. The message we received was proceed, but carefully. At the same time as advocating a statutory footing for ICSs, think tanks such as the Nuffield Trust and the Health Foundation observed that over many decades, successive different Governments had oversold the scale of the likely potential benefits of NHS legislative changes, and not paid sufficient attention to mitigating the potential risks of local disruption and needless uncertainty for staff. In line with this, we heard strong support for our proposed transitional employment commitment for staff working below board level affected by the legislative changes – including in CCGs.

35. We heard a strong appetite for ICSs to integrate care and improve population health, in line with the wider vision we described – at the same time, we also

heard an equally clear desire for legislative underpinnings to be as short, simple, and enabling as possible. Legislation should be carefully designed to recognise the heterogeneity of ICSs – what works best in a large ICS like North East and North Cumbria is not the same as what works best in Dorset ICS. The more extensive the legislative provisions, the more disruptive they are likely to prove. We also heard that over-specifying arrangements at a whole ICS level is likely to undermine the importance of place-based arrangements.

36. As part of the response to the key question of the statutory basis of ICSs, enabling decision-making at ‘place’ was a key theme for a number of respondents:
- *“If option 2 is to be successful, this will be largely dependent on delegating back to place and allowing sufficient freedom to develop relationships.”* (Northumberland CCG)
  - *“A framework regarding the relationship between systems and places would also be welcomed. This is likely to be applied differently in large systems with large places compared to smaller systems. Local flexibility to develop places and the designation of functions / resources is welcomed.”* (Nottingham and Nottinghamshire CCG)
37. To achieve this, we have proposed additional legislative flexibilities. Our 2019 recommendations allowed for the creation of Joint Committees and more flexible commissioning arrangements. Our November 2020 engagement document proposed that NHSE and ICSs should be allowed to transfer or delegate their functions, alongside associated budgets. The ICS body would be able to establish place-based committees and delegate functions and money to them. Local authorities would also be able, voluntarily, to pool functions and money into these committees. The membership of these place-based committees should be determined locally. Based on developments around the country so far, we expect them to be broad-based bringing together representatives from PCNs, social care, public health, mental health services, acute care as well as voluntary sector organisations and patient groups.
38. NHSE/I will produce guidance in line with future legislative proposals to ensure both system and place-based arrangements are sufficiently clear and transparent. We do not propose legislative requirements for establishing place-based arrangements, acknowledging the different geographies of existing systems.
39. Our document proposed that any transition should minimise disruption by offering an employment commitment for all staff below board level who are affected by the legislative changes:
- *“We welcome the ‘lift and shift’ approach for CCG staff which should harness existing skills and expertise within CCGs, rather than wholesale organisational change with all the accompanying loss of productivity, focus, morale and increased costs particularly during a period when we are asking our staff to work unrelentingly on responding to the pandemic and recovery.”* (Gloucestershire CCG)

40. There was some concern about timescales raised across a large number of responses – both in agreement and disagreement. Whilst many organisations wanted pace, others felt the timeframes were tight. We heard that respondents wanted the enactment of legislation itself to trigger minimal disruption and allow for continued evolution of ICSs and CCGs prior to a potential Act, and afterwards:

- *“Our suggestion would be to secure legislative change in such a way that the vision and direction were enabled but with time to allow for the practical processes to be completed properly.”* (Bradford District and Craven CCG)

**Legislative recommendation 2: ICSs should be put on a clear statutory footing, but with minimum national legislative provision and prescription, and maximum local operational flexibility. Legislation should not dictate place-based arrangements.**

## Which legislative model?

Survey question	1,711 unique responses (KONP responses: 5,104)
2	Do you agree that option 2 offers a model that provides greater incentive for collaboration alongside clarity of accountability across systems, to Parliament and most importantly, to patients?

41. Our engagement document set out two possible options for enshrining ICSs in legislation:

- **Option 1: a mandatory statutory committee** model with an Accountable Officer that binds together current statutory organisations. This Accountable Officer would not replace individual NHS organisation AOs/CEOs but would be recognised in legislation and would have duties in relation to delivery of the Board’s functions. There would be a duty for the Board to agree and deliver a system plan and all members would have an explicit duty to comply with it. In accordance with our stated ambition, there would be one aligned CCG only per ICS footprint.
- **Option 2: a statutory corporate NHS body** model that additionally brings CCG statutory functions into the ICS. The CCG governing body and GP membership model would be replaced by a board consisting of representatives from the system partners. As a minimum it would include representatives of NHS providers, primary care and local government alongside a Chair, a Chief Executive and a Chief Financial Officer. The power of individual organisational veto would be removed. The ICS Chief Executive would be a full-time Accounting Officer role, which would help strengthen lines of accountability and be a key leadership role in ensuring the system delivers.

42. Of the unique and clearly identifiable responses received, 48% agreed or strongly agreed with our proposals, with 39.9% disagreeing or strongly disagreeing. 12.1% of respondents were neutral towards the proposal.
43. Positive responses focused on the benefits of clearer accountability. For example:
- *“Making Integrated Care Systems statutory bodies would be a significant step forward in terms of enabling local organisations, working in partnership, to make the best decisions for the people they serve and directing their collective resources accordingly.”* (Norfolk and Waveney Health and Care Partnership)
  - *“A single statutory body is a much cleaner way to achieve accountability. Such a body can then agree its own sub-structures at a locality level in a coherent manner.”* (PCN Managing Director)
  - *“Historically, there has been confusion among NHS leaders, staff, patients and partner organisations regarding who is accountable for what service, with variation spreading across the country. Model two would therefore hopefully deliver a clearer structure of ICSs for users of the health service, as well as for those that work within it.”* (Royal College of Obstetricians and Gynaecologists (RCOG)).
  - *“Option 2 structure supports “smoothing out collaboration and decision making processes, removing some of those bottlenecks that might be encountered when engaging across several individual organisations“ (Non-clinical NHS staff)*
44. There was a view from others that option 1 was a better model for health and care system partnership while option 2 offers a clearer model of accountability for the NHS:
- *“Some [councils] strongly favour Option 2 while others support Option 1. The LGA can see that both have merits. Option 1- that ICSs will be a statutory joint committee - has the benefit of more able to act as strategic partnership body for the whole system. With regard to Option 2, there is value of having a single corporate body across NHS organisations in a health economy. This should be effective in increasing collaboration and join up between NHS organisations in an area, with the ability to plan strategically and deploy resources to best effect. But important though this is in improving access to health care, this is a different task to leading a partnership to address the wider determinants of health, improve population health and address health inequalities. As a statutory NHS body the ICS would be a welcome and important partner within the system but the ICS is not the whole health and wellbeing system nor indeed the leader within an entire system. Whichever statutory model is chosen for ICSs, it is essential that there is a system level partnership in which local government and other partners work alongside the NHS to drive real change in health, care and wellbeing services; address the wider determinants of health, reduce health inequalities and improve health outcomes.”* (LGA)

- *“It is important to note, however, that a fundamental aim and success of many ICSs to date has been to bring partners (not just NHS partners) together in a collaborative and integrated way with collective aims so it is essential that if ICSs become statutory bodies (who also have to perform some of the assurance function that currently sits in regional NHSE/I teams) that this doesn’t preclude partnership and collaborative working.”* (St Helens MBC & NHS St Helens CCG)
- *“It is important to clarify the difference between forums for participation and engagement, and those tasked with taking decisions – governance”* (Good Governance Institute)

45. There is no clear and definitive preference for one model over the other, but there was clear support for both. We propose to adopt both in combination.
46. Recognising the strong sentiment that this body alone could not represent the entirety of the health and care system we propose the NHS ICS body and local authorities should be required by statute to establish a statutory health and care partnership. This would be made up of a wider group of organisations than the NHS ICS body and would be required to develop an overarching plan to cover health, social care and public health. There should be flexibility as to how this is done. We suggest that the NHS ICS board would have to have regard to that plan when developing their health plan, while local authorities would also have to have regard to that plan in exercising their functions.
47. As part of the proposals to legislate for ICS, we do not propose changing the accountability structures of NHS Trusts and Foundation Trusts. Some of those NHS providers working across a larger footprint – such as ambulance trusts and larger acute providers – highlighted the inevitable complexity entailed in working across several systems. We will work with the sector on this.
48. A new ‘triple aim’ duty and duty of collaboration will help provide a shared sense of focus – as will the development and delivery of a system-level plan and system-level financial allocations. We also intend to develop and issue revised guidance to explain how Foundation Trust directors’ and governors’ duties can better support collaborative system working.
49. A number of comments related to the role of voluntary and independent sector providers within ICSs and in providing NHS services more generally. These were a mix of comments supporting and advocating for an ongoing role in both provision of services and wider–system work – usually from organisations already involved in NHS provision – and broader comments expressing opposition to the private sector being involved in NHS provision and ICSs.
50. We heard that the voice of patients and residents should be heard at both system and place level. The NHS ICS body, like all statutory NHS bodies including CCGs, will have a duty to engage with communities – we recommend that statutory ICSs continue to hold CCG duties and functions, including around public engagement. Our October 2019 legislative proposals also included a commitment for community engagement for NHS organisations, linked to the

new triple aim. Patient and service user representation and VCSE representation would be expected at the health and care partnership level and on place-level committees. We would also expect Healthwatch to form part of these partnership arrangements.

51. We will work with stakeholders to develop guidance on how these arrangements can be most effectively discharged, building on learning from CCGs and ICSs to date. We also recognise the role of the VCSE as a strategic system and transformation partner: in service provision, support for community resilience, wellbeing and inequalities, advocacy, engaging communities, volunteering and person-centred care. But personalising care and tackling inequalities is about more than just strengthening patient voice and involving the VCSE as a partner in provision – Chapters 1 and 2 of the NHS Long Term Plan directly address these issues, and we recommit to continuing to achieve their implementation.

52. A number of responses stressed the need for transparency in appointments and decision-making. Legislation should set out core requirements in terms of openness and transparency. This could include requirements on NHS ICS Boards and health and care partnerships to hold meetings in public, publish papers in advance, maintain a register of members’ interests, hold an AGM and publish an annual report.

**Legislative recommendation 3: ICSs should be underpinned by an NHS ICS statutory body *and* a wider statutory health and care partnership. Explicit provision should also be made for requirements about transparency.**

## What level of national prescription for governance arrangements?

<b>Survey proposal</b>	1,739 responses (5,112 KONP responses)
3	<i>Do you agree that, other than mandatory participation of NHS bodies and Local Authorities, membership should be sufficiently permissive to allow systems to shape their own governance arrangements to best suit their populations needs?</i>

53. Of the unique and clearly identifiable responses received, 54.5% agreed or strongly agreed with our proposals, with 37.3% disagreeing or strongly disagreeing. 8.2% of respondents were neutral towards the proposal.

54. Responses to this question varied considerably in terms of how NHS ICS boards should be constituted. We received clear feedback to avoid overriding what is currently working locally:

- *“All ICSs are different and within a broad framework the model should be as permissive as possible reflecting different histories, geographies, institutional structures and stages of development. The biggest risk to*

*success will be disempowering local partners through detailed national prescription*". (SE London ICS)

- *"Each system will understand and work within a complex system that has been developed and evolved over time. The governance infrastructure should be adaptable to allow systems to establish mechanisms that recognise these complexities and enable all relevant participants to actively engage."* (The Royal Wolverhampton NHS Trust)

55. A significant number of responses focussed on different sector membership or representation. This was heard most frequently in relation to the role of primary care and clinical representation. Replacing the GP-led governance model of a CCG with a broader representation from across the health and care system, led to a number of respondents expressing that a primary care 'representative' was not strong enough. Similarly, a significant number of responses wanted to see a strong clinical voice – noting its importance as a vital link between patients and commissioning and an independent challenge. It was felt this was a key success of the current CCG model.

56. Many responses recognised the importance of PCNs as system partners, but acknowledged the need for continued PCN development to support working at place: "we should acknowledge the extent of the continued support for PCNs that will be required into the future, if they are to function both as local delivery groups and partners in the wider system." (North Kirklees CCG).

57. A specific concern expressed frequently, by similar letters submitted by a number of LMCs, related to the future of the GMS/PMS contract: *"General Practice is funded through the GMS/PMS contract. The consultation document does not give detail of whether or not GMS/PMS funding is included in the "single pot". This needs to be specified in any proposal, and negotiated with the General Practitioners Committee (GPC) of the BMA, before any proposed changes can be accepted by the profession."* (Various LMCs from across the country). We confirm that our proposals to legislate for ICSs do not propose changes to the contractual model for general practice. Nor will they impact upon nationally agreed GMS contractual terms and conditions.

58. We expect primary care to play a key leadership role in the future of ICSs, with a central role in providing joined up care at neighbourhood and place level. There will also be an important role for primary care professionals in place-level committees, working with partners to integrate services for their patients. Clinical, and wider multi-professional, involvement will be central to success at system and place level: *"Care should be taken in the implementation of either of the two options set out not to lose the clinical voice in system level decision making. This should be multi-professional and not entirely Primary Care or Acute dominant."* (Surrey Heartlands CCG). There are various possible options including professional representation in place-based committees. We will work with professional groups and emerging ICSs over the next few months to develop guidance on professional involvement. In approving the establishment of statutory ICSs, NHSE/I will expect to see proposals for professional involvement which have been developed locally with those professionals.

59. We also heard a clear message from NHS leaders that the NHS ICS body needs effective decision-making arrangements, consistent with their statutory accountabilities, to enable ICSs to take decisions on behalf of their populations. The think-tanks also pointed to the practical operational problems of having overly large, representative boards. We conclude that NHS trust and Foundation Trust, general practice and local authority officer membership should explicitly be required as minimum arrangements within the composition of the board of the NHS ICS body, alongside the Chair and Chief Executive. The body would have the flexibility to add beyond this minimum, in a way that best takes account of local circumstances. Formal accountability for spending and performance (and meeting statutory duties) would flow from the ICS AO (the Chief Executive) to NHSE AO to Parliament. The NHS ICS Chair appointment process should be locally driven, with an appointment formally made by NHSE.

**Legislative recommendation 4: There should be maximum local flexibility as to how the health and care partnership is constituted, for example using existing arrangements such as existing ICS partnership boards or health and wellbeing boards where these work well.**

**The composition of the board of the NHS ICS body must be sufficiently streamlined to support effective decision-making. It must be able to take account of local circumstances as well as statutory national guidance. Legislation should be broadly permissive, mandating only that the members of the Board must include a chair and CEO and as a minimum also draw representation from (i) NHS trusts and Foundation Trusts, (ii) general practice, and (iii) a local authority. As with CCGs now, NHSE/I should approve all ICS constitutions in line with national statutory guidance. Explicit provision should also be made for requirements about transparency.**

## Should ICSs take on some NHSE direct commissioning functions?

60. The proposal set out in our engagement document questioned whether – where appropriate – the direct commissioning functions of NHSE should be transferred to ICSs or delegated at an appropriate point. As there would no longer be a conflict of interests with the current GP-led CCG model (created by the 2012 Act), many commissioning functions for which NHSE is currently responsible could, for the most part, be transferred or delegated to ICS bodies – although safeguards such as national contracts and service specifications would remain. It would also be possible to allocate combined population-level primary care, community health services and specialised services population budgets to ICS bodies, enabling greater integration in the way services are arranged and delivered.

<b>Survey proposal</b>	<b>1,738 responses (5,142 KONP responses)</b>
4	Do you agree, subject to appropriate safeguards and where appropriate, that services currently commissioned by NHSE should be either transferred or delegated to ICS bodies?

61. Of the unique and clearly identifiable responses received 42.5% agreed or strongly agreed with our proposals, with 43.7% disagreeing or strongly disagreeing. 13.9% of respondents were neutral towards the proposal. Although a range of commissioning bodies, providers and representative bodies across the range of directly commissioned services responded, the majority of responses to this question referenced specialised services and/or primary medical services, with a smaller number outlining the impacts on the other directly commissioned services. Many of the reservations here related to concerns about general practice contracts.

62. Whilst many respondents recognised the potential opportunities around integrating commissioning responsibilities currently sitting across NHSE and CCGs through transferring or delegating NHSE’s commissioning of primary care services (i.e. primary medical, dental, ophthalmology and pharmaceutical services) to ICSs, they raised a number of issues that will need to be addressed as part of any transition and implementation.

- *Commissioning decisions should be made as locally, as possible. In principle commissioning of services by ICS rather than by NHSE is preferable in areas such as primary care where integration between, for example, pharmacy, dentistry and general practice may be very valuable.* (Healthwatch Richmond Upon Thames)
- *Whether transfer or delegation is appropriate or safe depends largely on the service in question. Some services are most efficiently and equitably commissioned at a national level (especially rare or standardised services). In others, the additional costs of more local commissioning are outweighed by local ‘fit’ and sensitivity to local circumstances.* (FODO, The Association for Eye Care Providers)
- *The LDC Confederation considers that commissioning dental services at a more local level would bring many benefits, providing that adequate funding and contract management experience is also devolved.* (LDC Confederation)

63. There were a number of specific comments on specialised services, the majority of which were supportive of the principles behind our proposals. Nearly all respondents recognised that some (mainly high-volume and low-cost services) would be suitable to be transferred or delegated to ICS bodies, with other services commissioned on a multi-ICS footprint, depending on the population and geography. There was also clear recognition that some services, including highly specialised, should continue to be commissioned at a national level. Over three quarters of responses highlighted a need for resources and funding to follow the function.

- *With regards to specialised commissioning, some services lend themselves well to devolution to system level or clusters of systems*

*regionally (such as kidney dialysis). Devolving such services makes sense if it allows systems to plan around the entire continuum of care (improved preventative care can lead to less need for high end/cost interventions further down the line). However, there is good reason for certain aspects of specialised commissioning being held at national level, not least to ensure national consistency in service quality for the most difficult and most expensive conditions to treat. Some services are so specific and high cost that they would be better retained at national level. Such services include those relating to rare diseases. (NHS Confederation)*

64. Of the few responses relating to health and justice services, one was supportive and the other supportive in principle. The Ministry of Justice and Prisons and Probation Service both believed transferring Health and Justice services would reduce gaps in support for continuity of care and would improve the delivery and availability of services for offenders in other parts of the criminal justice system, by collaboratively working across the prison and probation pathway. It flagged a concern that for offender health personality disorder, current arrangements should be maintained for several years. In considerable potential delegation or transfers, it will be important to protect the existing national focus that has developed in recent years.

65. A limited number of responses directly mentioned section 7A public health services. All were supportive or supportive in principle of the proposal, with a minority seeking further detail. Comments were of a similar nature to those of other directly commissioned services, suggesting that resources should follow the function at the point of transfer or delegation. Some responders identified an opportunity to go further in integrating sexual and reproductive services.

- *Supportive, number of services should transfer. Further delegation to ICPs where appropriate. Resources should follow for direct and specialised teams. Strengthen connections between public health. (Pennine ICP)*
- *The RCOG broadly agrees with this point, but considers that centralisation of commissioning needs to go further than what is outlined in this consultation. The RCOG, the Faculty of Sexual and Reproductive Healthcare (FSRH), the Royal College of General Practitioners (RCGP), the Royal College of Pathologists (RCPATH), the Royal College of Paediatrics and Child Health (RCPCH), and the Academy of Medical Royal Colleges have long called for holistic integrated commissioning of sexual and reproductive healthcare with one body maintaining oversight and holding accountability for all commissioning decisions. (RCOG)*

66. Some respondents sought further clarity on what ‘appropriate safeguards’ would be in place both before the transfer or delegation took place, and how it would be monitored going forward. This was also a common theme across respondents who were supportive or did not state a position.

- *At this stage, without clarity on the ‘appropriate safeguards’ we are not able to fully support this proposal. We have some concerns that delegating or transferring specialised commissioning responsibilities to*

*ICS bodies from NHSE could lead to inappropriate variation developing at local or regional level. (RCN)*

67. A number of respondents mentioned the need for both the funding of the function and resources (i.e. staff) to move with that function so there isn't a gap in resources or skills to continue to perform that function well.

- *ICSs should also be allocated the resources for primary care, with the expectation that much of this is likely to be delegated in turn to place based partnerships. When transferring or delegating responsibility and budgets to ICSs it will also be important to ensure that they have the staff and access to expertise to undertake these functions. (Kings Fund)*

68. Whilst appreciating the ambition and appetite expressed by many respondents to ensure that commissioning of services should be integrated wherever possible, NHSE/I recognises that this is not a simple process. Consideration needs to be given to how, as much as which, services are transferred or delegated. This is in terms of the timing and transition; the safeguards that must be put in place to ensure consistency of approach; maintaining quality of services for patients; and ensuring financial flows:

- *We agree that specialised services currently commissioned by NHS England should be transferred or delegated to ICS bodies where appropriate. There should be a clear methodology to define which services remain commissioned by NHS England and this methodology is likely to be a mix of the rarity of the condition along with possible complexities in treatment that mean only very limited number of national providers are sustainable. For services transferred to ICSs, ICSs should be allowed to come together to commission services where appropriate and this is likely to vary across the country given the differences in population density and the number of providers. When transferring or delegating responsibility and budgets to ICSs it will also be important to ensure that they have the staff and access to expertise to undertake these functions. (Kings Fund)*

69. NHSEI will undertake a comprehensive primary care commissioning transformation programme, working with contractors, clinicians, NHSE's commissioners, ICSs and others to ensure the safe and effective transfer of any primary care commissioning functions to ICS bodies. At the same time we will maintain a national role in agreeing and maintaining contracts, and managing back office functions (such as transactional payments for eye tests or dental check-ups) and performers lists. For specialised, health and justice, armed forces and s.7A public health services, NHSE/I will work with regional and local teams, and stakeholders, to ensure it takes as flexible approach as legislation allows to transfer or delegation of those directly commissioned services, so that:

- services are commissioned at the most appropriate footprint (population size). Particularly for specialised services, this means that commissioning of certain services will remain the responsibility of NHSE, and others will become the responsibility of ICS bodies either singularly or as groups of ICSs;

- for all services (regardless of who the commissioner is), NHSE/I will continue to have a role in setting national standards and service specifications, and maintaining nationally mandated contracts to ensure continuing national consistency, alongside any other appropriate safeguards NHSE/I and stakeholders identify as essential to preserving the safe and effective commissioning of these services (e.g. an appropriate assurance and oversight framework);
- there can be a phased approach to the implementation of any future operating model to ensure the safe transfer of service commissioning, once safeguards are in place, financial flows and resources are clear, and all systems fully prepared for any new responsibility.

**Legislative recommendation 5: Provisions should enable the transfer of appropriate primary medical, dental, ophthalmology and pharmaceutical services by NHS England to the NHS ICS body. Provision should also enable the transfer or delegation by NHS England of appropriate specialised and public health services we currently commission. And at the same time, NHS England should also retain the ability to specify national standards or requirements for NHS ICSs in relation to any of these existing direct commissioning functions.**

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

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To:  
CCG Accountable Officers  
ICS and STP leaders  
NHS Trust and NHS Foundation Trust Chief Executives

Skipton House  
80 London Road  
Elephant and Castle  
London  
SE1 6LH

Thursday 11 February 2021

Dear Colleague

## **INTEGRATED CARE SYSTEMS: NEXT STEPS**

The whole country is rightly proud of the way the NHS has responded so swiftly and magnificently to coronavirus, the biggest public health emergency in its history, from the rapid implementation of innovative solutions to provide care for our most vulnerable communities to the impressive vaccine rollout.

Throughout the pandemic, the innovation of local leadership and hardworking staff has allowed us to accelerate the real progress made in breaking down barriers to integrated care in the way our patients and communities clearly need.

As you know, last November, NHS England and NHS Improvement invited views on strengthened proposals to put integrated care systems (ICSs), on a statutory footing.

We received thousands of responses from every part of the health and care system as well as the public. I am writing to update you on a few next steps and how we will take your responses forward.

The legislative proposals go with the grain of what patients and staff across the health service all want to see – more joined-up care, less legal bureaucracy and a sharper focus on prevention, inequality and social care.

It builds on the past seven years of practical experience and experimentation across the health service kicked off by the NHS Five Year Forward View, and the NHS Long Term Plan and reinforced by the flexibility NHS staff and organisations have shown throughout the pandemic.

The proposals are designed to be flexible, allowing the health and care system to continue to evolve, and are designed to better equip the NHS and local health services to meet the longer-term health and societal challenges over the coming years.

## Our legislative recommendations to Government and Parliament

Your responses to our November paper have directly informed our recommendations to Government and Parliament and the recommendations below will form the basis of the Government's White Paper.

We are publishing [Legislating for Integrated Care Systems](#), which sets the five recommendations we are making, alongside principles to guide how the Government progresses this work.

The recommendations are:

1. The Government should set out at the earliest opportunity how it intends to progress the NHS's own proposals for legislative change.
2. ICSs should be put on a clear statutory footing, but with minimum national legislative provision and prescription, and maximum local operational flexibility. Legislation should not dictate place-based arrangements.
3. The NHS ICS statutory body should be supported by a wider statutory health and care stakeholder partnership. Explicit provision should also be made for requirements about transparency.
4. There should be maximum local flexibility as to how the ICS health and care stakeholder partnership is constituted, for example using existing arrangements such as existing ICS partnership boards or health and wellbeing boards where these work well. The composition of the board of the NHS ICS statutory body itself must however be sufficiently streamlined to support effective decision-making. It must be able to take account of local circumstances as well as statutory national guidance. Legislation should be broadly permissive, mandating only that the members of the NHS ICS Board must include a chair and CEO and as a minimum also draw representation from (i) NHS trusts and Foundation Trusts, (ii) general practice, and (iii) a local authority. As with CCGs now, NHSE/I would approve ICS constitutions in line with national statutory guidance.
5. Provisions should enable the transfer of responsibility for primary medical, dental, ophthalmic and community pharmacy services by NHS England to the NHS ICS statutory body. Provision should also enable the transfer or delegation by NHS England of appropriate specialised and public health services we currently commission. And at the same time, NHS England should also retain the ability to specify national standards or requirements for NHS ICSs in relation to any of these existing direct commissioning functions.

## **Publication of Government White Paper**

Based on our legislative proposals, the Department of Health and Social Care is today setting out new proposals to streamline and update the legal framework for health and care. Key measures included in the 'Integration and Innovation: working together to improve health and social care for all' White Paper include:

- Support for our proposal to create statutory Integrated Care Systems (as set out above).
- Support for our proposal to scrap mandatory competitive procurements by which NHS staff currently waste a significant amount of time on unnecessary tendering processes for healthcare services. Under today's proposals, the NHS will only need to tender services when the NHS itself considered this has the potential to lead to better outcomes for patients. The Competition Market Authority will no longer be involved in NHS oversight. Local NHS services will have more power to act in the best interests of their communities.
- The safety of patients is at the heart of NHS services. The upcoming Bill will put the Healthcare Safety Investigations Branch permanently into law as a Statutory Body so it can continue to reduce risk and improve safety. The Healthcare Safety Investigations Branch already investigates when things go wrong, so that mistakes can be learned from, and this strengthens its legal footing.
- Support for our proposal to formally fold Monitor and the Trust Development Authority (i.e. NHS Improvement) into NHS England.
- A package of measures to deliver on specific needs in the social care sector. This will improve oversight and accountability in the delivery of services through new assurance and data sharing measures in social care, update the legal framework to enable person-centred models of hospital discharge, and improve powers for the Secretary of State to directly make payments to adult social care providers where required.
- The pandemic has shown the impact of inequalities on public health outcomes and the need for Government to act to help level up health across the country. Legislation will help to support the introduction of new requirements about calorie labelling on food and drink packaging and the advertising of junk food before the 9pm watershed.

## **Supporting staff through the transition**

We have proposed that the NHS ICS statutory body will take on the commissioning functions that currently reside with Clinical Commissioning Groups (CCGs) alongside some of the responsibilities that currently reside with NHS England. If these proposals are passed by Parliament, this will of course impact our staff, so we need to ensure the implementation is right.

Under these proposals we need to ensure that we support our staff during organisational change by minimising uncertainty and limiting employment changes as much as possible. We are therefore seeking to provide as much stability of employment as possible so that ICSs can use the skills, experience and expertise of our NHS people.

To make the transition process as smooth as possible for you teams we will introduce an 'employment commitment' for colleagues within the wider health and care system (below board level) affected directly by these legislative proposals including where relevant CCGs, NHS England and NHS Improvement and NHS providers.

Further information can be found in the [FAQs](#) on how we will support our people, give confidence over future employment arrangements and ensure that we can keep our collective focus on the recovery and transformation challenges that lie ahead which will be regularly updated.

### **Consultation on updates to the procurement regime**

A common theme within the responses to the November paper was the frustration faced by your teams due to general competition rules and powers. To address these concerns we are also publishing [The Provider Selection Regime](#), a new approach to procurement of services, to make it easier to develop stable collaborations and to reduce some of the cost burden associated with the current regime.

We have heard that you want a decision-making process that makes space for real collaboration to happen. The creation of statutory ICSs brings the opportunity to create a way of making decisions about healthcare services that is in step with the integrated, collaborative approach we have developed in recent years.

### **Supporting your teams with the guidance they need**

Removing legislative barriers to integrated care is important but it is only one part of how we embed and take forward how our services are planned and delivered.

Throughout our engagement, you have reaffirmed your support for the idea that collaboration is more effective than competition in tackling the health and care challenges we face. In several important areas, we will share more detail and take specific action to fully realise this vision.

The experience of systems will inform planning guidance that we expect to provide in April 2021 and the future ambition for systems from April 2022. The ***Integrating Care*** paper was not the beginning of our engagement and it will not be the end.

We will give all systems the chance to directly shape this and the other guidance and advice that they need during 2021.

The changes set out today will help to shape our future work, which at its heart is about enabling everyone we serve to live a healthier and happier life for longer, with more convenient, responsive services when people need them.

I look forward to working with you all on further developing and implementing Integrated Care Systems.

Your sincerely

A handwritten signature in black ink that reads "A. Pritchard". The signature is written in a cursive style with a large, stylized initial 'A'.

Amanda Pritchard

Chief Operating Officer, NHS England and NHS Improvement  
and Chief Executive, NHS Improvement

# FAQs on NHS England and NHS Improvement's legislative recommendations on ICSs

Version 1, 11 February 2021

## 1. Why do you need to legislate for ICSs and why now?

- Legislation helps to clarify roles and responsibilities between health and care organisations, and we do not believe that existing legislation provides a sufficiently firm foundation for system working. It is only one part of the solution, but it is an important one.
- In part this is a reflection of response to the COVID-19 pandemic, which showed that collaboration is more effective than competition in protecting health and treating disease. As well as posing new challenges, the pandemic allowed the NHS and its partners to make important and beneficial changes to how they work, leading to new gains that we want to lock in for future.

## 2. How did you decide these recommendations?

- Our legislative recommendations are based on several years of 'bottom up' conversations with people who use and work in services, partners such as local government and the voluntary sector, the experience of the earliest ICSs and what they told us they need to get better results for those they serve.
- Most recently, we received thousands of responses to an invitation to comment on draft proposals set out in November and ran more than 30 sessions with stakeholders including patients groups, charities and organisations representing NHS clinicians and managers.
- It follows a clear and consistent direction of travel which also draws on the work of STPs and vanguards, through which local organisations worked more closely together. This was signposted in the *NHS Five Year Forward View*, the *NHS Long Term Plan* and many other documents in between.
- One of its central aims is to remove outstanding barriers and fragmentation that exist to partnership working, simplifying process and cutting bureaucracy that get in the way of partnership working. One of our aims is to ensure as little disruption as possible while having the greatest possible impact.

## 3. What will the recommendations mean for our patients and communities?

- We must never lose sight of the purpose, which is improving health for everyone, with better and more convenient care for those who needed, while spending every pound of public money wisely. Any organisational or legislative change should be the minimum necessary to support that ambition.
- ICSs and STPs have done great things during the past few years: improving mental health services for those at times of crisis, supporting children to get the healthiest possible start in life, and identifying and shielding the most vulnerable during the COVID-19 pandemic. Our recommendations are about making it easier behind the scenes to support people who provide health and care services to be supported do more things like these.

#### **4. What will they mean for commissioning responsibilities?**

- Distinct commissioning and provider responsibilities will remain in individual organisations or systems in law, even with legislative changes that place statutory NHS commissioning functions with ICSs.
- Nevertheless, we want to support commissioning functions to become more strategic and better equipped to plan how to meet the whole needs of their populations. This will also involve providers playing an enhanced role, particularly in drawing on clinical expertise to make decisions about service change and pathway redesign.
- We want to support commissioners and providers to work together, bringing together their distinct perspectives and expertise to make genuinely cross-system decisions about how we improve health and care for all citizens.

#### **5. What does this mean for our clinical and professional leaders?**

- Clinical and other frontline staff have led the way in working across professional and institutional boundaries and will be supported to continue to play a significant leadership role in places and systems. We will be producing advice for ICSs on embedding system-wide clinical and professional leadership at every level of governance, including through their health and care partnership.
- This should include a central role for GPs and primary care networks. As well as planned primary care representation on the NHS ICS board, clinical leaders representing primary care will sit in place-based partnerships reflecting their important part in place-based planning and local leadership.
- Experience of the earliest ICSs shows that great leadership is critical to success and can come from any part of the health and care system. To be effective, it must draw on the talents of leaders from every part of a system. The earliest ICSs developed a new style of behaviour, which makes the most of the leadership teams of all constituent organisations and empowers frontline teams, and we want to share this experience everywhere.

#### **6. What does it mean for local authorities?**

- Local authorities are integral partners and have an important role in the approach we are recommending to Government.
- We are recommending the statutory establishment in each ICS of a health and care partnership which brings together NHS organisations and local councils in a partnership of equals, alongside the statutory ICS bodies which will allow the NHS and local government to act as strong partners.
- We expect the devolution of more functions and resources to place-based committees to enable further local decision-making.
- One of the core purposes here is for the NHS to make a full contribution to economic and social recovery that can only be achieved in partnership with local councils. We know that this includes the full run of their work – for example, housing, leisure and employment services as well as public health and social care.

## **7. How will the voluntary sector be involved?**

- The voluntary, community and social enterprise (VCSE) sector is a critical strategic partner in ICSs and brings skills and a perspective that can help improve systems' work. There are many examples of the VCSE sector playing a full role in the work of systems: providing services and understanding of local communities and their health and care needs.
- From a legislative point of view, although there would be a core mandatory membership requirement for the health and care partnership and the NHS ICS Board, local systems would be able to invite any other organisation or representative to be involved in a way that best suits their local population.
- We will be setting out further guidance and support later in 2021 to help all systems involve the VCSE sector in their work at every level.

## **8. How will a statutory ICS be different from a CCG?**

- ICSs will be a different type of decision-making body from CCGs – by bringing in the perspectives and skills of a wider range of partners. We want to empower them to take the best of CCGs, but to be better equipped to respond to the whole needs of the population they serve.
- Although we propose the ICS takes on many of the CCG functions, its remit will be much broader and have a much greater system role. NHS trusts, FTs or local authorities will be full and active partners in the leadership of the ICS and could also delegate some of their functions into the collaborative arrangements in the system.

## **9. Will this change accountability arrangements for NHS trusts and foundation trusts?**

- Our recommendations for ICS will not fundamentally change the core duties and functions of NHS trusts and foundation trusts to improve quality of care for patients and meet key financial requirements.
- The move towards greater collaboration will foster mutual accountability for health outcomes between NHS and other organisations at system level, drawing on the collective expertise of commissioners and providers to plan services in the best interests of local people and the wider health economy.
- To help achieve this, NHSE/I's legislative recommendations for government include new duties to support more collective decision-making in order to improve quality of care, ensure effective use of resources and take into account the health needs of the local community.

## **10. How will the transition be handled?**

- We want to take a different approach to this transition: one characterised by care for our people without distracting them from the 'day job' and the critical challenges of recovery for the NHS and tackling population health.
- We also want to provide as much stability of employment as possible while NHS ICS bodies develop new roles and functions that not only

improve health and care but also make better use of the skills, experience and expertise of all our NHS people.

- There will be a set of HR principles developed nationally to support this transition and these will be available in April 2021. The aim of these principles is to provide a framework for a consistent approach, including the employment commitment, but to enable local implementation, recognising the differences in systems across the country.

## **11. How will creation of statutory ICSs affect those who work in CCGs and ICSs?**

- Under these proposals we need to ensure that we support our staff during organisational change by minimising uncertainty and limiting employment changes as much as possible.
- We want to take a different approach to this transition; one that is characterised by care for our people and no distraction from the 'day job' - the critical challenges of recovery for the NHS and tackling population health.
- We are therefore seeking to provide as much stability of employment as possible while NHS ICS bodies fulfil their purpose, functions and roles, and ensure they use the skills, experience and expertise of all our NHS people in doing so.
- Colleagues in CCGs will become employed by the NHS ICS body as the legislation comes into effect and the ICS becomes the statutory body. There is still a requirement for strong place based work within an NHS ICS Body which is why we think this option can provide both the necessary change but with minimal organisational change.
- NHS people within the wider health and care system (below board level) affected directly by these legislative changes, including CCGs, NHSEI and NHS providers, will receive an employment commitment to continuity of terms and conditions (even if not required by law) to enable all affected colleagues to be treated in a similar way despite a variety of contractual relationships. This commitment is designed to provide stability and remove uncertainty during this transition.
- We will promote best practice in engaging, consulting and supporting the workforce during a carefully planned transition, minimising disruption to staff.

## **12. Will NHS England and NHS Improvement staff be affected?**

- For NHS England and NHS Improvement staff, this has been a long-standing direction of travel with many staff already supporting ICSs directly and some working within or alongside ICS teams. We believe this has and will continue to, create attractive opportunities, focussed on the needs of patients and communities.
- With the continued development of this policy NHS England and Improvement staff in some areas will be affected depending on which function they are performing. We have heard support for this direction of travel and are engaging colleagues to define the impact on staff as we move towards embedding current NHSEI direct commissioning functions in ICSs.

- If legislative change is agreed and if any NHS England or NHS Improvement functions are to transfer to newly created organisations or reshaped within NHSE/I as a consequence, the same employment commitment to continuity of terms and conditions would apply to those colleagues directly impacted.
- We will promote best practice in engaging, consulting and supporting the workforce during a carefully planned transition, minimising disruption to staff.

### **13. Will there be a national HR framework to support the transition?**

There will be a set of HR principles developed nationally to support this transition and these will be available in April 2021. The aim of these principles is to provide a framework for a consistent approach, including the employment commitment, but to enable local implementation, recognising the differences in systems across the country.

### **14. Will there be national guidance for appointments to the roles in the new NHS ICS body?**

There will be national guidance to support appointments to the new roles in NHS ICS body as specified in the legislation.

### **15. How has our commitment to support staff changed since the recent engagement?**

- The reference to the employment commitment only lasting until 2022 has been removed in recognition of the different forms each transition journey is likely to take locally.
- Clarity that the commitment relates to colleagues below board level only but also applies to people in CCGs, NHSEI and NHS providers across the health and care system if they are affected by these legislation changes.

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

7 January 2021

**To:** GPs in England, Regional Directors of Primary Care and Public Health and CCGs

Dear colleagues,

### **Freeing up practices to support COVID vaccination**

We would like to thank you and your teams for the tremendous response in rapidly mobilising vaccination centres over December and January while continuing to manage the ongoing needs of your population and continuing to provide additional and much needed support to your local urgent and emergency care systems. By next week, the vast majority of designated PCN vaccination sites will have started to deliver vaccinations.

This letter sets out further support we are taking to free up GPs, practice teams and PCNs to advance the vaccine rollout.

We recognise that the challenge of balancing how best to allocate your practice and PCN resources including workforce time is a daily reality for many practices. It is our intention to support the professional judgement of clinicians in making these decisions, where needed.

To do this, we are asking **CCGs to take the following steps immediately with respect to prioritisation of work:**

1. Take a supportive and pragmatic approach to minimise local contract enforcement across routine care, with attention and support focused on the core areas set out above.
2. Suspend any locally commissioned services, **except** where these are specifically in support of vaccination, or other COVID-related support to the local system, eg wherever they contribute to reducing hospital admissions or support hospital

discharge. For example, suspension of reporting requirements relating to PMS key performance indicators. Budgeted payment against these services should be protected to allow capacity to be redeployed.

3. Review whether clinical staff involved in CCG management could be made available to redeploy in support of practices or PCN work.

**We will also take the following steps nationally:**

4. In recognition of the role of PCN Clinical Director in managing the COVID vaccination response, we will provide further funding for PCN Clinical Director support temporarily for Q4 (Jan-March 21), equivalent to an increase from 0.25WTE to 1WTE for those PCNs where at least one practice is participating in the COVID-19 Vaccination Programme Enhanced Service.

This is in recognition of the additional demands on the role in managing the COVID response, vaccination process and coordinating the engagement and access for harder to reach groups. Recognising that many Clinical Directors may have clinical and other commitments, this funding will be able to be flexibly deployed by PCNs to support the leadership and management of the COVID response.

5. The Minor Surgery DES income will be income protected until March 2021 and we intend to make similar provision for the additional service income related to minor surgery within the global sum.
6. The Quality Improvement domain within QOF will be protected in full at 74 points per practice until March 2021.
7. The 8 prescribing indicators within QOF will be income protected on the same basis as the existing 310 points which have been income protected. Payment will be made on past performance against the relevant clinical domains. We will use the 20/21 recorded register size to apply the usual prevalence adjustment as well as the usual list size adjustment to 20/21 QOF payments.
8. Appraisals can be declined during this period but if you are going ahead, please use the revised, shortened, supportive 2020 model.

Alongside the vaccination programme, we have set out a number of areas which represent the biggest priorities for general practice over the coming quarter, to be

supported through the COVID-19 Capacity Expansion Fund. In addition to securing additional workforce these priorities are as set out in our [9 November letter](#):

- Ensure general practice remains fully and safely open for patients, including maintenance of appointments.
- Supporting establishment of the simple COVID oximetry@home patient self-monitoring model and identifying and supporting patients with Long COVID.
- Continuing to support clinically extremely vulnerable patients and maintain the shielding list.
- Continuing to make inroads into the backlog of appointments including for chronic disease management and routine vaccinations and immunisations. Note that any prioritised chronic condition management reviews may be carried out remotely where clinically appropriate.
- On inequalities, making significant progress on learning disability health checks and ethnicity recording.

### **Extended access arrangements from April 2021**

In [our recent letter](#) describing the necessary preparation for the COVID-19 vaccine programme, we urged local providers and CCGs to repurpose extended hours and access capacity to support the vaccination programme. This letter provides an update on extended access arrangements from April 2021 in order to ensure that previously planned contractual changes do not disrupt vaccination activity.

We have previously set out – in [Investment and Evolution](#) – that from April 2021 the wider CCG-commissioned extended access service would become part of the Network Contract Directed Enhanced Service (DES).

Given the uncertainty around the timing of the COVID vaccination programme, we have agreed with the British Medical Association's General Practitioners Committee (England) that we will delay the planned introduction of the new standardised specification for extended access as part of the Network Contract DES – and the associated national arrangements for the transfer of CCG extended access funding. We do not anticipate that the national introduction of the new enhanced access service or the associated transfer of funding will take place before April 2022.

The extended hours access requirements in the existing Network Contract DES will remain as they are for the same period. In instances where the capacity is not

required for vaccine delivery, it should be used for local priorities. This includes access to urgent and pre-booked appointments over the coming winter months.

CCGs must now make arrangements for the CCG-commissioned extended access services to continue until April 2022. Where these services are already commissioned from PCNs, we would expect these arrangements to continue.

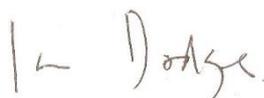
We would also strongly encourage commissioners to make local arrangements for a transition of services and funding to PCNs before April 2022, where this has been agreed with the PCN, and the PCN can demonstrate its readiness.

Thank you for your continued hard work and rapid action to do all that is necessary to respond to this pandemic.

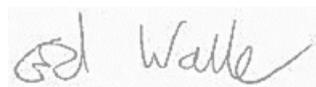
Yours sincerely,



**Dr Nikita Kanani MBE**  
Medical Director for  
Primary Care



**Ian Dodge**  
National Director,  
Strategy and Innovation



**Ed Waller**  
Director of Primary Care

## GOVERNING BODY

11 March 2021

### Covid-19 Response and Phase 3 Recovery update

#### PART 1A – SUMMARY REPORT

<b>1.</b>	<b>THIS PAPER IS FOR</b>											
	Decision	<input type="checkbox"/>	Approval									
		<input checked="" type="checkbox"/>	Assurance									
		<input checked="" type="checkbox"/>	Information									
		<input type="checkbox"/>										
<b>2.</b>	<b>PURPOSE</b>											
	<p>To provide Governing Body with an update in relation to the current situation and the CCG response to the Coronavirus Disease (COVID19) pandemic.</p> <p>At the Governing Body meeting on 14 January, information was provided on the COVID-19 Vaccination Programme in Primary Care. This paper provides a further update on plans and delivery to date.</p>											
<b>3.</b>	<b>REPORT OF</b>											
	<table border="1"> <thead> <tr> <th></th> <th>Name</th> <th>Designation</th> </tr> </thead> <tbody> <tr> <td>Clinical Lead</td> <td>Nick Balac</td> <td>Chair</td> </tr> <tr> <td>Executive Lead &amp; Author</td> <td>Jamie Wike</td> <td>Chief Operating Officer</td> </tr> </tbody> </table>				Name	Designation	Clinical Lead	Nick Balac	Chair	Executive Lead & Author	Jamie Wike	Chief Operating Officer
	Name	Designation										
Clinical Lead	Nick Balac	Chair										
Executive Lead & Author	Jamie Wike	Chief Operating Officer										
<b>4.</b>	<b>SUMMARY OF PREVIOUS GOVERNANCE</b>											
	<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 MT Call</td> <td>Updates and COVID related decisions</td> </tr> </tbody> </table>			Group / Committee	Date	Outcome	Management Team	Weekly MT Call	Updates and COVID related decisions			
Group / Committee	Date	Outcome										
Management Team	Weekly MT Call	Updates and COVID related decisions										
<b>5.</b>	<b>UPDATE REPORT</b>											
<b>5.1</b>	<b>Introduction</b>											
	<p>Following the declaration by the World Health Organisation (WHO) on 11 March that the COVID19 outbreak be classified as a pandemic and the introduction of 'lock down' restrictions on 23 March the CCG Governing Body noted on 26 March that the situation was being managed as a level 4 incident for the NHS with national</p>											

command and control structures in place. From 1 August, as a result of COVID inpatient numbers falling and a reduced demand on the NHS, the NHS EPRR was reduced from level 4 (national) to level 3 (regional). This continued to be the case until 4 November 2020, however following continued increases in the number of cases and particularly increases in the number of hospital inpatients, the Government introduced national restrictions, initially for a period from 5 November to 2 December 2020 followed by a new tiered system to reflect level of risk. To coincide with this, from 5 November the NHS EPRR level was increased back to level 4 (national) and the latest guidance is that we will remain in a level 4 incident for at least the rest of this financial year, maintaining the level of control that NHS England have over commissioning functions.

On 3 January due to continued high infection rates and high hospital admissions there was an introduction of further lockdown restrictions which were stronger than the tiered system and included the closure of Secondary and Primary schools. The period following the introduction of these measures, coinciding with the introduction vaccination programme has had a positive impact upon both infection rates and hospital admissions.

On the back of this, on 22 February 2021 a 'Road map out of lockdown' was published which sets out the pathway to removing all restrictions. From 8 March, restrictions will start to lift and the government's four-step roadmap aims to provide a route back to a more normal life. Coinciding with this the NHS will need to focus on our recovery plans with a particular focus on reversing the trend of increasing waits for some healthcare services. In Barnsley this work will be taken forward as part of the work of the Planned Care Board and Urgent and Emergency Care Delivery Board.

The roadmap is set around 4 key steps with indicative dates for moving through these steps however all the dates are indicative and subject to change if there are any factors that could put recovery at risk. There will be a minimum of five weeks between each step: four weeks for the scientific data to reflect the changes in restrictions and to be analysed; followed by one week's advance notice of the restrictions that will be eased.

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

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

The earliest date for Step 4 would be 21 June 2021 and at this point the government hopes to be in a position to remove all legal limits on social contact.

As we move through the 4 steps, the CCG will continue to work with local partners in Barnsley and across the South Yorkshire and Bassetlaw Integrated Care System to deliver against our local priorities and plans as described in the Barnsley COVID19 Reset Plan. This plan will be reviewed and refined on an ongoing basis to ensure that agreed actions are having the positive desired impact upon healthcare and health outcomes for Barnsley people.

**5.2 Command, Control and Co-ordination Arrangements**

The command, control and co-ordination structures described to Governing Body on 30 April currently remain in place across the health and care system in Barnsley. This includes the health and care coordination arrangements consisting of a Barnsley Health and Social Care Strategic Co-ordination Group (Gold), a Health and Social Care Tactical Group (Silver) and operational groups (Bronze). These arrangements will be reviewed in light of the 'roadmap' to allow the health and care system to continue to respond to any emerging COVID related issues but as importantly to begin to move towards business as usual and to embedding the positive changes that have emerged during the COVID pandemic. An example would include the use of digital solutions to increase access the healthcare.

The CCG command and control structure and clinical leadership arrangements also remain in place through the Senior Management Team.

**5.3 COVID-19 Vaccination Programme**

The COVID vaccination programme, the biggest and most ambitious in NHS history began on 8 December 2020 following the approval the first vaccine by the Medicines and Healthcare products Regulatory Agency (MHRA) on 2 December.

At the same time the Joint Committee for Vaccination and Immunisation (JCVI) set out the priorities for roll out of the vaccine.

There are a number of elements to the vaccination programme, these include:

- Hospital Hubs
- Large scale vaccination centres
- PCN/Community Hubs
- Roving vaccination teams (to vaccinate housebound, care home residents and other vulnerable groups)

Whilst there have been numerous challenges in implementing the vaccination programme, with support from local partners in Barnsley the top four priority cohorts were all offered, and had the opportunity to be vaccinated by 15 February 2021 in line with national targets. This included everyone over 70, people who are Clinically Extremely Vulnerable (CEV), residents in care homes for older people and frontline health and care staff.

The vaccination programme has now moved on to the next priority cohorts. This includes all people aged over 60 and people aged 16-69 with specific clinical conditions and their carers.

This is a large cohort of the population and therefore local primary care services are initially being asked to focus on those people with clinical conditions and people identified as carers on the GP registers.

All people aged 65-69 also have been sent a letter to invite them to book an appointment for a vaccine through the national booking system. This provides those who are able to travel to large scale vaccination sites to do so. This will be followed by letters to everyone over 60 who have not yet received a vaccine.

	<p>Those who are not able to travel are able to wait and they will be contacted by the local services however the key message to all eligible people to it take up the vaccine at the earliest opportunity available.</p> <p>From the week commencing 1 March, second dose vaccinations will also begin for those people who were vaccinated in mid-December in line with the recommended gap between doses.</p> <p>The current ambition is for all people in the JCVI priority cohorts 1-9 (50+ or 16+ with clinical conditions, front line health and care staff and carers) to be able to receive the first dose of the vaccine by 19 April 2021, with the rest of the adult population able to receive the first vaccine by the end of July 2021.</p> <p>To ensure equitable access and uptake to the vaccination locally, specific work is being undertaken engage with all communities, utilising community champions and considering vaccination models to target groups of the population who may be hesitant in coming forward or who may not feel able to access the vaccination through the current vaccination clinics.</p>
<b>6.</b>	<b>THE GOVERNING BODY IS ASKED TO:</b>
	<ul style="list-style-type: none"> <li>Note the update provided in this paper including the progress in implementing the vaccination programme.</li> </ul>

<b>Agenda time allocation for report:</b>	<i>10 minutes</i>
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**PART 1B – SUPPORTING INFORMATION & ASSURANCE**

<b>1.</b>	<b>Links to Corporate Priorities, GBAF and Risk Register</b>	
	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	✓
	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	✓
	11.1 Delivery of Enhanced Health in Care Homes	✓
	The report also provides assurance against the following red or amber risks on the Corporate Risk Register:	N/A
<b>2.</b>	<b>Links to statutory duties</b>	
	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)	
	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)	
<b>3.</b>	<b>Governance Considerations Checklist</b> ( <i>these will be especially relevant where a proposal or policy is brought for decision or approval</i> )	
<b>3.1</b>	<b>Clinical Leadership</b>	
	Have GB GPs and / or other appropriate clinicians provided input and leadership?	Y
	Proposals to be signed off by virtual Governing Body meeting	
<b>3.2</b>	<b>Management of Conflicts of Interest (s14O)</b>	
	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
<b>3.3</b>	<b>Discharging functions effectively, efficiently, &amp; economically (s14Q)</b>	
	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	<b>Improving quality (s14R, s14S)</b>	
	Has a Quality Impact Assessment (QIA) been completed if relevant?	<b>NA</b>
	Have any issues or risks identified been appropriately addressed having taken advice from the Chief Nurse (or Deputy) if appropriate?	<b>NA</b>
3.5	<b>Reducing inequalities (s14T)</b>	
	Has an Equality Impact Assessment (EIA) been completed if relevant?	<b>NA</b>
	Have any issues or risks identified been appropriately addressed having taken advice from Equality Diversity & Inclusion Lead if appropriate?	<b>NA</b>
3.6	<b>Public Involvement &amp; Consultation (s14Z2)</b>	
	Has a s14Z2: Patient and Public Participation Form been completed if relevant?	<b>NA</b>
	Have any issues or risks identified been appropriately addressed having taken advice from the Head of Comms & Engagement if appropriate?	<b>Y</b>
	<i>GB and PCCC meetings will not be held in public for the duration of the outbreak due to the need for social distancing.</i>	
3.7	<b>Data Protection and Data Security</b>	
	Has a Data Protection Impact Assessment (DPIA) been completed if relevant?	<b>NA</b>
	Have any issues or risks identified been appropriately addressed having taken advice from the SIRO, IG Lead and / or DPO if appropriate?	<b>NA</b>
3.8	<b>Procurement considerations</b>	
	Have any issues or risks identified been appropriately addressed having taken advice from the procurement Shared Service if appropriate?	<b>NA</b>
	Has a Single Tender Waiver form been completed if appropriate?	<b>NA</b>
	Has a Primary Care Procurement Checklist been completed where GPs, networks or Federations may be a bidder for a procurement opportunity?	<b>NA</b>
3.9	<b>Human Resources</b>	
	Have any significant HR implications been identified and managed appropriately, having taken advice from the HR Lead if appropriate?	<b>NA</b>
3.10	<b>Environmental Sustainability</b>	
	Have any significant (positive or negative) impacts on the environment or the CCG's carbon footprint been identified?	<b>NA</b>

## Governing Body

11 March 2021

### Transforming Care Programme Update

#### PART 1A – SUMMARY REPORT

<b>1.</b>	<b>THIS PAPER IS FOR</b>							
	<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"/>
<b>2.</b>	<b>PURPOSE</b>							
	<p>The purpose of this report is to assure Governing Body members of the ongoing work that is being undertaken to ensure that, where appropriate, patients falling within the TCP Programme are being discharged into placements within the local community.</p>							
<b>3.</b>	<b>REPORT OF</b>							
		<b>Name</b>	<b>Designation</b>					
	Executive / Clinical Lead	Patrick Otway	Head of Commissioning (Mental Health, Children's and Maternity)					
	Author	Gina Johnson	Complex Case Manager – TCP Programme					
<b>4.</b>	<b>SUMMARY OF PREVIOUS GOVERNANCE</b>							
	<p>The matters raised in this paper have been subject to prior consideration in the following forums:</p>							
	<b>Group / Committee</b>	<b>Date</b>	<b>Outcome</b>					
	Governing Body	Sep 2020	Noted					
<b>5.</b>	<b>EXECUTIVE SUMMARY</b>							
	<p>On the 1<sup>st</sup> June 2011 BBC Panorama revealed a pattern of serious abuse at Winterbourne View private hospital in Bristol against a number of patients with a learning disability. 11 staff in total were sentenced for ill treatment. The care quality commission concluded there was a <b>systemic failure to protect people, over use of medications and restraint.</b></p> <p><b>The Transforming Care programme (TCP) began in October 2014, the aims being to:</b></p> <p>1. Empower and support people and their families to be listened to and to be equal partners in their own care and treatment pathway</p>							

2. Prevent people being admitted unnecessarily into learning disability and mental health inpatient beds through identifying alternatives where appropriate
3. Promptly review the proposed care and treatment and discharge plans of people who have been urgently admitted to hospital
4. Ensure that any admission is supported by a clear rationale of planned assessment and treatment together with defined and measurable intended outcomes
5. Review care and treatment and discharge plans of people who have been inpatients for a defined period of time (or sooner by request where there is dissatisfaction with progress)
6. Ensure that all parties work together with the person and their family to support discharge into the community (or if the only option, to a less restrictive setting) at the earliest opportunity
7. Ensure the involvement of the local authority including, where appropriate, children's social care, adult's social care, the Special Educational Needs (SEN) team, or school or college so that all relevant issues can be fully addressed and solutions explored for the discharge of people into community based settings, or back home to their families
8. Support a constructive and person-centred process of challenge to current and future intended care and treatment plans where necessary
9. Identify barriers to progress and make clear and constructive recommendations for how these could be overcome
10. Result in an agreed action plan at the end of the CTR that has clear actions, each of which is allocated to a named individual together with a specific timescale
11. Improve health outcomes through early access to the most appropriate services and the provision of integrated and holistic care.

### **Policy Changes**

- Throughout the latter half of 2020 there were significant changes in CTR policy. The recording templates have changed to include probe questions and extra prompts when answering the Key Lines of Enquiry (KLOE) The aim of this change is to try and improve the structure of CTRs.
- NHSE recommends a minimum of 6 hours to complete a CTR. Inclusion North are reluctant to provide Experts by Experience for any less than 5 hours.
- NHSE have Introduced stat inpatient visits of 6 weeks for adults and 4 weeks for children to increase quality assurance, ensure patient safety and to facilitate discharge planning.
- From April 2021 there is a requirement for Clinical Commissioning Groups to develop and maintain a Dynamic Support Register to the new NHSE Gold Standards. The register is to be completed by a multidisciplinary team from both health and social care. The register includes people with a

learning disability, autism or both who display, or are at risk of developing, behaviour that challenges or mental health conditions who were most likely to be at risk of admission. This should ensure that local services plan appropriately and provide early interventions, including preventative support and where necessary a CTR when the level of risk of breakdown of community support and potential hospital admission is high.

### **Covid pandemic**

NHSE has introduced specific COVID-19 questions to consider:

- the individual's risk of COVID-19 – both the risk of contracting COVID-19 initially, and the risk to them if they do contract it – and what is in place to support and protect them
- the impact of any additional restrictions brought about by COVID-19 (eg limited visits from family or outings, impact on discharge from hospital)
- the potential distress that this may cause, leading to the possibility of increased restrictive interventions (eg increase in psychotropic medication)
- how to ensure the rights of the person are being upheld.

CTRs and the majority of stat visits have been held virtually.

During the first Covid restrictions/lock down, there was a significant increase in requests for children's CTRs with the reduced school timetables and the risks of family/placement breakdowns due to increased anxiety and behaviours. These seemed to settle in August.

The Adult CTRs significantly increased on the lead up to Christmas and during the most recent restrictions introduced in January 2021 - Many adults with a learning disability and or Autism appear to struggle around the advent period but this year, we have seen increased anxieties and mental illness. This has been linked to the changes in people's routines, reduced family contact and also the slow pace of court hearings/proceedings and the "waiting game" of the criminal justice system have played a role. Many of the young adults we support have criminal convictions and forensic histories and many are still waiting for trial and sentencing. The Covid pandemic has also delayed a number of discharges, especially those complex discharges where the patient requires a purpose built provision to enable them to live in the community successfully.

### **Numbers**

In the last six month period, there have been 9 CETRs completed and 16 CTRs. We currently have 8 adult inpatients, 3 of whom are on mainstream adult mental health wards with greenlight adaptations. There are 5 adults in secure hospitals and we currently have 1 child admitted to hospital.

All long stay patients **have a discharge plan in place** and the patients within mental health services are planned to return to their own homes with support.

We currently have one case in court proceedings. Barnsley CCG and RDASH are joint parties against Barnsley Local Authority. There is an ongoing dispute in regards to this patient's capacity to understand their risks towards children and the amount of restrictions required to maintain safety. The patient is placed

	<p>under s37/41 of The Mental Health Act and the question of capacity conflicts with the MM case law judgement which states a person with capacity cannot have care and support which ultimately will deprive them of their liberty even if the patient is agreeing to the care and support.</p> <p>We also have one patient who is going on trial for a serious offence. The patient has been detained under the Lunacy Act since 2009 but has recently been assessed as having capacity to stand trial and be sentenced.</p> <p><b>Developments.</b></p> <ul style="list-style-type: none"> <li>• The closure of the Leeds ATU – this will reduce the amount of beds available across the West Yorkshire TC Cohort which Barnsley is included. Barnsley currently spot purchase a bed on The Horizon Ward within Fieldhead Hospital. This will no longer be the case and a spot purchase arrangement will have to be agreed and negotiated. Currently we pay £800 per day to spot purchase any additional beds which we require. In future, we may need to approach the private sector.</li> <li>• Mayman lane, a £2.8m specialist housing development scheme, is due to open on the 8<sup>th</sup> March 2021 with a Barnsley patient being the first admission.</li> <li>• SYB ICS housing needs assessment is now complete and will be circulated to the public in March 2021. This identifies the current housing gaps within the market and should encourage a new growth in provider services which ultimately should increase the opportunity for a prompt discharge from hospital or prevent an admission.</li> <li>• Safe space – This is something that the Barnsley are in need of. There are a number of providers looking at options currently. The safe space could be utilised as a step up/step down facility to avoid an admission.</li> <li>• The West Yorkshire TCP (CKWB) have developed a working hub to support commissioners and this should be operational by the end of February 2021. This will provide admin support to arrange CTRs.</li> </ul>
<b>6.</b>	<b>THE GOVERNING BODY / COMMITTEE IS ASKED TO:</b>
	<ul style="list-style-type: none"> <li>• Note the contents of the report</li> </ul>
<b>7.</b>	<b>APPENDICES / LINKS TO FURTHER INFORMATION</b>
	None

<b>Agenda time allocation for report:</b>	<i>10 minutes</i>
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**PART 1B – SUPPORTING INFORMATION & ASSURANCE**

<b>1.</b>	<b>Links to Corporate Priorities, GBAF and Risk Register</b>		
	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:		<i>Provide ref(s) or state N/A</i>
<b>2.</b>	<b>Links to statutory duties</b>		
	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)	<b>See 3.2</b>	Duties as to reducing inequalities (s14T) <b>See 3.5</b>
	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)	<b>See 3.3</b>	Duty as to patient choice (s14V) x
	Duty as to improvement in quality of services (s14R)	<b>See 3.4</b>	Duty as to promoting integration (s14Z1)
	Duty in relation to quality of primary medical services (s14S)	<b>See 3.4</b>	Public involvement and consultation (s14Z2) <b>See 3.6</b>
<b>3.</b>	<b>Governance Considerations Checklist</b> ( <i>these will be especially relevant where a proposal or policy is brought for decision or approval</i> )		
<b>3.1</b>	<b>Clinical Leadership</b>		
	Have GB GPs and / or other appropriate clinicians provided input and leadership?		<b>NA</b>
<b>3.2</b>	<b>Management of Conflicts of Interest (s14O)</b>		
	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?		<b>NA</b>
<b>3.3</b>	<b>Discharging functions effectively, efficiently, &amp; economically (s14Q)</b>		
	Have any financial implications been considered & discussed with the Finance Team?		<b>NA</b>
	Where relevant has authority to commit expenditure been sought from Management Team (<£100k) or Governing Body (>£100k)?		<b>NA</b>

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

## GOVERNING BODY REPORT

10 March 2021

### Barnsley Enhanced Health in Care Homes Delivery Plan

#### PART 1A – SUMMARY REPORT

<b>1.</b>	<b>THIS PAPER IS FOR</b>											
	<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"/>				
<b>2.</b>	<b>PURPOSE</b>											
	The purpose of this report is to update the Governing Body on the progress made with the Barnsley Enhanced Health in Care Homes Delivery Plan.											
<b>3.</b>	<b>REPORT OF</b>											
	<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr style="background-color: #d9e1f2;"> <th style="width: 30%;"></th> <th style="width: 35%;">Name</th> <th style="width: 35%;">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>Jo Harrison</td> <td>Specialist Clinical Portfolio Manager</td> </tr> </tbody> </table>				Name	Designation	Executive / Clinical Lead	Jayne Sivakumar	Chief Nurse	Author	Jo Harrison	Specialist Clinical Portfolio Manager
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Executive / Clinical Lead	Jayne Sivakumar	Chief Nurse										
Author	Jo Harrison	Specialist Clinical Portfolio Manager										
<b>4.</b>	<b>SUMMARY OF PREVIOUS GOVERNANCE</b>											
	The matters raised in this paper have been subject to prior consideration in the following forums:											
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Group / Committee	Date	Outcome										
Quality and Patient Safety Committee	20/08/2020	Noted										
<b>5.</b>	<b>EXECUTIVE SUMMARY</b>											
	<p><b>5.1 Introduction and background</b></p> <p>The Barnsley Care Homes Plan was formulated through the Bronze Discharge and Out of Hospital Care Delivery Group (Bronze Group) during the ‘first wave’ of the Covid-19 pandemic. This plan was initially set up in response to two documents sent to all NHS organisations and Local Authorities, when it had become clear that many care homes were reaching crisis point in terms of levels of infection, staffing shortages and deaths in resident population:</p> <ul style="list-style-type: none"> <li>• DHSC Letter: The NHS Covid 19 response: Primary care and community health support care home residents</li> </ul>											

- ADASS Confidence Matrix for support to care homes

The documents set the requirements of a local universal offer to care homes and were primarily focused on Infection Prevention and Control (IPC), hospital admission prevention and discharge and financial support, with direct wrap around support from local NHS and Social Care services.

The principles and key deliverables were then set out in a joint health and social care document:

- *Responding to Covid-19 in Care Homes: Principles to Deliver an Enhanced Universal Support Offer to Care Homes in the North East and Yorkshire Region*

Specific reference was made within the documents to the Enhanced Health in Care Homes (EHCH). It was evident that there were elements of the Covid-19 specific support that covered key elements of the EHCH and there was an opportunity to drive EHCH at pace.

The care homes delivery plan was commissioned by Executive Managers from the CCG, BMBC Adult Social Care and BMBC Public Health and was jointly programme managed between both organisations.

It was felt that the delivery of the plan sat best within the Bronze Group, as the group has the operational leadership attendance and service level structures to enable mobilisation of support at pace and scale. At this point it is worth noting that almost all of the Covid-19 specific elements of the plan were already being delivered to Barnsley care homes. Members of Bronze Group developed the delivery plan and brought together the short and medium term pandemic specific support elements and the longer term EHCH requirements.

## **5.2 Current delivery plan**

Please see Appendix 1 for the current version of the plan, which forms part of an overall 'workbook', to include underpinning national and regional guidance and a risk log, which is updated at regular intervals.

During the second wave of the pandemic, the care homes support and key initiatives already underway have continued, however, there has been less focus on the overall longer term plan, as it was necessary to ensure that the core support continues to be delivered to the care homes (IPC, intermediate care bed availability etc). As the vaccination programme progresses and operational pressures ease, there has been an opportunity to review the plan. There has been significant progress in all sections. Key markers of progress are:

- Regular and consistent communication and engagement with all homes, facilitated formally by BMBC Commissioning and Contracting Team, supported by multi-agency colleagues
- IPC training delivered to all care homes within an NHSEI specified 2 week period – this was delivered on time by 29<sup>th</sup> May 2020
- IPC outbreak management – resulting in relatively lower numbers of affected care home.

	<ul style="list-style-type: none"> <li>• The delivery of the Primary Care Network Direct Enhanced Service (PCN DES) – of particular note is the alignment of care homes to a primary and secondary GP practice</li> <li>• Supply, optimisation and review of medications</li> <li>• Financial support to homes experiencing high levels of bed voids and to facilitate safe staffing levels and plans in place for provider failure</li> <li>• Local mutual aid in terms of PPE, staffing, testing, vaccination etc.</li> <li>• Wrap around support, including psychological support to staff</li> <li>• The procurement of separate intermediate care facilities for patients with Covid 19 and those who are negative and implementation of ‘designated premise’</li> <li>• Roll – out of testing to residents and staff at all homes</li> <li>• Roll – out of vaccinations</li> <li>• Roll – out of pulse oximetry equipment and training to all homes</li> <li>• Named clinicians for each home, coordination of ward rounds, MDTs and consultations (remotely where possible) – resulting in timely and appropriate care</li> <li>• Digital capability pilot initiated, facilitated by Sheffield IT service and sponsored by NHS Digital First funding – this is progressing well and there are plans to extend the pilot across the Integrated Care System (ICS)</li> <li>• Commitment to deliver the Barnsley Excellence In Care (EIC) Programme – a Programme Board has been formed. The Board have set Terms of Reference, but requires a Programme Manager to drive and coordinate it. It is important that this is addressed without delay</li> <li>• A multi-agency Quality Improvement Panel has been formulated and is now meeting regularly – the panel will report to the EIC Programme Board</li> <li>• A borough wide detailed market shaping exercise is underway – led by BMBC. This collaborative initiative will set commissioning intentions up to 2024</li> </ul> <p><b>5.3 Next steps</b></p> <ul style="list-style-type: none"> <li>• Continue to work with commissioning and provider partners to embed EHCH and other care home actions contained in the action plan</li> <li>• Support the digital capability work across all care homes in Barnsley</li> <li>• Work with Safeguarding colleagues in BMBC to improve communication between the CCG and BMBC to strengthen safeguarding processes</li> <li>• Set up a support network and complete a baseline analysis (training, numbers of Registered Nurses, agency or substantive etc.) for the Registered Nurses in Care Homes led by the Chief Nurse</li> </ul>
<b>6.</b>	<b>THE GOVERNING BODY / COMMITTEE IS ASKED TO:</b>
	Note the progress to date on the care homes plan and the planned next steps.
<b>7.</b>	<b>APPENDICES / LINKS TO FURTHER INFORMATION</b>
	<ul style="list-style-type: none"> <li>• Appendix A – EHCH Delivery Plan / Workbook (embedded)</li> </ul>

<b>Agenda time allocation for report:</b>	<i>10 minutes</i>
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**PART 1B – SUPPORTING INFORMATION & ASSURANCE**

<b>1.</b>	<b>Links to Corporate Priorities, GBAF and Risk Register</b>		
	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	x	7.1 Transforming Care for people with LD
	3.1 Cancer		8.1 Maternity
	4.1 Mental Health	x	9.1 Digital and Technology
	5.1 Integrated Care @ System		10.1 Compliance with statutory duties
	5.2 Integrated Care @ Place	x	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>Provide ref(s) or state N/A</i>
<b>2.</b>	<b>Links to statutory duties</b>		
	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) x
	Duty to exercise its functions effectively, efficiently and economically (s14Q)	See 3.3	Duty as to patient choice (s14V) x
	Duty as to improvement in quality of services (s14R)	See 3.4	Duty as to promoting integration (s14Z1) x
	Duty in relation to quality of primary medical services (s14S)	See 3.4	Public involvement and consultation (s14Z2) See 3.6
<b>3.</b>	<b>Governance Considerations Checklist</b> ( <i>these will be especially relevant where a proposal or policy is brought for decision or approval</i> )		
<b>3.1</b>	<b>Clinical Leadership</b>		
	Have GB GPs and / or other appropriate clinicians provided input and leadership?		<b>Y</b>
	<i>Via QPSC</i>		
<b>3.2</b>	<b>Management of Conflicts of Interest (s14O)</b>		
	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?		<b>NA</b>
<b>3.3</b>	<b>Discharging functions effectively, efficiently, &amp; economically (s14Q)</b>		
	Have any financial implications been considered & discussed with the Finance Team?		<b>NA</b>
	Where relevant has authority to commit expenditure been sought from Management Team (<£100k) or Governing Body (>£100k)?		<b>NA</b>

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

## Appendix 1 – EHCH Delivery Plan / Workbook



V8.0 BARNSELEY  
CARE HOME WORK F

## GOVERNING BODY

10<sup>th</sup> March 2021

### Out of Area Locked Rehabilitation Report

#### PART 1A – SUMMARY REPORT

<b>1.</b>	<b>THIS PAPER IS FOR</b>							
	<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"/>
<b>2.</b>	<b>PURPOSE</b>							
	The report will sight Governing Body on the issues and risks regarding a cohort of high risk, high cost patients within the current Out of Area Locked Rehabilitation system and outlines the mitigating actions.							
<b>3.</b>	<b>REPORT OF</b>							
		<b>Name</b>	<b>Designation</b>					
	Executive / Clinical Lead	Jayne Sivakumar	Chief Nurse					
	Author	Jo Harrison	Specialist Clinical Portfolio Manager					
<b>4.</b>	<b>SUMMARY OF PREVIOUS GOVERNANCE</b>							
	The matters raised in this paper have been subject to prior consideration in the following forums:							
	<b>Group / Committee</b>	<b>Date</b>	<b>Outcome</b>					
	Quality and Patient Safety Committee	14/12/2020	Noted					
<b>5.</b>	<b>EXECUTIVE SUMMARY</b>							
	<b>5.1 Introduction and background</b> <p>Barnsley CCG delegates the commissioning of out of area Locked Rehabilitation (OOALR) beds for adults with Mental Health Needs, who have come to the end of an acute phase of inpatient treatment, but require a period of focused rehabilitation before they can be discharged. This is via a devolved budget to South West Yorkshire Mental Health Foundation Trust (SWYFT). Please see Appendix A for the current criteria and referral process for patients to access the service.</p>							

All cases requiring a locked rehabilitation placement are referred to the OOALR commissioning panel, which is attended by a SWYFT General Manager, a SWYFT Patient Flow and Bed Management Service Manager and a Senior Clinician from the CCG. A SWYFT finance representative also attends in a non-decision-making capacity. The panel meets monthly. Decisions can be made outside panel for urgent cases. Recommendations for approval by panel are subsequently authorised by a SWYFT Deputy Director of Operations.

The OOALR budget has experienced significant pressures over the past 2 years. The SWYFT Director of Operations wrote to the CCG early in 2020 to outline the budgetary pressures, citing an increase in complexity and risk profile of some patients. This pressure has increased during 2020.

From cases discussed at panels and out of panel throughout 2020, it is evident that there is a cohort of young women who are extremely complex and who challenge services. It is noted that most of them have been Looked After Children.

There are currently 5 patients in the OOA system, who are particularly complex and who pose a significant challenge to services. They have a history of multiple acute admissions, leading to requiring OOALR placements. Some of them, despite high levels of staffing and observations (varying from 24 hour 1:1 to episodes of 3:1) have been deemed too risky and challenging within numerous independent locked rehabilitation services and those services have given notice to terminate their placements. It has been necessary for the CCG to commission specialist out of area Psychiatric Intensive Care Unit (PICU) beds for 2 of the patients in 2020.

The 5 cases are stated to have added IRO £1,000,000 of budget pressure to the devolved budget in 2020/21. In addition, the two patients who have occupied specialist independent PICU beds, one from August 2020 and the other from October 2020 have cost the CCG IRO £400,000.

Not only is this a significant cost to the NHS, it is concerning in terms of patient experience and outcomes. The patients are stuck in a medical model pathway that does not appear to be promoting their recovery and rehabilitation into their local community and is largely nihilistic.

The young women have, at some point been in some services at the same time. There is a tendency for them to encourage each other to either self harm or assault other patients or staff. This presents a high risk to the patients and staff. The risks include serious harm, potential suicide and subsequent inquiry, potential litigation and reputational damage to provider and commissioning organisations.

## **5.2 Mitigating actions**

5.2.1 A detailed review of the SWYT OOA budget will be conducted. This work is included in the Quality Team QIPP plan and is progressed through the SWYFT / CCG Commissioning Priorities meetings and will be discussed at SWYFT Clinical Quality Board meetings.

	<p>5.2.2 Discussions have commenced to explore the feasibility of community options for step-down and admission prevention. This is being linked in with wider commissioning work such as ‘Commissioning Mental Health Transformation’ / Mental Health Long Term Plan. There is an opportunity to carry out service modelling across the SYB ICS.</p> <p>5.2.3 There is a strong link to Looked After Children and transitions planning. Discussions have commenced with BMBC partners and NHSEI regionally and nationally. This area of the work sits well with the borough ‘Start Well’ programme as part of the All Age Integration Strategy.</p> <p>5.2.4 The CCG has appointed a Complex Case Manager who will support SWYFT Care Coordinators to challenge and confirm treatment and interventions and the cost of observation levels in appropriate cases.</p> <p>5.2.5 It is planned that the CCG will request a review of the journey of the two patients who have needed OOA PICU beds. One such review has already commenced. This work is aimed at understanding a number of factors contributing to the current position of the patients, with a view to identifying any quality and safety issues and also to support service transformation going forward.</p>
<b>6.</b>	<b>THE GOVERNING BODY / COMMITTEE IS ASKED TO:</b>
	Note the issues raised and mitigating actions to reduce risks.
<b>7.</b>	<b>APPENDICES / LINKS TO FURTHER INFORMATION</b>
	<ul style="list-style-type: none"> <li>• Appendix A – <i>Out of Area Locked Rehabilitation Referral Process</i></li> </ul>

<b>Agenda time allocation for report:</b>	10 minutes
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**PART 1B – SUPPORTING INFORMATION & ASSURANCE**

<b>1.</b>	<b>Links to Corporate Priorities, GBAF and Risk Register</b>		
	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	<b>x</b>	9.1 Digital and Technology
	5.1 Integrated Care @ System		10.1 Compliance with statutory duties
	5.2 Integrated Care @ Place	<b>x</b>	
	The report also provides assurance against the following red or amber risks on the Corporate Risk Register:		<i>N/A but impacts into domains 1 and 5</i>
<b>2.</b>	<b>Links to statutory duties</b>		
	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)	<b>See 3.2</b>	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)	<b>See 3.3</b>	Duty as to patient choice (s14V)
	Duty as to improvement in quality of services (s14R)	<b>See 3.4</b>	Duty as to promoting integration (s14Z1)
	Duty in relation to quality of primary medical services (s14S)	<b>See 3.4</b>	Public involvement and consultation (s14Z2)
<b>3.</b>	<b>Governance Considerations Checklist</b> ( <i>these will be especially relevant where a proposal or policy is brought for decision or approval</i> )		
<b>3.1</b>	<b>Clinical Leadership</b>		
	Have GB GPs and / or other appropriate clinicians provided input and leadership?		<b>Y</b>
<b>3.2</b>	<b>Management of Conflicts of Interest (s14O)</b>		
	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?		<b>NA</b>
<b>3.3</b>	<b>Discharging functions effectively, efficiently, &amp; economically (s14Q)</b>		
	Have any financial implications been considered & discussed with the Finance Team?		<b>Y</b>
	Where relevant has authority to commit expenditure been sought from Management Team (<£100k) or Governing Body (>£100k)?		<b>Y</b>
	<i>Business case for fixed term Complex Case Manager</i>		

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

## Out of Area Locked Rehabilitation Referral process

### Background and context

Within Barnsley we have a small number of people currently accessing our Mental Health Services who have developed severe and complex mental health conditions. This is often some form of psychosis which will need long term care. Rehabilitation services should be able to provide the extensive interventions which this highly complex service user group will require. What is known is that when rehab is provided early in an integrated way this can significantly improve the outcomes for people who experience the long term effects of severe mental health conditions. With the decline of NHS local provision there has been a significant rise in the use of Independent providers under the banner of Locked Rehabilitation. Often requiring our service users to be moved far away from loved ones and their usual place of residency.

The term 'locked rehabilitation unit' is not formally recognised and is a term which has been adopted by independent providers of Mental Health Services and subsequently NHS commissioners.

'Locked Rehabilitation Units' cover

1. Long- term High Dependency Units
2. Long-term Complex Care Units
3. Highly Specialised Units.
4. Low Secure Rehabilitation Units

Over time with difference in funding streams the term OOA Locked Rehab in Barnsley has been applied to any form of hospital setting which provides on-going care and treatment and is outside the NHS. Often OOA placements do not follow any recognised service model.

Clarity around what we mean by Locked Rehabilitation is needed as frequently OOA placements are used routinely despite their negative impacts which include detrimental impacts directly on the person and the cost implications. Regularly OOA placements are used to 'contain' rather than provided effective treatments that are truly recovery focused. They are also be used to provide respite to in-patient and community-based teams who feel unable to meet the ongoing challenging behaviours and complex needs of this service user group.

### When should an external placement be pursued?

An external placement must only be pursued when all less restrictive options have been exhausted. A return to the community must always be the first consideration

Where there is a perceived need for a long-term placement it must be able to demonstrate how with the use of a multi-disciplinary team it is recovery focused and

will work with the person to stabilise and develop personal life skills around their mental health and wellbeing.

A provider must be able to set out clearly timelines and intervention which will be available to the person. There should be a clear indication as to the length of stay which should be between 1- 2 years from start to discharge back to a community setting.

OOA placements should never be used for the following reasons

- An alternative to acute in-patient setting when staff feel purely overwhelmed by a person's behaviours
- When other less restrictive options are available
- Where the service user has capacity relating to their care and treatment and is not in agreement with the placement
- When the care teams providing care to the person disagree.
- Where the placement is viewed as a long-term solution with no exit strategy.

When considering a placement, the following may provide some guidance

- The person must have a significant mental health disorder e.g. psychosis such as schizophrenia /schizoaffective disorder and has required repeated and lengthy admissions to hospital.
- They are experiencing negative symptoms which may impact on motivation, self-care skills, activity of daily living (ADL) which may place them at a significant risk of self-neglect or makes them vulnerable
- They are treatment resistant to frontline medications or require highly complex medication regimes.
- They have a significant co-morbidity. Alongside their Mental Health Disorder there are physical health issues/substance misuse. Which will be directly impacting on the person's ability to 'recover'.
- They fulfil the criteria of cluster 13 (complex needs/high support) which describes a person with a history of psychotic symptoms which are not controlled. The person may also have features of depression or anxiety. There maybe an element of cognitive and or physical difficulties linked to the use of long-term medication. They may have specific problems with basic life skills and ADLs and these will directly impact on the person ability to function in the community without an extensive support.
- Other clusters to consider are 16 (Dual Diagnosis) and 17 (Psychosis and affective disorder, difficult to engage)

## **Referral and funding request process for Out of Area Placement Panel**

### **NB: Prerequisites:**

- **All potential cases must go through this process**
- **Placement assessments requested outside this process will not be considered**

### **Process:**

- Case discussed at ward round – all inclusion / exclusion criteria discussed and community options ruled out with a clear rationale. Decision made if a referral for an Out of Area / Independent sector Placement is required
- Medical lead refers case to allocated Care Coordinator to progress a referral for a placement
- Care Coordinator presents case to local panel representative:  
(Sharon can you fill in details of this and contact please?)

The Care Coordinator must provide:

- Evidence of eligibility for a placement
- Choice of appropriate providers
- Rationale for chosen providers
- Local panel representative checks referral criteria has been met and refers case to the OOA panel lead :  
Jill Jinks – need contact details
- OOA panel lead will consider the referral and advise the Care Coordinator if assessments can go ahead
- Care Coordinator to requests assessments and costings and forward to the OOA panel lead
- OOA panel lead will consider assessment / placement options and costings, decide on which placement is most appropriate and advise the Care Coordinator

JH/SF/JJ October 2020

## QUALITY & PATIENT SAFETY COMMITTEE

18 February 2021

### Quality Highlights Report

#### PART 1A – SUMMARY REPORT

<b>1.</b>	<b>THIS PAPER IS FOR</b>		
	Decision	<input type="checkbox"/>	Approval
		<input type="checkbox"/>	Assurance
		<input checked="" type="checkbox"/>	Information
		<input checked="" type="checkbox"/>	
<b>2.</b>	<b>PURPOSE</b>		
	Provide the March 2021 Governing Body with the agreed highlights of the discussions at the Quality & Patient Safety Committee on 18 February 2021. The information provided is in addition to the monthly performance report and ongoing risk management via the Assurance Framework and Risk Register.		
<b>3.</b>	<b>REPORT OF</b>		
		<b>Name</b>	<b>Designation</b>
	Executive / Clinical Lead	Jayne Sivakumar	Chief Nurse
	Author	Hilary Fitzgerald	Quality Manager
<b>4.</b>	<b>SUMMARY OF PREVIOUS GOVERNANCE</b>		
	The matters raised in this paper have been subject to prior consideration in the following forums:		
	<b>Group / Committee</b>	<b>Date</b>	<b>Outcome</b>
	Quality and Patient Committee	18 February 2021	To raise as highlights to the Governing Body
<b>5.</b>	<b>EXECUTIVE SUMMARY</b>		
	<p>At the Quality and Patient Safety Committee meeting on 18 February 2021, it was agreed that the following six quality issues are highlighted to the Governing Body and rated:</p> <ul style="list-style-type: none"> <li>• Green – Digital Plan for Care Homes</li> <li>• Amber– Reporting on GP Activity</li> <li>• Red – Care Homes Quality Assurance</li> <li>• Red – Ophthalmology Services</li> <li>• Red – D1s</li> </ul>		

	Details of the highlights can be found in Appendix A of this report.
<b>6.</b>	<b>THE GOVERNING BODY / COMMITTEE IS ASKED TO:</b>
	Note the Quality Highlights identified for information and assurance.
<b>7.</b>	<b>APPENDICES / LINKS TO FURTHER INFORMATION</b>
	Appendix A – Quality Highlights Report

<b>Agenda time allocation for report:</b>	10 minutes.
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**PART 1B – SUPPORTING INFORMATION & ASSURANCE**

<b>1.</b>	<b>Links to Corporate Priorities, GBAF and Risk Register</b>		
	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		
	The report also provides assurance against the following red or amber risks on the Corporate Risk Register:		N/A
<b>2.</b>	<b>Links to statutory duties</b>		
	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)
<b>3.</b>	<b>Governance Considerations Checklist</b>		
<b>3.1</b>	<b>Clinical Leadership</b>		
	Have GB GPs and / or other appropriate clinicians provided input and leadership?		<b>Y</b>
	Jayne Sivakumar, Chief Nurse		
<b>3.2</b>	<b>Management of Conflicts of Interest (s14O)</b>		
	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?		<b>NA</b>
<b>3.3</b>	<b>Discharging functions effectively, efficiently, &amp; economically (s14Q)</b>		
	Have any financial implications been considered & discussed with the Finance Team?		<b>N</b>
	Where relevant has authority to commit expenditure been sought from Management Team (<£100k) or Governing Body (>£100k)?		<b>NA</b>
<b>3.4</b>	<b>Improving quality (s14R, s14S)</b>		
	Has a Quality Impact Assessment (QIA) been completed if relevant?		<b>NA</b>
	Have any issues or risks identified been appropriately addressed having taken advice from the Chief Nurse (or Deputy) if appropriate?		<b>NA</b>
	<b>See Appendix A</b>		

3.5	<b>Reducing inequalities (s14T)</b>	
	Has an Equality Impact Assessment (EIA) been completed if relevant?	NA
3.6	<b>Public Involvement &amp; Consultation (s14Z2)</b>	
	Has a s14Z2: Patient and Public Participation Form been completed if relevant?	NA
3.7	<b>Data Protection and Data Security</b>	
	Has a Data Protection Impact Assessment (DPIA) been completed if relevant?	NA
3.8	<b>Procurement considerations</b>	
	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	<b>Human Resources</b>	
	Have any significant HR implications been identified and managed appropriately, having taken advice from the HR Lead if appropriate?	NA
3.10	<b>Environmental Sustainability</b>	
	Have any significant (positive or negative) impacts on the environment or the CCG's carbon footprint been identified?	NA

**Appendix A Quality Highlights Report**

<b>Issue</b>	<b>Consideration</b>	<b>Action</b>
Digital Plan for Care Homes	QPSC received positive assurance regarding the good progress of the Digital Ability in Care Homes project. The aim of this work is to implement a basic standard of digital ability in care homes.	QPSC noted for assurance the content and progress described in the update.
GP Activity	QPSC received for the first time a report showing the number of General Practice contacts so far in 2020/21 and the whole of 2019/20. QPSC agreed that the data provided positive assurance that the level of contacts was similar to the previous year and would provide the public with confidence that GP services were being maintained during the Covid pandemic.	QPSC agreed that further work was needed to understand whether patient experience information of remote consultations would shed light on the low level of video consultations in 2020/21 compared with 2019/20, and the high numbers of DNAs.
Care Homes Quality Assurance	The Chief Nurse raised a concern regarding the level of assurance the CCG currently receives around quality of clinical care in care homes. More work is needed to ensure that all suitable sources of quality and safety intelligence relating to care homes are captured and triangulated.	QPSC noted the concern and agreed that this topic should be a standing agenda item on the QPSC's agendas.
Ophthalmology Services Red –	QPSC was briefed on the discussions held by the CCG's Medical Director with BHNFT regarding their Ophthalmology Service, in particular out of hours cover for the service and the outcome of an external peer review.	QPSC noted the update and agreed that further assurance should be sought at the next BHNFT CQB meeting.
D1s	The Committee discussed the long standing risk on the CCG's risk register relating to D1s and the outstanding re-audit work required by the CCG to provide assurance on this issue. QPSC noted the Trust's feedback that it is not in a position to undertake the reaudit due to Covid19 pressures. QPSC agreed that the risk relating to D1s could increase further following with the implementation of the Discharge Medicines Service.	The Committee noted the update and agreed that they needed further assurance from the Trust and the re-audit of D1s should be pursued at the next BHNFT CQB meeting.

## GOVERNING BODY

11<sup>th</sup> March 2021

### Children and young people's Commissioning Update

#### PART 1A – SUMMARY REPORT

<b>1.</b>	<b>THIS PAPER IS FOR</b>																	
	<input 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"/> <i>x</i>													
<b>2.</b>	<b>PURPOSE</b>																	
	The purpose of this report is to inform Governing Body members as to the issues and challenges within children's services commissioned within the Borough.																	
<b>3.</b>	<b>REPORT OF</b>																	
	<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr style="background-color: #d9e1f2;"> <th style="width: 30%;"></th> <th style="width: 30%;">Name</th> <th style="width: 40%;">Designation</th> </tr> </thead> <tbody> <tr> <td>Executive / Clinical Lead</td> <td>Jamie MacInnes</td> <td>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	Jamie MacInnes	Clinical lead	Author	Patrick Otway	Head of Commissioning (Mental Health, Children's and Maternity)						
	Name	Designation																
Executive / Clinical Lead	Jamie MacInnes	Clinical lead																
Author	Patrick Otway	Head of Commissioning (Mental Health, Children's and Maternity)																
<b>4.</b>	<b>SUMMARY OF PREVIOUS GOVERNANCE</b>																	
	<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;"> <thead> <tr style="background-color: #d9e1f2;"> <th style="width: 40%;">Group / Committee</th> <th style="width: 15%;">Date</th> <th style="width: 45%;">Outcome</th> </tr> </thead> <tbody> <tr> <td>Governing Body</td> <td>Sep 2020</td> <td>Noted</td> </tr> <tr> <td>Governing Body</td> <td>Mar 2020</td> <td>Noted</td> </tr> <tr> <td>Governing Body</td> <td>Sep 2019</td> <td>Noted</td> </tr> <tr> <td>Governing Body</td> <td>Jul 2019</td> <td>Noted</td> </tr> </tbody> </table>			Group / Committee	Date	Outcome	Governing Body	Sep 2020	Noted	Governing Body	Mar 2020	Noted	Governing Body	Sep 2019	Noted	Governing Body	Jul 2019	Noted
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Governing Body	Sep 2020	Noted																
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Governing Body	Jul 2019	Noted																
<b>5.</b>	<b>EXECUTIVE SUMMARY</b>																	
	Children's commissioning of health services focuses around continued improvements in supporting the emotional health and wellbeing of Barnsley's																	

children and young people (especially with the impact of Covid-19), acute and community paediatric services, Special Educational Needs and Disabilities (SEND) and neurodevelopment disorders, young people accessing the Youth Justice System (YOT) and jointly commissioned services with the Local Authority.

### Children and young people’s emotional health and wellbeing

As members are aware, over the past 18 months or so a significant amount of work has been progressed to improve and transform the provision of children and young people’s emotional health and wellbeing (CYP EWB) services within Barnsley. Following NHS England’s Intensive Support Team’s review of Barnsley’s Child and Adolescent Mental Health Service (CAMHS), a number of recommendations for Barnsley as a whole system were made, including:

- a) The development of a service specification with key performance indicator targets relating to access, activity, clinical quality, throughput and productivity; and
- b) The establishment of a joint forum across commissioner and the providers with clinical and managerial representation.

A new, co-produced CAMHS service specification was developed which moved away from the traditional, medical Tiered model towards a more system-wide approach based on the iThrive framework.

The iThrive Framework for system change (Wolpert et al, 2019) is an integrated, person-centred and needs led approach to delivering mental health services for

children, young people and families which conceptualises need in five categories: Thriving, Getting Advice and Signposting, Getting Help, Getting More Help, and Getting risk support – as shown in the diagram below.



In relation to the iThrive model a significant proportion of the CAMHS work is expected to focus on the ‘Getting Help’ and Getting More Help’ quadrants, as well as working in partnership with and supporting other agencies, such as Chilypep and Mental Health Support Teams (MHST’s) in schools.

In October 2020 a Children and Young People's Mental Health Services (CYPMHS) Steering Group was established consisting of both senior clinical and management representatives from both commissioner and provider plus the CYP EWB Transformational Lead (a joint post between Public Health and the Clinical Commissioning Group (CCG)).

To date, the focus of the CYPMHS Steering Group's work has been:

- a) Developing a mutual understanding of the elements of the service specification including clarity of Commissioner expectations where required / appropriate
- b) Enabling transparency of the CAMHS team's interpretation of the service specification when undertaking the demand and capacity modelling for the proposed clinical pathways of the new CAMHS model, which reflect the iThrive quadrants
- c) Reviewing and signing off the proposed clinical pathways
- d) Ongoing updates of the CAMHS waiting list position in terms of numbers and waiting times
- e) Highlighting service pressures, e.g. Attention Deficit Hyperactivity Disorder (ADHD) and service gaps in terms of current resourcing shortfalls.

In the last 18 months Barnsley CCG have funded two initiatives to improve the CAMHS waiting list, which were:

- Additional temporary medical staffing services to enable an additional 100 children and young people (CYP) who were awaiting commencement of ADHD medication to commence this treatment prior to the end of March 2020
- Reduce the number of CYP waiting for specialist mental health intervention (214 CYP) and associated waiting times as well as preventing 50 CYP coming on to the CAMHS waiting list as a result of re-directing/signposting, CYP to be supported by Chilypep and/or MindSpace.

By the end of March 2020, 78% of the 100 cases had been offered appointments and the remaining 22 cases had been accepted into treatment by the end of April 2020. The slight delay is attributed to the first lockdown associated with the Covid-19 situation. CAMHS service along with other Trust services took the decision to minimise the number of face-to-face contacts and were in the early stages of learning how to offer services in a different way. The Trust has continued with these temporary staffing resources throughout 2020/21 to enable continuation of medication reviews (every six months) for those who were commenced on ADHD medication as well as offering appointments to other CYP who were awaiting ADHD medication.

As a result of the second initiative, there were 108 CYP on the waiting list at the end July 2020 compared with 330 CYP at end of September 2019. During this period, CAMHS accepted 146 CYP as new cases for treatment. CAMHS achieved a total reduction of **335** cases. In addition, 105 CYP were re-directed to Chilypep (71 cases) and/or MindSpace (34 cases) and thus prevented appropriately from coming onto the CAMHS waiting list.

The position at the end of January 2021 (as shown in the table below) is that there is a total of **66** CYP waiting for initial CAMHS treatment and the cumulative waiting reduction is a total of **533** cases.

**CAMHS Waiting List tracker – By Month and cumulative effect  
For period: September 2019 – January 2021**

Aspect	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21
Total no. of CYP waiting for treatment (Rx) (all pathways)	330	325	297	290	269	236	210	191	156	113	108	100	87	99	85	65	66
Nos accepted for CAMHS Rx				14	22	17	18	25	15	16	19	15	19	33	35	29	25
Waiting List Reduction for month				21	43	50	44	44	50	59	24	23	32	21	49	49	24
Actual Waiting List Reduction (Cumulative) for month				21	64	114	158	202	252	311	335	358	390	411	460	509	533

The opportunity for CAMHS to re-direct referrals to other partners appropriately is not to be under-estimated. This has been a key 'enabler' for referrers, CYP and their families as well as other professionals, including CAMHS staff, to recognise that CAMHS should not be seen as the 'only service' who supports CYP with mental health issues.

Seeing CAMHS as just one part of a system that supports the emotional health and wellbeing of children and young people is key to transforming support services within the borough. To enable and support the delivery of this 'whole system approach' Barnsley Public Health and the CCG joint fund the post of the CYP EWB Transformational Lead who is beginning to facilitate and support key partners in moving towards our shared vision.

The CYP EWB Transformational Lead has undertaken a comprehensive service mapping of all of the services providing emotional health and wellbeing support within Barnsley. This service mapping is currently in draft form and with partners to review and will be shared when finalised. In addition, the CYP EWB Transformational Lead has also written a detailed report outlining the progress made in supporting our CYP emotional health and wellbeing whilst also highlighting key recommendations and actions we need to take as a system to continue to develop and transform services to enable improved life outcomes for the children and young people of Barnsley. This report is available to governing body members upon request.

### **Acute and Community Paediatric Services**

Members will be aware that following the Independent Review of acute paediatric

services at Barnsley Hospital NHS Foundation Trust (BHNFT) towards the end of 2019, the CCG's safeguarding nurse was asked to progress a number of recommendations outlined within the final report. The current pandemic and resulting actions, taken as a consequence, significantly hindered any progress with this work and it was therefore put on hold. This work has very recently recommenced and two service specifications are now in development, one covering the Children's Assessment Unit and one in relation to the Children's Community Nursing service. Once the initial drafts of the specifications have been completed they will be brought to the CCG's Clinical Forum for discussion, prior to sharing wider for comment.

The Children's Community Nursing service operates on a Monday to Friday basis and BHNFT are currently in discussions with their staff to expand the operation of the service to become a seven day service. It is expected that this change will be implemented from April 2021.

### **Special Educational Needs and Disabilities (SEND)**

Members will be aware that the 5 year programme of local area Joint SEND Inspections undertaken by Ofsted and the Care Quality Commission (CQC) comes to a close in 2021. To date, Barnsley is one of the few areas still to be inspected and whilst the full inspections have been put on hold, shorter, interim inspections have been undertaken which have focused on the local area responses to the current pandemic. It is expected that the full Joint Inspection programme will be re-started with the opening of schools in March 2021 and it is highly likely that Barnsley will receive notice of an inspection shortly.

A significant amount of work has been undertaken within the local area over the past 2 years in preparation for the inspection and primarily to improve the life outcomes of the children and young people in Barnsley with a special educational need or disability. There is a comprehensive SEND Improvement Plan to which all partners are contributing with an appropriate action plan against which success is measured. The SEND Performance data highlights the improvements and challenges that we face as a system if we are to continue to make a significant and positive impact in the lives of these young people.

The majority of this work has been led by the Local Authority's SEND Service and Strategy Manager and the Local Authority's SEND Commissioner. The CCG is linked into this work through the Designated Clinical Officer for SEND and Head of Commissioning (Mental Health, Children's and Maternity).

Barnsley's SEND Strategy is due for renewal in 2022 and a number of short term Task and Finish Groups are being established to focus on key elements of the strategy to ensure full co-production with all partners, including at the heart of everything, those young people with SEND and their parents / carers.

A key part of the SEND Strategy focuses on the Boroughs sufficiency strategy in terms of education and our ability to support our young people with SEND closer to home. The evidence suggests that the numbers of young people with SEND will continue to increase in Barnsley over the next few years and with only one Special

School in the borough, this could increase dependency on costly, out of borough school placements.

Linked into this work are the challenges faced within the system of an increase in demand for short term respite and the continued overdemand faced by Newsome Avenue. The CCG makes a financial contribution towards these facilities and the Local Authority had requested that this financial contribution be increased given the increasing cost pressures faced. The whole service provision was to be reviewed together with the increase in children's continuing healthcare packages and provision for children with complex health needs. Once the outcomes of the review(s) are known the various levels of contribution will be able to be determined.

### **Neurodevelopment disorders**

Members have been previously updated as to the successful reduction in waiting times for children and young people on all of the autism assessment and diagnostic pathways. Although the impact of the current coronavirus pandemic has meant inevitable delays in the pathway, the pathways have remained fully compliant to the standards of the National Institute for Health and Care Excellence (NICE).

There remains however, a significant issue in terms of support services for people with autism / autistic traits and the Autism Steering Group (a collaborative partnership group chaired by the CCG) are working together to consider how best to implement Clinical Guidelines CG170 and CG142, to implement the Autism Friendly Charter within the borough. The CCG continue to fund an Autism parenting practitioner as part of Barnsley Metropolitan Borough Council's (BMBCs) Family Services offer and this post is proving effective in supporting parents at a particularly challenging time. The development of an all-age autism strategy and associated action plan is being led by the CCG.

We have seen in recent months, with the implementation of targeted CAMHS waiting list initiatives, a reduction in the waiting times on the ADHD pathway. As a significant amount of time on this pathway is linked to medication reviews and robust shared care protocols the CYPMHS Steering Group are considering how this is best managed within the system. There had previously been a suggestion that a number of the CCG's Clinical Pharmacists may be able to support this part of the pathway and an action plan was developed but not implemented. Discussions have recommenced and it is anticipated that the action plan will be reviewed and, if still appropriate, implemented.

### **Youth Offending Team (YOT)**

The Head of Commissioning (Mental Health, Children's and Maternity) recently gave a presentation to the Youth Crime and Antisocial Behaviour Board by. Whilst the number of young people accessing YOT services in Barnsley is a small number of the local population it is worthwhile noting that a significant amount of these vulnerable young people have some level of Learning Disability and a large number also have a Speech, Language and Communication Need (SLCN). This service is also one of the highest referrers into the Children and Young People's Substance Misuse Service.

	<p>The presentation highlighted the positive outcomes that are achieved by this service and the challenges faced in terms of ensuring the best possible outcomes in the overall health and wellbeing of these often, vulnerable young people.</p> <p><b>Joint Commissioning</b></p> <p>There are numerous plans / strategies developed in relation to children and young people but the overarching plan for Children’s services is the Children’s Services Improvement plan (CSIP), developed and maintained by BMBC and supported by partners.</p> <p>The CSIP plan focuses on the following key areas:</p> <ul style="list-style-type: none"> <li>• Safeguarding</li> <li>• Private Fostering</li> <li>• Care Leavers</li> <li>• ‘Front Door’</li> <li>• Early Help</li> <li>• Individual Child Plans</li> <li>• Neglect and Child Abuse</li> <li>• Diversity</li> <li>• Edge of Care – Teenagers and Homelessness</li> <li>• Mental Health</li> <li>• Voice and Engagement of the Child</li> <li>• Permanent Placements – Care / Adoption / Fostering</li> <li>• Placement Stability</li> </ul> <p>Linked into these aspects, BMBC’s Business Intelligence team analyses performance data and provides an update to the Children’s Trust Executive Commissioning Group at regular intervals.</p> <p>As previously mentioned within this report service reviews are being undertaken, in conjunction with the CCG, on areas covering children and young people with complex health needs, children’s continuing healthcare, learning disabilities support and short breaks / respite provision. The CCG will also lead on a review of children and young people’s Speech and Language services within the borough but due to the current priorities this review is not likely to begin until June 2021.</p> <p>The main challenge however that continues to be faced by the system is a continued increase in demand and how best to utilise existing resources to deliver the most appropriate and effective support.</p>
<p><b>6.</b></p>	<p><b>THE GOVERNING BODY / COMMITTEE IS ASKED TO:</b></p>
	<ul style="list-style-type: none"> <li>• Governing Body is asked to note the report and the progress outlined.</li> </ul>
<p><b>7.</b></p>	<p><b>APPENDICES / LINKS TO FURTHER INFORMATION</b></p>
	<ul style="list-style-type: none"> <li>• Not applicable</li> </ul>

<b>Agenda time allocation for report:</b>	10 Mins
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**PART 1B – SUPPORTING INFORMATION & ASSURANCE**

<b>1.</b>	<b>Links to Corporate Priorities, GBAF and Risk Register</b>		
	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		
	The report also provides assurance against the following red or amber risks on the Corporate Risk Register:		N/A
<b>2.</b>	<b>Links to statutory duties</b>		
	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)	<b>See 3.2</b>	Duties as to reducing inequalities (s14T) <b>See 3.5</b>
	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)	<b>See 3.3</b>	Duty as to patient choice (s14V)
	Duty as to improvement in quality of services (s14R)	<b>See 3.4</b>	Duty as to promoting integration (s14Z1)
	Duty in relation to quality of primary medical services (s14S)	<b>See 3.4</b>	Public involvement and consultation (s14Z2) <b>See 3.6</b>
<b>3.</b>	<b>Governance Considerations Checklist</b> ( <i>these will be especially relevant where a proposal or policy is brought for decision or approval</i> )		
<b>3.1</b>	<b>Clinical Leadership</b>		
	Have GB GPs and / or other appropriate clinicians provided input and leadership?		<b>Y</b>
<b>3.2</b>	<b>Management of Conflicts of Interest (s14O)</b>		
	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?		<b>/NA</b>
<b>3.3</b>	<b>Discharging functions effectively, efficiently, &amp; economically (s14Q)</b>		
	Have any financial implications been considered & discussed with the Finance Team?		<b>NA</b>

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

## GOVERNING BODY

11 March 2021

### RISK AND GOVERNANCE EXCEPTION REPORT

#### PART 1A – SUMMARY REPORT

<b>1.</b>	<b>THIS PAPER IS FOR</b>			
	<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"/>
<b>2.</b>	<b>PURPOSE</b>			
	<ul style="list-style-type: none"> <li>To assure the Governing Body re the delivery of the CCG's annual strategic objectives</li> <li>To assure the Governing Body that the current risks to the organisation are being effectively managed and monitored appropriately</li> <li>To assure Governing Body that the Primary Care Commissioning Committee Terms of Reference have been subject to review</li> <li>To provide the Governing Body work plan for comment and information.</li> </ul>			
<b>3.</b>	<b>REPORT OF</b>			
		<b>Name</b>	<b>Designation</b>	
	Executive / Clinical Lead	Richard Walker	Head of Governance & Assurance	
	Author	Paige Dawson	Governance, Risk & Assurance Facilitator	
<b>4.</b>	<b>SUMMARY OF PREVIOUS GOVERNANCE</b>			
	The matters raised in this paper have been subject to prior consideration in the following forums:			
	<b>Group / Committee</b>	<b>Date</b>	<b>Outcome</b>	
	N/A			
<b>5.</b>	<b>EXECUTIVE SUMMARY</b>			
<b>5.1</b>	<b>Governing Body Assurance Framework</b>			
	<p>The Governing Body Assurance Framework (GBAF) facilitates the Governing Body in assuring the delivery of the CCG's annual strategic objectives. One of the key priority areas (3 - Cancer) is rated as red meaning that there is currently a significant risk that the deliverables in this area may not be achieved in 2020-21.</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 (September and March) with exception reports brought to intervening meetings. This report therefore provides the Governing Body with a full report of the Corporate Risk Register (Appendix 2).

There are currently 8 red (extreme) risks on the CCG's Risk Register which have been escalated to the Assurance Framework as gaps in assurance against risks on the Assurance Framework:

- Ref CCG 18/04 (rated score 20, 'extreme') - If the health and care system in Barnsley is not able to commission and deliver out of hospital urgent care services which have sufficient capacity and are effective in supporting patients in the community to avoid the need for hospital attendance or non-elective admission there is a risk that non- elective activity will exceed planned levels potentially leading to (a) failure to achieve NHS Constitution targets (with associated reputational damage, and (b) contractual over performance resulting in financial pressure for the CCG.
- Ref 18/02 (rated score 16 'extreme') - If the CCG and BMBC do not develop a collaborative commissioning approach underpinned by shared values there is a risk that BMBC commissioned services will not meet the requirements and aspirations of the CCG for the people of Barnsley leading to increased health inequalities and poorer health outcomes.
- Ref CCG 14/10 (rated score 16 'extreme') – Risks resulting from not being able to attract and retain a suitable and sufficient Primary Care clinical workforce.
- Ref CCG 20/03 (rated score 16 'extreme') – Potential adverse consequences if the BCCG CHC team is unable to deliver its recovery plan to enable the backlog of reviews to be cleared and new cases to be processed in a timely way, with robust case management processes in place
- Ref CCG 14/15 (rated score 15 'extreme') – Potential impact on quality & patient safety of incomplete D1 discharge letters.
- Ref CCG 19/05 (rated score 15 'extreme') - If the health and care system in Barnsley is not able to commission and deliver end of life care services of sufficient quality and capacity to support end of life patients in the community, there are risks for the CCG across a number of areas.
- COVID 1 - Disruption to health and social care – hidden harm - During the C19 peak healthcare seeking behaviours changed along with service delivery models resulting in lower urgent and emergency care presentations and fewer referrals to healthcare services. This 'hidden harm' may cause a double burden that may be caused by people not presenting or delaying presenting with new or existing conditions.
- COVID 2 - Backlog and demand surge - A backlog of non-COVID-19 care following the suspension of routine clinical care that is likely to result in an increased number of poorly-managed chronic conditions or undiagnosed diseases and be combined with a surge in post-COVID-19 morbidity (which needs to be quantified). Reducing the backlog of care will be hampered by reduced operational capacity across NHS organisations designed to prevent transmission of COVID-19.

	<p><b>Updates:</b></p> <ul style="list-style-type: none"> <li>• Governing Body is asked to note and approve the risk reduction to COVID 3 (2x5=10) from its previous score of 20 - Flu season 2020/21 in light of current low flu levels and high vaccine uptake.</li> <li>• Governing Body is also asked to note the risk reduction to both COVID 1 and 2 in relation to disruption to health and social care – hidden harm and Backlog and demand surge. Both risks still remain a red risk, just at a reduced score detailed in appendix 2.</li> <li>• Members are asked to consider and approve a new risk in relation to Children’s Continuing Health Care detailed in appendix 2 – this has been drafted in response to a request from Governing Body following its development session in January 2021, and has been considered and approved by both the Quality &amp; patient Safety Committee and the Finance &amp; Performance Committee.</li> <li>• The Quality and Patient Safety Committee will be reviewing risk 14/15 (rated score 15 ‘extreme’) – Potential impact on quality &amp; patient safety of incomplete D1 discharge letters at the April 2021 meeting to look at increasing the risk score to 4x5=20 due to the national Community Pharmacy Discharge Service launch on the 15th February 2021. Community Pharmacies will be receiving D1 letters and will (in addition to GP practices) be undertaking medicines reconciliation against their PMR systems (medicines supply pre admission). This service will be significantly affected (clinical risk and efficiency) by the quality of the discharge meds information. The mapping of hospital systems and audit work remains on hold due to impact of COVID-19.</li> </ul> <p>Risk owners continue to review and refresh all the risks allocated to them to ensure the risk register is complete and up to date. The CCG’s Committees continue to review and manage all the risks identified.</p>
5.3	<p><b>Committee Terms of Reference</b></p> <p>Governing Body is asked to consider and approve the following minor change to the Primary Care Commissioning Committee Terms of Reference, which reflects recent changes to the sub-groups of that Committee. Once approved the revised Terms of reference will be saved on the CCG website as part of the CCG’s Constitution.</p> <p><b>“Sub-groups of the Committee</b></p> <p><i>The CCG has established a Primary Care Strategic Group as a forum for partners in Barnsley to articulate the strategic direction for primary care in Barnsley in the context of national and system wide guidance and priorities. This Group will be supported by a Primary Care Forum to coordinate the operational delivery of this strategic direction. The Primary Care Strategic Group will make recommendations to the Primary Care Commissioning Committee where decisions are required to implement the strategy, and on operational contractual issues impacting on primary care delivery; however decision making remains the responsibility of the Primary Care Commissioning Committee. Where necessary the Committee would seek clarifications and make suggestions to the Primary Care Strategic Group about specific pieces of work which could then be refined and re submitted as appropriate. The Primary Care Strategic Group has formal</i></p>

	<i>Terms of Reference which are presented to Primary Care Commissioning Committee for approval.”</i>	
<b>5.4</b>	<b>Governing Body work plan 2021-22</b>	
	<p>As part of governance and assurance processes the Governing Body is required to have a timetable of agenda items and plan of its work. The work plan is submitted to the Governing Body on a quarterly basis for review and update as appropriate.</p> <p>The Governing Body Assurance Work Plan / Agenda Timetable at appendix 3 has been updated to March 2022.</p>	
<b>6.</b>	<b>THE GOVERNING BODY IS ASKED TO:</b>	
	<ul style="list-style-type: none"> <li>• Review the Assurance Framework and Risk Register</li> <li>• Note and approve risk score reductions to COVID 1, 2 and 3.</li> <li>• Consider and approve new risk in relation to Children’s Continuing Health Care</li> <li>• Consider whether all risks are being appropriately Managed</li> <li>• Identify any potential new risks or risks for removal</li> <li>• Approve the proposed changes to the Primary Care Commissioning Committee Terms of Reference</li> <li>• Receive and provide comments on the Governing Body work Plan &amp; Agenda Timetable 2020/21</li> </ul>	
<b>8.</b>	<b>APPENDICES / LINKS TO FURTHER INFORMATION</b>	
	<ul style="list-style-type: none"> <li>• Appendix 1 – GBAF</li> <li>• Appendix 2 – Corporate Risk Register</li> <li>• Appendix 3 – Governing Body Work Plan 2021-22</li> </ul>	
<b>Agenda time allocation for report:</b>		10 minutes

**PART 1B – SUPPORTING INFORMATION & ASSURANCE**

<b>1.</b>	<b>Links to Corporate Priorities, GBAF and Risk Register</b>	
	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
<b>2.</b>	<b>Links to statutory duties</b>	
	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)	
<b>3.</b>	<b>Governance Considerations Checklist</b> ( <i>these will be especially relevant where a proposal or policy is brought for decision or approval</i> )	
3.1	<b>Clinical Leadership</b>	
	Have GB GPs and / or other appropriate clinicians provided input and leadership?	NA
3.2	<b>Management of Conflicts of Interest (s14O)</b>	
	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	<b>Discharging functions effectively, efficiently, &amp; economically (s14Q)</b>	
	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	<b>Improving quality (s14R, s14S)</b>	
	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	<b>Reducing inequalities (s14T)</b>	
	Has an Equality Impact Assessment (EIA) been completed if relevant?	<b>NA</b>
3.6	<b>Public Involvement &amp; Consultation (s14Z2)</b>	
	Has a s14Z2: Patient and Public Participation Form been completed if relevant?	<b>NA</b>
3.7	<b>Data Protection and Data Security</b>	
	Has a Data Protection Impact Assessment (DPIA) been completed if relevant?	<b>NA</b>
3.8	<b>Procurement considerations</b>	
	Have any issues or risks identified been appropriately addressed having taken advice from the procurement Shared Service if appropriate?	<b>NA</b>
	Has a Single Tender Waiver form been completed if appropriate?	<b>NA</b>
3.9	<b>Human Resources</b>	
	Have any significant HR implications been identified and managed appropriately, having taken advice from the HR Lead if appropriate?	<b>NA</b>
3.10	<b>Environmental Sustainability</b>	
	Have any significant (positive or negative) impacts on the environment or the CCG's carbon footprint been identified?	<b>NA</b>

PRIORITY AREA 1: URGENT & EMERGENCY CARE				Delivery supports these CCG objectives:		PRINCIPAL THREATS TO DELIVERY			
<ul style="list-style-type: none"> <li>Increased clinical assessment of calls to NHS 111 &amp; CAS</li> <li>Implementation of 111 First Approach to reduce attendance to ED where suitable alternative service exist (including front door clinical streaming/booking to alternative services)</li> <li>Delivery of ambulance targets / conveyance with zero tolerance of delays over 30 minutes</li> <li>Delivery of 4 hour A&amp;E standard</li> <li>Improved patient flow and reduce length of stay</li> <li>Free up hospital beds - Reduce non-elective activity</li> <li>Enhance Same Day Emergency Care, increasing the proportion patients discharged on the day of attendance</li> <li>Reduce A&amp;E by default selections on the DOS</li> </ul>				Highest quality governance		If partners locally and across the ICS do not engage constructively together, to develop a model for urgent care at a South Yorkshire and Bassetlaw and Barnsley level, in line with best practice and national guidance there is a risk that urgent care services are unable to meet the growing demand, constitution standards for urgent care are not achieved and the quality of patient care is negatively impacted			
				High quality health care				✓	
				Care closer to home				✓	
				Safe & sustainable local services				✓	
				Strong partnerships, effective use of £					
				Links to SYB STP MOU					
				8.4. Urgent and Emergency Care					
Committee Providing Assurance			FPC	Executive Lead		JW	Clinical Lead	JH & MS	
Risk rating	Likelihood	Consequence	Total					Date reviewed	Feb-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								
<b>Key controls to mitigate threat:</b>				<b>Sources of assurance</b>				<b>Rec'd?</b>	
Operational planning templates for 2020/21 were submitted to NHSE in February 2020 prior to the impact of the COVID 19 pandemic. Revised plans have been submitted in September 2020 as part of the NHS Phase 3 response to COVID 19. All activity plans are in line with national expectations to increase activity levels back to 2019/20, reflecting local restrictions and transformation work to redesign services. Plans at provider and commissioner level are aligned.				CCG have worked with the SYB ICS to formulate an ICS level activity plan. Plan submitted to NHSE in line with required deadlines. Activity levels are monitored on an ongoing basis to monitor delivery against submitted plans.				Yes	
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 Director of Strategic Planning and Performance represent the CCG as members of the local delivery board. 2020/21 Winter Plans being developed by providers and feeding into the system wide winter plan and escalation arrangements. 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. Barnsley Flu Plan has been developed by an operational Flu group and was signed off by the UEC Delivery Board in September 2020				Ongoing	
Urgent and Emergency Care Steering Board is in place as the UEC Programme Board of the South Yorkshire and Bassetlaw Integrated Care System. Representation in place for the UEC Delivery Board partners on the Steering Group and Commissioner Reference Group.				Barnsley UEC Delivery Board are represented by Barnsley CCG Director of Strategic Planning and Performance and Barnsley Hospital Deputy Director of Nursing (Operations) ensuring Barnsley place is contributing to system developments. SYB UEC Steering Board has agreed priorities which all places are signed up to deliver locally. Oversight by the SYB Steering Board and locally through the UEC Delivery Board.				Ongoing	
The CCG is developing a clear, prioritised delivery plan, to improve the out of hospital service offer and ensure that more people are able to be cared for and treated at home or in a community setting without the need for an hospital attendance or admission.				Community Services specification is being mobilised for integrated community and primary care services working as part of the PCN/Neighbourhood arrangements with a focus on providing proactive care at home or in a community setting and supporting people to be better able to manage their own conditions. Integrated Care Partnership Group principles have been agreed and partnership plans developed to support the overall vision for 'left shift'				In progress	
Urgent Care Services are in place and continuing to deliver improvements to already strong performance and enabling the ongoing delivery of planning priorities. An Integrated extended hours and out of hours primary care services (IHEART 365) is in place with contracts for both elements of service delivered by Barnsley Healthcare Federation.				IUC/CAS is in place, increasing access to clinical advice and with the ability to book directly into primary care appointments for patients with a primary care need A&E waiting time performance is consistently high, length of stay low and flow good through and out of hospital ensuring low levels of DTOC Ambulatory Care/SDEC pathways are in place including Clinical 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	
<b>Gaps in assurance</b>				<b>Positive assurances received</b>					
<b>Gaps in control</b>				<b>Actions being taken to address gaps in control / assurance</b>					
A possible influenza epidemic that will be additive to the challenges above. The size and severity of the influenza epidemic in winter 2020/21 will be particularly difficult to estimate. A generalised increase in respiratory infections over the winter could also rapidly overwhelm test and trace capacity.				Local flu group mobilised, and any issues are being picked up at local, regional and national flu delivery calls.					
RR 18/04: If the health and care system in Barnsley is not able to commission and deliver out of hospital urgent care services which have sufficient capacity and are effective in supporting patients in the community to avoid the need for hospital attendance or non-elective admission there is a risk that non-elective activity will exceed planned levels potentially leading to (a) failure to achieve NHS Constitution targets (with associated reputational damage, and (b) contractual over performance resulting in financial pressure for the CCG				Regular review of activity data as part of contract and performance management and monitoring arrangements. Other data reviewed and analysed to identify new opportunities to reduce non-elective activity e.g. NHS Rightcare Packs, Dr Foster data etc. The UEC Delivery Board is overseeing work to develop appropriate services to ensure that patients are able to access appropriate care and support outside of hospital, or in a different way in hospital utilising ambulatory care pathways and implementing a model to incorporate '111 First' CCG commissioned Out of Hospital Services being remodeled as part of the Neighbourhood Team mobilisation and includes PCN/Neighbourhood developments.					

Committee Providing Assurance				PCCC	Executive Lead	JW / JF	Clinical Lead	NB (pending MD)
<b>PRIORITY AREA 2: PRIMARY CARE</b> Delivery of 'GP Forward View' and 'Forward View - Next Steps for Primary Care' to: Deliver investment into Primary Care Improve Infrastructure Ensure recruitment/retention/development of workforce Address workload issues using 10 high impact actions Improve access particularly during the working week, more bookable appointments at evening and weekends. Every practice implements at least 2 of the high impact 'time to care' actions Deliver delegated Primary Care functions to be confirmed via mandated internal audit reviews Develop and maintain PCN with 100% coverage by 30 June.2019 and support the transition and further development of the PCNs Work with PCNs to maximise recruitment under the Additional Roles Reimbursement Scheme and take action to support them. Support the recruitment and retention of extra doctors working in general practice. Work with PCNs to a particular early focus on supporting improvements in practices with long waits for routine appointments. Work with PCNs to deliver national service requirements from 2020/21, details of which will be set out in the final version of the forthcoming GP contract and Network Contract Direct Enhanced Service (DES). Provide CCG support to implement the NHS's comprehensive model of personalised care and meet 2020/21 system trajectories for personalised care and support planning, Personal Health Budgets and social prescribing.				<b>Delivery supports these CCG objectives:</b> Highest quality governance ✓ High quality health care ✓ Care closer to home ✓ Safe & sustainable local services ✓ Strong partnerships, effective use of £ ✓		<b>PRINCIPAL THREATS TO DELIVERY</b> There is a risk to the delivery of Primary Care priorities if the following threat(s) are not successfully managed and mitigated by the CCG: - Engagement with primary care providers and workforce - Workforce and capacity shortage, recruitment and retention - Under development of opportunities of primary care at scale, including new models of care - Primary Care Networks do not embed and support delivery of Primary Care at place - Not having quality monitoring arrangements embedded in practice - Inadequate investment in primary care - Independent contractor status of General Practice		
<b>Risk rating</b> Initial 3 4 12 Current 3 4 12 Appetite 3 4 12 Approach <b>TOLERATE</b>						<b>Date reviewed</b> Feb-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.		
<b>Key controls to mitigate threat:</b> All practices are required to complete the National Workforce Data Return. The APEX tool has been decommissioned and replaced by the National reporting. ARRs roles identified in the PCN workforce plan and recruitment plans in place Additional investment above core contracts through PDA delivers £4.2 to Barnsley practices to improve sustainability and attract workforce to the Barnsley area Optimum use of BEST sessions A contract is in place with BHF for the BEST programme which enables the CCG to support the programme Development of locality working through the establishment of PCN's The 3 service specification from the Network Contract DES are now being undertaken by practices across each Neighbourhood, these are the care home work, medication reviews and early cancer diagnosis work BHF - Existence of strong federation supports Primary Care at Scale Practices increasingly engaging with voluntary and social care providers (e.g. My Best Life) Social Prescribing - My Best Life is a successful programme supporting the people of Barnsley to work towards self care. This service has now extended to include high intensity users. Social prescribing link workers are now delivering a young peoples Social Prescribing service as part of the PCN additional roles recruitment. Programme Management Approach of GPFV & Forward View Next steps Care Navigation roll out - First Port of Call Plus Engagement and consultation with Primary Care (Membership Council, Practice Managers etc.) SY Workforce Group in place, ICS has a workforce hub and a workforce lead for Barnsley the workforce hub is a collaboration with CCG's, HEE, providers and Universities.				<b>Sources of assurance</b> All practices have now completed the HEE tool to allow the CCG to create a workforce baseline. ARRs recruitment of SPLW, CP, PAs, Care Coordinators and H&W Coordinators Ongoing monitoring of PDA (contractual / QIPP aspects via FPC, outcomes via PCCC). BEST programme and Programme co-ordination being led by BHF 6 Neighbourhood Networks have been agreed with the support of a single super Primary Care Network worked by the GP Federation. These are co-terminous with previous CCG and Local Authority localities (submission completed) and signing up to the new Network Framework Agreement and Network Contract DES. This supports the transition and development of formal Primary Care Networks to deliver the primary care elements of the NHS Long Term Plan. Meetings are set for the year to ensure that the PCNs are able to meet regularly. BHF contract monitoring, oversight by PCCC Social Prescribing is a key element in the Long Term Plan and a new cohort of Social Prescribing Link Workers have been recruited by the PCN to deliver a Children's and Young person Social Prescribing Service. My Best Life contract has been extended to ensure an adults service is in place. GPFV assurance returns submitted quarterly to NHSE. Regular updates on progress are reported to PCCC as per PCCC work plan. This has been delivered and the contract has now ended NHS England 360 Stakeholder Survey results shared with stakeholders and published on the CCG website. Results show that BCCG stakeholders have a high level of satisfaction with the CCG's leadership & engagement. BCCG is represented on the group. BCCG is represented on all workforce groups. Reporting is via PCCC for Primary care.				<b>Rec'd?</b> Ongoing Ongoing Ongoing Ongoing Ongoing Complete Ongoing Ongoing
<b>Gaps in assurance</b> Slow recruitment to Additional Roles in the PCN				<b>Positive assurances received</b> JAN 2021 - Recruitment into Primary Care via the PCN is adding to the available workforce to support practices.				
<b>Gaps in control</b> RR 14/10: If the Barnsley area is not able to attract & retain a suitable & sufficient Primary Care clinical workforce there is a risk that: (a) Some practices may not be viable, (b) Take up of PDA or other initiatives could be inconsistent (c) The people of Barnsley will receive poorer quality healthcare services (d) Patients services could be further away from their home.				<b>Actions being taken to address gaps in control / assurance</b> The CCG and BHF 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. Practices encouraged to look at skill mix with innovative recruitment. The Primary Care Network and underpinning 6 Neighbourhood Networks are established and working on all elements of the Network Contract DES and Long Term Plan. The CCG Primary Care team work closely with the PCN to ensure delivery is on track NHS England 360 Assurance audit in progress to provide NHS England with assurance of robust Primary Care processes. New topics are identified each year and the Head of Primary Care works with 360 to complete each plan. Working closely with BHF to maximise the recruitment opportunity for Barnsley.				

PRIORITY AREA 3: CANCER				Delivery supports these CCG objectives:		PRINCIPAL THREATS TO DELIVERY			
<ul style="list-style-type: none"> <li>Preventing cancer incidence</li> <li>Reduced Inequalities especially those diagnosed at emergency admission.</li> <li>Improved cancer diagnosed rates at stage 1 or 2</li> <li>Early Diagnosis - Implement rapid assessment and diagnosis pathways for all tumour sites</li> <li>Improve care and treatment - embed new cancer waiting times system</li> <li>Improve Patient Experience along pathways and LWBAC</li> <li>Increasing Positive Experience at EOL by increasing early identification and reducing 3 or more admissions in last 3 months of life</li> <li>Deliver Survivorship Program (LWABC) including recovery package and stratified pathways</li> <li>Commissioning for Value adopted if appropriate</li> <li>Achieve 10 waiting time standards including the 62 day referral-to-treatment cancer standard and 28 day faster diagnosis standard and pre-covid position.</li> </ul>				Highest quality governance		✓			
				High quality health care		✓			
				Care closer to home		✓			
				Safe & sustainable local services		✓			
				Strong partnerships, effective use of £		✓			
Links to SYB STP MOU				8.6. Cancer					
Committee providing assurance		FPC	Executive Lead		JW	Clinical Lead		Dr H Kadarsha	
<b>Risk rating</b>	Likelihood	Consequence	<b>Total</b>				<b>Date reviewed</b>		Feb-21
Initial	3	4	12				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		
Current	5	4	20						
Appetite	5	4	20						
Approach	Treat								
<b>Key controls to mitigate threat:</b>				<b>Sources of assurance</b>			<b>Rec'd?</b>		
Programme Governance arrangements									

<p>Steering Group: On track. CCG Contracting process: Reporting requirements relating to cancer coming via contracting plus weekly P3 restoration progress meetings. Monthly reporting to SMT about minimising harm and P3 restoration programme delivery progress plus areas that require escalation</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 &amp; 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</p>	<p>Ongoing</p>
<p><b>62 Day Waits</b></p>		
<p>Current CCG performance for Q1 is not being recorded (target 85%). Pre-Covid the CCG only had 1-2 people per quarter whom this affected past RTT 104 days and 6-10 for those breaching past 62 days compared to 115 now.. There are still 80 patients whom have no diagnosis or treatment date agreed. The total numbers breaching past 62 days have reduced from 180 to 115 patients over the last 8 weeks by 36%. Currently CCG diagnostic figures are diagnostic RTT pts waiting more than 6 weeks (3,027). 2019 level was 6.Current capacity levels not on track to meet phase 3 targets- increased COVID restrictions may stop endoscopy tests again</p>	<p>Performance is reported to CCG via Finance &amp; Performance committee and via CA board reporting arrangements. CCG meets BHNFT cancer lead weekly to monitor performance and gain assurance about improvement actions to address minimising COVID impact and P3 restoration. Steering group meeting 4 weekly and produces monthly programme assurance and risk register that is approved by steering group and shared with CA. This group monitors programme delivery and updates shared with CCG SRO monthly . CCG attends BHNFT CPIG group and raises assurance points that are addressed via the action log process. Reduction in performance due to large number endoscopy backlog breaches and Urology. Escalated to CCG via Finance &amp; Performance committee and mitigating actions provided for assurance . P3 Restoration plan agreed with BHNFT by CCG. DON gaining assurance about maintaining quality from BHNFT and STHT during restoration period.</p>	<p>Ongoing</p>
<p><b>Prevention</b></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 .Escalated to PHE that breast screening reporting continues to be a high risks areas , as no permanent staff in place and only 1 person in place - risks that screening postponed again due to lack of staff resources.</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><b>Early Diagnosis</b></p>		

<p>Timed pathways: All timed pathway been affected - Lung, Lower &amp; upper GI &amp; urology (red rating ): not meeting 28 day STT FDS. Endoscopy started extra slots and having an impact but still have 115 62 day breaches for RTT. BHNFT signed up to ICS endoscopy remote radiology procurement to increase capacity. Community diagnostic pathways/hub planning started and mapped overlaps with ICS elective care areas Scoping being undertaken with BHNFT and PCN . Will identify pathway efficiencies and how can reduce demand on current pathway. PCN agreed Early diagnosis DES project action plan with CCG – to reduce the variation in screening and early diagnosis rates across PCN practices and within the different Neighbourhood areas. vague symptoms pathway evaluation completed with primary care and improvement action plan agreed with BHNFT.</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 ED group and reports back to CCG actions and ensures actions agreed are adopted via CCG governance routes including reporting and gaining approval at MT for vague symptoms pathway and lower GI pathway implementations. CCG attends CA monthly ED group and reports back to CCG actions and ensures actions agreed are adopted via CCG governance routes including reporting and gaining approval at MT for vague symptoms pathway and lower GI pathway implementations. 6 weekly reporting to SMT about minimising harm and P3 restoration programme delivery progress plus areas that require escalation</p>	<p>Ongoing</p>
<p><i>Better treatment and care</i></p>		
<p>Waiting times: Start again rolling out timed pathway to reduce pressure on system. Tele dermatology : CCG SMT agreed VEAT contract to 31/12/2021. All 104 breaches had a RCA undertaken and safety netting in place by BHNFT for all patients on 2WW and routine pathway. Raised at CQB BHNFT that concern about breast screening and urology pathway quality due to staff turn over. Producing harm policy with CA that is more holistic definition that includes psychological harm of being on a prolonged pathway .</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>	<p>Ongoing</p>
<p>LWABC</p>		
<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 delays still on local completion. Project evaluation: evaluation work on-going with the Regional LWABC programme. New men's peer group for prostate cancer starting in sept 2020.</p>	<p>Barnsley LWABC steering group governance framework in place and LWABC Leads membership of CA LWABC programme ensures programme reported to CCG</p>	<p>Ongoing</p>
<p>End of Life</p>		
<p>EoL strategy group meets to progress action plan - new objectives/actions agreed. Macmillan ANP for Care homes: Post-holder back in post after 4 month gap due to COVID. Continuing to roll out project.</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>	<p>Ongoing</p>
<p><i>Communication and engagement</i></p>		
<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 4 weekly cancer programme assurance process that ensures programme is on track and lack of progress addressed; Macmillan post educational events reported via evaluation reporting process and bi-monthly reporting process to Macmillan ensures on track and monthly meetings between Macmillan GP and CCG CL for cancer. The CCG via CA established communication and engagement and Barnsley Communication and engagement group ensures actions and reporting are to CCG and via 4 weekly reporting for the cancer programme assurance reporting.</p>	<p>Ongoing</p>
<p>Gaps in assurance</p>	<p>Positive assurances received</p>	

Gaps in control	Actions being taken to address gaps in control / assurance

**NHS Barnsley CCG Governing Body Assurance Framework 2020-21**

PRIORITY AREA 4: MENTAL HEALTH	Delivery supports these CCG objectives:	PRINCIPAL THREATS TO DELIVERY										
<p>Increase the number of children and young people receiving evidence-based treatment to improve their emotional health and wellbeing - the access target to be achieved in 2019/20 is 35% - CAMHS service to move towards delivering the new co produced service specification over the next 2 years under a 'managed change process'</p> <p>Develop a Children and Young People's Emotional Health and Wellbeing Hub within the Borough</p> <p>Continue to expand Psychological Therapies, especially IAPT, to be able to deliver the recommendation of the NHS Long Term Plan</p> <p>Maintain the IAPT recovery target above the national recommended target of 50% and support improving the recovery rate to an ambitious target of 60%</p> <p>Focus on improving the access targets and plan to deliver these targets against a new 'prevalence' figure which will be a stretch target for Barnsley</p> <p>Develop plans to effectively utilise the forthcoming Community Mental Health Transformation Funding, especially in relation to developing pathways for Adult Eating Disorders, Personality Disorders and Community Mental Health Rehab services</p> <p>Improve pre and post mental health crisis care support by considering Safe Haven / Crisis Cafe models and establish third sector services; improve self-harm support</p> <p>All-age liaison mental health service now operational - NHS E funding successfully bid for to ensure liaison service achieves 'CORE 24'</p> <p>Reduce the numbers of suicides in Barnsley to the national average as a minimum - targeted work to continue to be undertaken re men and older people</p> <p>Specialist Perinatal Mental Health Services established and funding agreed to achieve the necessary expansion to achieve the LTP access requirements</p> <p>Develop a South Yorkshire and Bassetlaw sustainable regional ASD /ADHD diagnosis and treatment service for adults</p> <p>Meet the Mental Health Investment Standard (MHIS)</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 &gt;65 should receive a formal diagnosis.</p>	<table border="1"> <tr> <td>Highest quality governance</td> <td></td> </tr> <tr> <td>High quality health care</td> <td style="text-align: center;">✓</td> </tr> <tr> <td>Care closer to home</td> <td style="text-align: center;">✓</td> </tr> <tr> <td>Safe &amp; sustainable local services</td> <td style="text-align: center;">✓</td> </tr> <tr> <td>Strong partnerships, effective use of £</td> <td style="text-align: center;">✓</td> </tr> </table> <p><b>Links to SYB STP MOU</b></p> <p>8.5. Mental Health</p>	Highest quality governance		High quality health care	✓	Care closer to home	✓	Safe & sustainable local services	✓	Strong partnerships, effective use of £	✓	<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 five year forward view for Mental Health will not be achieved.</p>
Highest quality governance												
High quality health care	✓											
Care closer to home	✓											
Safe & sustainable local services	✓											
Strong partnerships, effective use of £	✓											

Committee providing assurance			FPC & QPSC	Executive Lead	PO	Clinical Lead	Dr M Smith
<b>Risk rating</b>	Likelihood	Consequence	<b>Total</b>			<b>Date reviewed</b>	<b>Feb-21</b>
Initial	4	3	12			Rationale: Likelihood set as 4 (likely) because delivering the recommendations of the five year forward view of mental health is dependent upon additional financial resources and a fully trained, accessible workforce. IAPT services have been successfully tendered and the new service commenced from 1	
Current	4	3	12				
Appetite	4	3	12				

Approach	Tolerate	A M J J A S O N D J F M	have been successfully tendered and the new service commenced from 1 August 2018 which is delivering a more ambitious programme. In order to increase access to Mental Health services, the capacity of the mental health services needs to be increased, primarily by increasing the workforce. There are limited, accredited training courses available locally which limits the ability of the service to grow. The South Yorkshire and Bassetlaw ICS MH/LD Board have established a workforce strategy group for South Yorkshire collaborating closely with Health Education England Consequence set as 3 (moderate) because the mitigated actions outlined will enable mental health services to provide, good quality outcomes and be in a state of readiness to effectively utilise the additional resources as and when they become available. NB Rising clinical need is escalated and responded to.
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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 must continue to be utilised to implement the local transformation plan (improving children and young peoples emotional wellbeing).	Quarterly Assurance reports / feedback to NHS England; monitored by C&YPT(Children and Young Peoples Trust) ECG (see note 2). ECG minutes to F&P Committee. 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. Action notes to JCU for info. Regular updates to Governing Body	Ongoing
Service provider developing robust workforce plans in conjunction with Health Education England National Workforce Strategy.	Monitored at ICS level SYB ICS MHL D Steering Group.	Ongoing
Commissioning capacity for the adult autism service has been increased for 20/21 but is still below the level of demand. Backlogs have developed and a proposal to reduce the backlog and reduce waiting times to less than 2 weeks has been submitted to the CCG in September 2020. The newly commissioned service for the over 11 autism pathway has reduced the waiting time on this pathway from 2.5 years to a maximum of 9 months. All Barnsely's children and young peoples autism assessment and diagnostic pathways are now 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		Ongoing
The newly revised IAPT service specification has been delivered by SWYPFT from October 2018 and is consistently achieving all national recommended targets with the exception of the access target. Support is being provided by SYB ICS to all South Yorkshire IAPT services in relation to achieving the recommended access targets.	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
Barnsley Crisis Care Concordat Group have established three Task and Finish groups to i) assess the MH liaison service against Clinical Guidance CG16 (Self-harm); ii) consider the implementation of the Australian Mental Health Traige Tool and iii) consider the development of a Crisis Cafe within the	Monitored via the Mental Health and Resilience Group	Ongoing
A new CAMHS service specification has been developed and is to be implemented over the next two years via a 'managed change process'	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 will report to both the ECG and CCG Governing Body. CCG clinical leads are involved and will drive the work forward	Ongoing
Barnsley CCG's bid re additional funding for Liaison Mental Health Services was successful and staff have been recruited to achieve CORE 24 Status. Barnsley CCG's bid to fund an alternative Crisis Assessment model was also successful and the model is to be evaluated by April 2021.	Performance and activity data submitted via contracts process. Quarterly Mental Health updates to CCG Governing Body	Ongoing
<p>Note (1) - Adult Joint Commissioning group minutes go to F&amp;PC for information. It reports into the Health &amp; Wellbeing Board which is attended by the CCG CO and Chair and minutes go to GB.</p> <p>Note (2) - the Childrens &amp; Young Peoples Trust ECG minutes go to F&amp;PC for information. It reports via TEG to H&amp;WB which is attended by the CCG Chair and CO and minutes go to GB. Specific issues may be raised with GB via quarterly Children's Services updates.</p>		
<b>Gaps in assurance</b>	<b>Positive assurances received</b>	

Gaps in control	Actions being taken to address gaps in control / assurance

## NHS Barnsley CCG Governing Body Assurance Framework 2020-21

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 &amp; enabling work streams:            Leadership and programme support            System-wide governance arrangements (including a system partnership board with NHS, Local Government and other partners) to enable a collective model of responsibility and decision-making between system partners.            System capabilities including population health management, service redesign, workforce transformation, and digitisation required to fulfil the two core roles of an ICS.            Agreed ways of working across the system in respect of financial governance and collaboration (noting that we propose, under the 2020/21 NHS Standard Contract streamlining commissioning arrangements, including typically one CCG per system).            Capital and estates plans at a system level, as the system becomes the main basis for capital planning, including technology.            Plans for how the system will operate in 2021/22 will need to be finalised for April 21</p>				Highest quality governance ✓ High quality health care ✓ Care closer to home ✓ Safe & sustainable local services ✓ Strong partnerships, effective use of £ ✓		<p>There is a risk that the effectiveness of the ICS will be undermined if any of the member parties is unable to sign up to the system MOU, the direction of travel, and the mechanisms for collective decision making.</p> <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</p>	
				Links to SYB STP MOU 8.7 Workforce; 8.8 Digital & IT; 8.9. Development of Integrated Care in Place & System; 8.10. Commissioning reform; 8.11. Sustainable Hospital Services Review			
Committee Providing Assurance		ICS CPB JCC of CCGs	Executive Lead		CE	NB	
<b>Risk rating</b>	Likelihood	Consequence	<b>Total</b>			<b>Date reviewed</b>	<b>Feb-21</b>
Initial	3	3	9			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.	
Current	3	3	9				
Appetite	3	4	12				
Approach	<b>Tolerate</b>						
<b>Key controls to mitigate threat:</b>				<b>Sources of assurance</b>		<b>Rec'd?</b>	
Governance review of the ICS currently underway to inform how the system operates in 2021/22				Minutes of HOB and JCCCG		Ongoing	
Collaborative Partnership Board (CPB) provides strategic direction and oversight of the ICS, while the Joint Commissioning Committee of CCGs facilitates collective commissioning decisions over defined areas.				Minutes of both CPB and JCCC of CCGs are taken through the Governing Body		Ongoing	

ICS Memorandum of Understanding signed by all parties in place outlining sign up to direction of travel in system and in place, recognising journey to local Integrated care partnerships	ICS MOU signed off by Governing Body and all Parties to the ACS for 17/18. MOU for 2018/19 between NHSE/I and ICS agreed and signed off by 1 October 2018. ICS go Live October 2018. Integration agreements between place and system developed (from October 2018).	Complete (Oct-18)
Clear governance arrangements in place to enable to ICS to make both collective commissioning and provider decisions through the Joint Committee of Clinical Commissioning Groups (JCCC) and Providers Committee in Common (CiC)	Minutes of both CPB and JCCC of CCGs are taken through the Governing Body. ICS governance arrangements for Level 3 ICS from April 19 in place	Complete
The ICS has a clear management structure with sufficient capacity and resources to take forward its transformation programmes on behalf of the system.	Agreement of 2018/19 ICS nationally allocated transformation funding and partner contributions and sign off of 2018/19 ICS budget. Revised ICS Executive Management Team in place.	Complete
Work underway to identify 2019/20 commissioning priorities to be taken forward across the ICS footprint with JCCC oversight and potentially delegation of joint decision making subject to agreement of partner CCGs.	Paper setting out 2019/20 ICS commissioning priorities and collaborative commissioning arrangements agreed in principle by BCCG Governing Body March 2019. Arrangements for delegation of decision making to JCCC subsequently signed off.	In progress
Collective approach to decision making in relation to the Hospital Services Review in place within the Barnsley partnership and across the ICS.	Hospital Services Review received both by ICS Collaborative Partnership Board and by Barnsley CCG Governing Body. Governing Body agreed to the publication of the Strategic Outline Case October 2018.	Complete
<b>Gaps in assurance</b>	<b>Positive assurances received</b>	
	SYB response to the NHS Long Term Plan collectively developed across partnership.	
	Workshops with ICS and CCG Chairs and AOs held in December 2019 and January 2020 to agree the way forward with commissioning reform Jan 2020	
<b>Gaps in control</b>	<b>Actions being taken to address gaps in control / assurance</b>	

## NHS Barnsley CCG Governing Body Assurance Framework 2020-21

PRIORITY AREA 5.2: INTEGRATED CARE AT PLACE LEVEL				Delivery supports these CCG objectives:		PRINCIPAL THREATS TO DELIVERY	
<p>Development of Integrated Care Partnership (ICP) in Barnsley bringing Barnsley providers and commissioners together to plan and deliver care. This will include:</p> <ul style="list-style-type: none"> <li>• Development of the primary care network and localities</li> <li>• Development of neighbourhood action plans that deliver better use of estates, support co-production and integration</li> <li>• Population health management including PHMU, integrated care outcomes framework and local profiles and needs assessments that support neighbourhood prioritisation</li> <li>• Development of a place-based workforce strategy</li> <li>• Integrated commissioning with BMBC</li> <li>• Service specification for the out-of-hospital model of care</li> <li>• Strategic outline case for integrated care in Barnsley</li> <li>• Set out how the local health system will specifically reduce health inequalities by 2023/24 and 2028/29</li> </ul> <p>Development of integrated delivery arrangements to support Phase 3 requirements, five priorities and to deliver financial balance.</p> <p>Development of integrated provider governance and shared leadership out of hospital, building on the PCN and or Neighbourhood Teams mobilisation.</p>				<p>Highest quality governance</p>		✓	
				<p>High quality health care</p>		✓	
				<p>Care closer to home</p>		✓	
				<p>Safe &amp; sustainable local services</p>		✓	
				<p>Strong partnerships, effective use of £</p>		✓	
				<p><b>Links to SYB STP MOU</b></p> <p>8.7 Workforce; 8.8 Digital &amp; IT; 8.9. Development of Accountable Care in Place &amp; System; 8.10. Commissioning reform; 8.11. Sustainable Hospital Services Review</p>			
						<p>There is a risk that if the following threats are not effectively managed and mitigated the key deliverables will not be achieved:</p> <ul style="list-style-type: none"> <li>• Financial pressure on individual organisations leads to reduced involvement/investment in the partnership working</li> <li>• Constraints within the current legislative and regulatory framework limit progress with partnership working despite the clear direction of travel set out in the 5YFV and NHS LTP. NHS England is consulting on possible legal changes but these are unlikely to come into effect for at least 3 yrs</li> <li>• Political uncertainty in part due to Brexit.</li> <li>• Maturity of the local provider partnership, financial and operating pressures in the system affect their ability to implement transformational change</li> <li>• Capacity to constructively engage all relevant stakeholders in the development of integrated care and to deliver the cultural and behavioural change required (both staff and service users)</li> <li>• Failure to demonstrate the impact and benefits of new ways of working in order to generate support and increase engagement</li> <li>• Limited local leadership capacity, particularly for Primary Care Networks</li> <li>• Ability of candidates to recruit into new primary care network roles</li> </ul> <p>Covid-19 is currently impacting on BAU transformation activities; potentially insufficient focus on BAU transformation delivery, in particular to achieve financial balance</p> <p>Covid-19 potentially impact on pace of full mobilisation of our Neighbourhood Teams and associated workstreams.</p>	
Committee Providing Assurance		Governing Body	Executive Lead		JB	Clinical Lead	NB
<b>Risk rating</b>	Likelihood	Consequence	<b>Total</b>			<b>Date reviewed</b>	<b>Feb-21</b>
Initial	3	4	12			Rationale:	
Current	3	4	12			- 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	
Appetite	3	4	12			- Likely (3) as it is possible that the impacts could recur occasionally	
Approach	<b>Tolerate</b>						
<b>Key controls to mitigate threat:</b>				<b>Sources of assurance</b>		<b>Rec'd?</b>	
Oversight of process by CCG Governing Body				Routine reporting of progress into Governing Body meetings (public and private) and discussions at development sessions		Ongoing	
Primary care engagement				Series of BEST events focussed on emerging guidance for primary care networks and the right model for Barnsley		Completed	
Engagement with the Membership Council and Local Medical Committee to gain support for integrated care objectives and primary care network proposals				Membership Council agreed to strategic direction at the meeting held on 3 July 2018		Completed	
Local partnership governance arrangements				The CCG is a member of the Integrated Care Partnership and Delivery Groups and leads the Strategic Estates Group and Workforce Transformation Group. CCG leads the Delivery Group. CCG is overseeing delivery of transformational workstreams through allocation of CCG staffing resource.		Ongoing	

Aligned resources	Place-based workforce lead appointed and transformation funding secured from HEE to support workforce modelling and strategy development. Commissioning team staff are aligned to integrated care priorities.	Ongoing
Independent legal advisors appointed	Record of legal advice requested and received to date.	Completed.
Communications and engagement	Communications leads from across the partners have co-produced a communications and engagement plan that has been signed off by ICPG.	Ongoing
<b>Gaps in assurance</b>	<b>Positive assurances received</b>	
<b>Gaps in control</b>	<b>Actions being taken to address gaps in control / assurance</b>	
18/02; If the CCG and BMBC do not develop a collaborative commissioning approach underpinned by shared values there is a risk that BMBC commissioned services will not meet the requirements and aspirations of the CCG for the people of Barnsley leading to increased health inequalities and poorer health outcomes.	Reset and Recovery Plan developed in line with NHS Phase 3 guidance, co-produced with BMBC and other Barnsley partners and focused on activities to deliver against the five priorities agreed by GB in September 2020. BMBC and the CCG have restarted work on Joint Commissioning, A successful workshop event for senior commissioning leaders has been held and resulted in commitment to a shared commissioning plan and also to further work to agree the scope of joint commissioning and to understand how we can align our resources to deliver the best outcomes for Barnsley and make best use of the Barnsley £.	
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.	<ul style="list-style-type: none"> <li>System agreement to be open and transparent re. recovery plans – plans to be shared</li> </ul>	
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"> <li>Modelling now being undertaken locally, regionally and nationally to understand impact</li> <li>Close monitoring of service demand against these models to give early signs for service escalation</li> <li>Developing a tool to support prioritisation based on medical, social and economic vulnerability that can support phased recovery of services for maximum health benefits</li> </ul>	

## NHS Barnsley CCG Governing Body Assurance Framework 2020-21

PRIORITY AREA 6: FINANCIAL BALANCE & EFFICIENCY PLANS				Delivery supports these CCG objectives:		PRINCIPAL THREATS TO DELIVERY																												
<ul style="list-style-type: none"> <li>Free up hospital beds</li> <li>Best value across all CCG expenditure</li> <li>Reduce avoidable demand</li> <li>Reduce unwarranted variation in clinical quality and efficiency</li> <li>Financial accountability and discipline for all trusts and CCGs</li> <li>Deliver financial balance in 2020/21</li> </ul>				Highest quality governance		✓																												
				High quality health care		✓																												
				Care closer to home		✓																												
				Safe & sustainable local services		✓																												
				Strong partnerships, effective use of £		✓																												
				<b>Links to SYB STP MOU</b>																														
				8.2. Managing demand and demand management																														
				8.1. Efficiency programmes																														
Committee Providing Assurance				FPC		Executive Lead																												
				RN		Clinical Lead																												
				Various																														
<b>Risk rating</b>	Likelihood	Consequence	<b>Total</b>	<table border="1"> <caption>Risk Rating Data</caption> <thead> <tr> <th>Month</th> <th>Risk Rating</th> </tr> </thead> <tbody> <tr><td>A</td><td>16</td></tr> <tr><td>M</td><td>16</td></tr> <tr><td>J</td><td>16</td></tr> <tr><td>J</td><td>16</td></tr> <tr><td>A</td><td>16</td></tr> <tr><td>S</td><td>12</td></tr> <tr><td>O</td><td>12</td></tr> <tr><td>N</td><td>12</td></tr> <tr><td>D</td><td>12</td></tr> <tr><td>J</td><td>12</td></tr> <tr><td>F</td><td>12</td></tr> <tr><td>M</td><td>12</td></tr> </tbody> </table>			Month	Risk Rating	A	16	M	16	J	16	J	16	A	16	S	12	O	12	N	12	D	12	J	12	F	12	M	12	<b>Date reviewed</b>	<b>Feb-21</b>
Month	Risk Rating																																	
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J	12																																	
F	12																																	
M	12																																	
Initial	4	4	16	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	<b>Tolerate</b>																																	
<b>Key controls to mitigate threat:</b>				<b>Sources of assurance</b>			<b>Rec'd?</b>																											
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 2020/21 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																											
<b>Gaps in assurance</b>				<b>Positive assurances received</b>																														
If the BCCG CHC team is unable to deliver its recovery plan to enable the backlog of reviews to be cleared and new cases to be processed in a timely way, with robust case management processes in place that demonstrate value for money whilst not compromising quality of care, there is a risk of adverse financial consequences for the CCG and inappropriate or out of date care packages being provided for patients which potentially would not be meeting their health needs. This could also have implications on meeting the KPI's as set by NHSE.				Discussions with partners remain positive and are ongoing in relation to the contract position for 2021/22.																														
<b>Gaps in control</b>				<b>Actions being taken to address gaps in control / assurance</b>																														

13/31 - There is a risk that if the CCG does not develop a robust QIPP plan supported by effective delivery and monitoring arrangements, the CCG will not achieve its statutory financial duties and NHS England business rules.

The CCG is currently monitoring the efficiency plans in place around Prescribing and CHC. All other efficiency requirements will be met through reductions in expenditure given the impact of Covid-19 and the timescales to deliver plans. The programmes of work agreed at Governing Body do however need to continue to be progressed to ensure improved patient care and access as well as ensuring services remain financially sustainable through delivery of efficiency to close the gap that remains across Barnsley place from 2021/22 and beyond. Plans continue to be progressed, however the impact of Covid does remain a barrier to full implementation and is likely to continue as we approach 2021/22.

Committee providing assurance				FPC & QPSC	Executive Lead	PO / AR	Dr M Smith
<b>PRIORITY AREA 7: TRANSFORMING CARE FOR PEOPLE WITH LEARNING DISABILITIES AND / OR AUTISTIC SPECTRUM CONDITIONS</b>				<i>Delivery supports these CCG objectives:</i>		<b>PRINCIPAL THREATS TO DELIVERY</b>	
<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"> <li>-Reduce inappropriate hospitalisation and lengths of stay to be as short as possible</li> <li>- Improve access to healthcare and deliver annual physical health checks (eg cervical screening)</li> <li>-Invest in community teams</li> <li>-Ensure all children with learning disabilities, autism or both receive Community Care, Education and Treatment Review (CETR) if appropriate</li> <li>- Ensure all adults with learning disabilities, autism or both receive Community Care and Treatment Review (CTR) as appropriate</li> <li>-Increase uptake on annual health checks and learn from learning disability mortality reviews</li> </ul>				<p>Highest quality governance ✓</p> <p>High quality health care ✓</p> <p>Care closer to home ✓</p> <p>Safe &amp; sustainable local services ✓</p> <p>Strong partnerships, effective use of £ ✓</p> <p>Links to SYB STP MOU</p>		<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"> <li>-People with a learning disability or autistic spectrum conditions will enter hospital inappropriately</li> <li>-There will be difficulty discharging current patients</li> <li>-Potential prohibitively high cost of meeting needs</li> <li>-Inability of current provider market to meet needs</li> <li>-Difficulty in ensuring that the quality of care is high</li> <li>- Insufficient funding to ensure the appropriate level of care within the community</li> </ul>	
<b>Risk rating</b>	Likelihood	Consequence	Total			<b>Date reviewed</b>	<b>Feb-21</b>
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			
<b>Key controls to mitigate threat:</b>				<b>Sources of assurance</b>			<b>Rec'd?</b>
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>JCU reports to Finance &amp; Performance Committee with any Quality issues escalated to Quality &amp; Patient Safety Committee. Quarterly update reports to CCG Governing Body</p> <p>Quarterly meetings with NHS England Spec Comm, who commission the existing placements for this cohort of patients, to determine progress made, working towards discharge.</p>			Ongoing
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							Ongoing
Strong partnership arrangements with Calderdale, Wakefield and Kirklees (Transforming Care Partners CKWB) remain in place and strong links exist with the SYB TCP. A re-design of the ATU (Assessment Treatment Unit) is underway and Barnsley CCG and Local Authority are involved in these discussions going forward							Ongoing
Development of LD Strategic Health & Social Care Improvement Group to maintain oversight of key legislation inc LEDER learning and transforming care. The identified LAC (Local Area Coordinator) for the LeDer Programme will be the Specialist Clinical Portfolio Manager							Ongoing
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							Ongoing
Detailed plans, with timescales, have been developed for each patient identified within the Transforming Care cohort, to return these patients to appropriate local community settings as quickly and as safely as possible to improve their life outcomes							Ongoing
<b>Gaps in assurance</b>				<b>Positive assurances received</b>			
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.							
<b>Gaps in control</b>				<b>Actions being taken to address gaps in control / assurance</b>			
Plans are to be established to improve the uptake of Annual physical Health checks for people with LD							

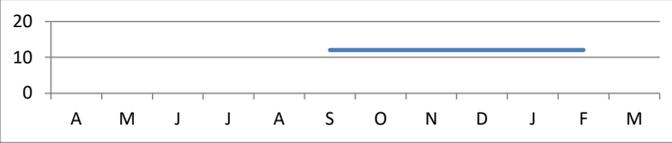
PRIORITY AREA 8: MATERNITY				Delivery supports these CCG objectives:		PRINCIPAL THREATS TO DELIVERY					
Continue to implement the Saving Babies' Lives care bundle version 2 to further reduce still birth, neonatal deaths, maternal deaths and brain injuries. Implement the SYB LMS (Local maternity service) - - Improve maternity safety, choice and personalisation - Liaise closely with the local MVP (Maternity Voice Partnership) to ensure local women are able to influence and shape the delivery of future services				Highest quality governance		There is a risk that the key deliverables will not be achieved if the following risks to delivery are not appropriately managed and mitigated: 1/ Achievement is dependent upon implementing the outcomes of the Hospital Services Review 2/ Lack of sufficient investment in additional staff resources to enable 'continuity of carer' 3/ Achievement is dependent on ICS maternity services and is at risk if there is failure of the ICS providers to integrate working practices fully to implement the LMS 4/ Lack of staff rotation between hospital and community based services may reduce the likelihood of fully delivering continuity of carer					
				High quality health care				✓			
Care closer to home		✓									
Safe & sustainable local services		✓									
				Strong partnerships, effective use of £							
				Links to SYB STP MOU							
				8.5.							
Committees providing assurance		FPC & QPSC		Executive Lead		PO		Clinical Lead		Dr M Smith	
Risk rating		Likelihood	Consequence	Total				Date reviewed		Feb-21	
Initial		4	3	12				Rationale: Likely primarily due to the staffing issue inherent in delivering continuity of carer and there are no additional funding streams available. Consequence is moderate because this is primarily a local issue which will potentially result in the late delivery of the key objective within the better birth recommendations of delivering the 'continuity of carer.'			
Current		4	3	12							
Appetite		3	4	12							
Approach		Tolerate									
Key controls to mitigate threat:				Sources of assurance				Rec'd?			
4 Continuity of care teams are established and Barnsley is on track to achieve the recommended CoC target of 51% by 21/22.				NHSE LMS assurance process				Ongoing			
CQB for each provider reports to Q&PSC				Yorkshire and Humber maternity dashboard (enables benchmark)				Ongoing			
Governing Body oversight				Reporting into QPSC, minutes to Governing Body with specific issues escalated by the Quality Highlights Report				Ongoing			
the local based maternity plan includes increasing the choice of where to give birth from the current two options available to the recommended three options (consultant led, home and midwifery led)				A newly established Maternity Hosted Network (led by Rotherham) will oversee the implementation of the Better Birth recommendations within the South Yorkshire and Bassetlaw region				Ongoing			
Enhanced specialist smoking cessation support for women who smoke during pregnancy will be provided								Ongoing			
Gaps in assurance						Positive assurances received					
						In 2017/18 BHNFT benchmarked well positive update to June Governing Body. NHS England positively assured the SY&B ICS Maternity Plan in the assurance round in December 2018. The SY&B ICS LMS achieved the 2018/19 target for CoC (Continuity of Carer) of 20%					
Gaps in control						Actions being taken to address gaps in control / assurance					

**NHS Barnsley CCG Governing Body Assurance Framework 2020-21**

PRIORITY AREA 9: DIGITAL AND TECHNOLOGY	Delivery supports these CCG objectives:	PRINCIPAL THREATS TO DELIVERY														
1. Development of a system wide shared care record 2. Ensure the delivery of the GP IT Operating Model to: - Comply with mandatory core standards re: interoperability and cyber security - Support the transition to HSCN from N3 ( <i>transition now complete</i> ) - Support the roll out of Windows10 to secure system security from cyber attack - Support the implementation and roll out of the NHS App, eConsultaion. APEX, GPIT refresh of IT equipment, Govroam ( <i>noting that NHS App rolled out, APEX decommissioned, GPIT refresh in place, Govroam under review</i> ) - Support the wider use of digital technology as described within the Long Term Plan - Comply with the transition from GPSoC to GP IT Futures ( <i>transition now complete</i> ) - Working closely with the SY&B digital and IT workstream to deliver the digital road map - Delivery of O365 across Barnsley - Support the catch up of Windows10 upgrades in primary care - Ensure full delivery of online consultation systems to general practices where these are not already in place - Lead the transition to the new GPIT Futures Digital Care Services Framework arrangements.	<table border="1"> <tr><td>Highest quality governance</td><td></td></tr> <tr><td>High quality health care</td><td>✓</td></tr> <tr><td>Care closer to home</td><td>✓</td></tr> <tr><td>Safe &amp; sustainable local services</td><td>✓</td></tr> <tr><td>Strong partnerships, effective use of £</td><td>✓</td></tr> <tr><td colspan="2"><b>Links to SYB STP MOU</b></td></tr> <tr><td colspan="2"> </td></tr> </table>	Highest quality governance		High quality health care	✓	Care closer to home	✓	Safe & sustainable local services	✓	Strong partnerships, effective use of £	✓	<b>Links to SYB STP MOU</b>				There is a risk that the key deliverables will not be achieved if the following threats to delivery are not appropriately managed and mitigated: - Lack of IT technical expertise locally for input into projects and programmes of work / lack of technical support to ensure deliverables are robust - Primary Care colleagues fatigued with the amount of IT work scheduled - Short timelines to deliver projects - Supplier and equipment delays - constructive and timely engagement by system partners to deliver a SCR by 20/21 - system wide strategic digital strategy and planning currently under-resourced with no dedicated Barnsley resource available to progress this work - Incomplete information available from NHS Futures regarding future work.
Highest quality governance																
High quality health care	✓															
Care closer to home	✓															
Safe & sustainable local services	✓															
Strong partnerships, effective use of £	✓															
<b>Links to SYB STP MOU</b>																

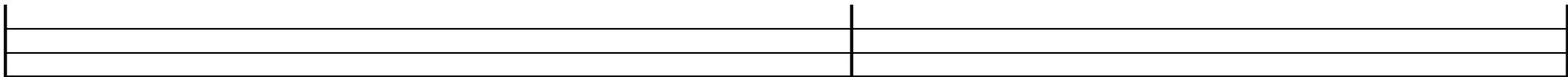
Committees providing assurance	PCCC & SMT	Executive Lead	JB	Clinical Lead	JH
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Risk rating	Likelihood	Consequence	Total	Date reviewed
Initial	3	4	12	Feb-21 Rationale: Likelihood has been scored at 3 as transition to new provider has been successfully completed but will be kept under review. Consequence has been scored at 4 given the major impact on the CCG and the system if digital and It technology is not safeguarded and fully exploited.
Current	3	4	12	
Appetite	3	4	12	
Approach	<b>Tolerate</b>			



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 EOLs 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. Issues 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 2020-21

PRIORITY AREA 10: COMPLIANCE WITH STATUTORY AND REGULATORY REQUIREMENTS				Delivery supports these CCG objectives:		PRINCIPAL THREATS TO DELIVERY																	
<ul style="list-style-type: none"> <li>• Delivery of all the CCG's statutory responsibilities</li> <li>• Deliver statutory financial duties &amp; VFM</li> <li>• Improve quality of primary &amp; secondary services (inc reductions in HCAI, ensuring providers implement learning from deaths, and reductions in medication errors);</li> <li>• Involve patients and public;</li> <li>• Promote Innovation;</li> <li>• Promote education, research, and training;</li> <li>• Meet requirements of the Equality Act;</li> <li>• Comply with mandatory guidance for managing conflicts of interest</li> <li>• Adhere to good governance standards.</li> </ul>				Highest quality governance		✓																	
				High quality health care		✓																	
				Care closer to home		✓																	
				Safe & sustainable local services		✓																	
				Strong partnerships, effective use of £		✓																	
Links to SYB STP MOU				Section 7 'Governance, Accountability, & Assurance'																			
Committee Providing Assurance <table border="1" style="float: right; margin-left: 20px;"> <tr> <th colspan="2">Audit Committee</th> <th colspan="2">Executive Lead</th> <th colspan="2">RW</th> <th colspan="2">Lay / Clinical Leads</th> </tr> <tr> <td>MG,MT,NBa, NBe, CM</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> </table>				Audit Committee		Executive Lead		RW		Lay / Clinical Leads		MG,MT,NBa, NBe, CM											
Audit Committee		Executive Lead		RW		Lay / Clinical Leads																	
MG,MT,NBa, NBe, CM																							
<b>Risk rating</b>	Likelihood	Consequence	<b>Total</b>				<b>Date reviewed</b>																
Initial	2	5	10				Feb-21																
Current	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.																
Appetite	3	4	12																				
Approach	<b>Tolerate</b>																						
<b>Key controls to mitigate threat:</b>				<b>Sources of assurance</b>				<b>Rec'd?</b>															
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															

<p>Patient &amp; 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 &amp; 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.</p>	<p>Oversight by Equality &amp; 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).</p>	<p>Ongoing</p>
<p>Equality: EDS2 used to ensure compliance with PSED requirements; Equality Action Plan monitored via E&amp;D Group and E&amp;E Committee; E&amp;D Lead; E&amp;D training provided to all staff; EQIA policy in place and EQIAs attached to GB papers where appropriate; Staff survey results considered &amp; acted upon; HR policies approved &amp; embedded.</p>	<p>Progress monitored by Equality, Diversity &amp; Inclusivity Group and reported quarterly to Equality &amp; Engagement Committee. Assurance to GB via E&amp;E Committee Minutes and annual assurance report. Summary of key actions on CCG website each year.</p>	<p>Ongoing</p>
<p>Conflicts of Interest: standards of business conduct policy in place &amp; compliant with statutory guidance; registers of interests maintained &amp; 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.</p>	<p>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.</p>	<p>Ongoing</p>
<p>Information Governance: strategy &amp; policies in place, SIRO / Caldicott Guardian identified, training provided for all staff, information asset register in place, committee report &amp; business case template prompts consideration of IG issues. GDPR / compliant processes in place. DPO service provided by third party provider.</p>	<p>DSP Toolkit (formerly IG Toolkit) compliance achieved every year. Reporting via IG Group==&gt;QPSC==&gt;GB.</p>	<p>Ongoing</p>
<p>Risk Management: Risk management framework (GBAF and RR) provides assurance that risks have been identified and are being managed</p>	<p>GBAF and Risk register updated monthly and considered at all Committees and meetings of the GB</p>	<p>Ongoing</p>
<p>Health &amp; Safety and Business Continuity Group established to oversee compliance with statutory Fire &amp; Health &amp; Safety &amp; Business Continuity requirements</p>	<p>Annual Report &amp; update reports taken to Audit Committee.</p>	<p>Ongoing</p>
<p>MAST: Statutory &amp; 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 &amp; assurance etc</p>	<p>L&amp;D team provides dashboard which is considered by management team on a regular basis.</p>	<p>Ongoing</p>
<p><b>Gaps in assurance</b></p>	<p><b>Positive assurances received</b></p>	
<p>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>The CCG received a 'Green Star' rating from NHSE in respect to compliance with statutory guidance on patient and public participation in the 2018/19 IAF ratings published in July 2019, and the 2019/20 ratings published in November 2020.  The CCG received a 'significant assurance' opinion from Internal Audit following its review of the Governance &amp; Risk Management arrangements (Sep 2019).  The CCG received a 'significant assurance' opinion from internal audit on its conflicts of interest arrangements (Dec 2020).  The CCG received a 'substantial assurance' opinion from internal audit on the Integrity of the General Ledger and Financial Reporting (Jan 2021).</p>	
<p><b>Gaps in control</b></p>	<p><b>Actions being taken to address gaps in control / assurance</b></p>	

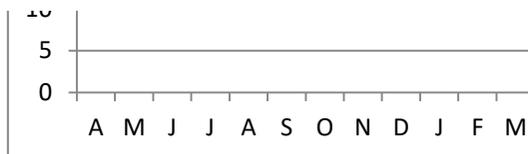
RR 14/15 Discharge medication risks related to poor or incomplete D1 discharge letters

The volume of hospital discharges has significantly reduced since beginning of March 20 ( due to COVID 19). The D1 Audit Report (November 2018 audit data) was received by the CCG Quality and Patient Safety Committee on 2nd July 2020. This showed an improvement; 61.4% of D1 forms had all medicines accurately accounted for at discharge. It was noted that the D1 e-form had been withdrawn at the beginning of the COVID pandemic and the Medway system introduced in July 20. BHNFT have advised they are re-establishing the pre-COVID D1 Task and Finish Group and are also undertaking a mapping of hospital pathways and primary care medicines management are being involved.

## NHS Barnsley CCG Governing Body Assurance Framework 2020-21

<b>PRIORITY AREA 11: DELIVERY OF ENHANCED HEALTH IN CARE HOMES</b>				<i>Delivery supports these CCG objectives:</i>	<b>PRINCIPAL THREATS TO DELIVERY</b>										
Delivery of all 17 elements and sub elements of the Barnsley Care Homes Delivery Plan. This includes the elements of the Enhanced Health in Care Homes (EHCH) Framework and the Covid-19 Pandemic specific support. 1. Engagement with care homes on all requisites of the delivery plan 2. EHCH Primary Care Network (PCN) Specification 3. Named Clinician for each care home 4. Coordinated health and social care MDT support 5. Specialist Support 6. Out of Hours support 7. Infection Prevention and Control (IPC) including Personal Protective Equipment (PPE) 8. Mutual Aid 9. Testing / Swabbing 10. Medicines 11. Equipment 12. Discharge to Assess (D2A) and Intermediate Care (IMC) 13. Secondary Care support 14. Personalised care 15. Workforce support 16. Technology 17. Integrated Care System link-in				<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="padding: 2px;">Highest quality care</td> <td style="width: 20px;"></td> </tr> <tr> <td style="padding: 2px;">High quality health care</td> <td style="text-align: center; width: 20px;">✓</td> </tr> <tr> <td style="padding: 2px;">Care closer to home</td> <td style="text-align: center; width: 20px;">✓</td> </tr> <tr> <td style="padding: 2px;">Safe &amp; sustainable local services</td> <td style="text-align: center; width: 20px;">✓</td> </tr> <tr> <td style="padding: 2px;">Strong partnerships, effective use of services</td> <td style="text-align: center; width: 20px;">✓</td> </tr> </table> <p style="margin-top: 5px;"><b>Links to SYB STP MOU</b></p>	Highest quality care		High quality health care	✓	Care closer to home	✓	Safe & sustainable local services	✓	Strong partnerships, effective use of services	✓	There is a risk that the CCG will not be able to deliver the elements of the Care Homes Delivery Plan if the following issues are not mitigated: 1. Acuity of the Covid 19 need across Barnsley meaning that the more transformational elements of the plan will need to be shelved or slowed down 2. Decrease in bed occupancy and risk to business viability and market sustainability 3. Financial pressures and priorities 4. CCG not having direct input and oversight of quality assurance monitoring and safeguarding in care homes 5. Best use of technology in care homes - variance types of technology used and in consistency of use 6. Potential IG issues in current methods of remote consultation using IT equipment 7. Insufficient staff/resource (Matrons, Clinical Pharmacists and some GP practices) to undertake delivery of MDTs in care homes. 8. Availability of essential equipment (e.g PPE) 9. Interdependencies with other work streams and potential for gaps in communication and escalation of issues
Highest quality care															
High quality health care	✓														
Care closer to home	✓														
Safe & sustainable local services	✓														
Strong partnerships, effective use of services	✓														
<i>Committee Providing Assurance</i>		<b>Q&amp;PSC</b>	<i>Executive Lead</i>	<b>JS</b>	<i>Clinical Lead</i>										
<b>Risk rating</b>	Likelihood	Consequence	<b>Total</b>	15	<b>Date reviewed</b>										
Initial	3	4	<b>12</b>	10	Feb-21										
					Likelihood assessed as 3 'possible'										

Current	3	4	12
Appetite	3	4	12
Approach	<b>Tolerate</b>		



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.

<b>Key controls to mitigate threat:</b>	<b>Sources of assurance</b>
Delivery work plan and risk log in place	<p>Monitored and managed via a multi - agency Delivery Group and Bronze Discharge and Out of Hospital Group.</p> <p>Minutes and action logs available.</p> <p>Leads and co-leads in place with clear responsibility for delivery – supervision of leads within line management structures</p> <p>Escalation of risks and issues to Silver and other appropriate forums as required.</p> <p>Regular reporting to Quality and Patient Safety Committee</p> <p>Weekly operational updates at Care Homes Delivery Group and regular Risk log updates as indicated by BRAG rating</p>
<b>Gaps in assurance</b>	<b>Positive assurances received</b>
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.	
<b>Gaps in control</b>	<b>Actions being taken to address gaps in control / assurance</b>

# RISK REGISTER – March 2021

Domains
1. Adverse publicity/ reputation
2. Business Objectives/ Projects
3. Finance including claims
4. Human Resources/ Organisational Development/ Staffing/ Competence
5. Impact on the safety of patients, staff or public (phys/psych)
6. Quality/ Complaints/ Audit
7. Service/Business Interruption/ Environmental Impact
8. Statutory Duties/ Inspections

Likelihood		Consequence		Scoring Description			Current Risk No's	Review
Almost Certain	5	Catastrophic	5	Red	Extreme Risk	(15-25)	8	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					
				<b>Total = Likelihood x Consequence</b>				

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			
COVI D 1	5, 6	<p><b>Disruption to health and social care – hidden harm</b></p> <p>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.</p>	5	5	25	<ul style="list-style-type: none"> <li>Relates to ability to recover</li> <li>ongoing analysis of mental health, but growing severity includes suicides look likely. Local and national initiatives to encourage people to still access primary care services and mental health services if they have any concerns.</li> </ul>	<p>Director of Commissioning</p> <p>CCG Gold Command</p> <p>F&amp;PC</p>	COVID-19	4	4	16	02/21	<p><b>Feb 2021</b></p> <p>Mitigating section updated to reflect more accurately. FPC recommended to reduce risk score in light of mitigations in place from 5x5=25 to 4x4=16 in light of mitigations now in place. Our integrated health and care partnership continues to monitor this risk. Specific work on planned care has</p>	03/21

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<i>COVID 2</i>	1,5,6	<b>Backlog and demand surge</b> 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	5	5	25	<ul style="list-style-type: none"> <li>Health and care saw a resurgence of COVID in the Autumn, with OPEL3-4 being hit and recovery being slowed.</li> <li>National lockdown has seen COVID cases and OPEL level reduce.</li> </ul> Plans in place to revisit recovery in a flexible way, including COVID-surveillance.	Director of Commissioning  CCG Gold Command  F&PC	COVID-19	4	4	16	02/21	<b>Feb 2021</b> Mitigating section updated to reflect more accurately. FPC recommended to reduce risk score in light of mitigations in place from 5x5=25 to 4x4=16. The Barnsley	03/21

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		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.										Health and Care recovery and stabilization plan will be updated in March 2021.		
CCG 18/04	1,2, 3, 5,6, 8	If the health and care system in Barnsley is not able to commission and deliver out of hospital urgent care services which have sufficient capacity and are effective in supporting patients in the community to avoid the need for hospital attendance or non-elective admission there is a risk that non- elective activity will exceed planned levels potentially leading to (a) failure to achieve NHS	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	Chief Operating Officer  (Finance & Performance Committee)	Contract and Performance Monitoring	5	4	20	02/21	<b>February 2021</b> Covid activity remains high impacting on the level of unplanned/emerg ency activity however current block contract arrangement during COVID means that PbR is not in place as part of contracts.  <b>November 2020</b> Increased COVID related activity is impacting on A&E and unplanned	03/21

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		Constitution targets (with associated reputational damage, and (b) contractual over performance resulting in financial pressure for the CCG.				<p>related targets. The Board is overseeing work to develop appropriate services to ensure that patients are able to access appropriate care and support outside of hospital, or in a different way in hospital utilising ambulatory care pathways and implementing a new model at the front of A&amp;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>Additional Primary Care Capacity is in place for same day appointments through IHEART and Home Visiting Services</p> <p>CCG commissioned Out of Hospital Services being remodeled as part of the Neighbourhood Team mobilisation and includes PCN/Neighbourhood developments.</p>						<p>care activity.</p> <p>Plans against priority areas are being refined to ensure clear focus on reducing activity in hospital and providing earlier support in the community.</p>		

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						Priority areas of work identified to support ICP vision and principles for proactive care and care out of hospital.								
18/02	1,2, 5,6	If the CCG and BMBC do not develop a collaborative commissioning approach underpinned by shared values there is a risk that BMBC commissioned services will not meet the requirements and aspirations of the CCG for the people of Barnsley leading to increased health inequalities and poorer health outcomes.	4	4	16	Escalation of CCG concerns to BMBC senior management  Escalation via SSDG and health & wellbeing board  To be raised and discussed at H&W Board development Session (August 2018)	Jeremy Budd (SSDG)	Added to the Corporate Risk register in context of long standing and frequently articulated concerns with respect to a basket of BMBC commissioned services notably:  0-19 Health Checks Weight management & smoking cessation	4	4	16	02/21	<b>Feb 2021</b> BMBC and the CCG have restarted work on Joint Commissioning, A series of successful workshop events for senior commissioning leaders has been held and resulted in commitment to a shared commissioning plan and also to further work to agree the scope of joint commissioning and to understand how we can align our resources to deliver the best outcomes for	03/21

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													<p>Barnsley and make best use of the Barnsley £.</p> <p><b>Oct 2020</b>  We have developed a Reset and Recovery Plan in line with NHS Phase 3 guidance. This has been co-produced with BMBC and other Barnsley partners and focuses on activities to deliver against the five priorities agreed by GB in September 2020. BMBC and the CCG have restarted work on Joint Commissioning, A successful workshop event for senior commissioning leaders has been held and resulted</p>	

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CCG 14/10	2, 5, 6	If the Barnsley area is not able to attract & retain a suitable & sufficient Primary Care clinical workforce there is a risk that: (a) Some practices may not be viable, (b) Take up of PDA or other initiatives could be inconsistent (c) The people of Barnsley will	3	3	9	The Long Term Plan includes a section on workforce planning and Network Contract DES includes provision for a number of Primary Care specific roles.  The Network Contract DES has a number of deliverables that will support staff and work to supporting sustainable services in Barnsley.  NHS England has published an Interim People Plan to	Head of Primary Care.  (Primary Care Commissioning Committee)	Governing Body	4	4	16	02/21	<b>Feb 2021</b> The recruitment is not yet at the pace expected and there has not been the additional increase as expected. This remains at the same risk level.  <b>Jan 2021</b> PCN recruitment continues for the ARRS. The	03/21

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		<p>receive poorer quality healthcare services</p> <p>(d) Patients services could be further away from their home.</p>				<p>support the workforce challenge.</p> <p>The CCG's Primary Care Development Workstream has a workforce element and the Barnsley Workforce Plan is under development which will include Primary Care.</p> <p>Links have been developed with the Medical School to enhance attractiveness of Barnsley to students</p> <p>The CCG continues to invest in primary care capacity. The PDA enables practices to invest in the sustainability of their workforce.</p> <p>The CCG has funded Clinical Pharmacists to provide support to all Practices in Barnsley. Approval was given to the recruitment of a second cohort of clinical pharmacists &amp; 2 technicians in March 2019.</p> <p>The PDA requires Practices to submit a workforce baseline assessment to the CCG on a quarterly basis. This will be monitored via the Primary</p>							<p>projected increase in staff has prompted a risk review at Jan 21 PCCC</p> <p><b>Dec 2020</b> No further updates.</p>	

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						Care Quality Improvement Tool to identify any capacity issues or pressure points.								
20/03	3,5,6	If the BCCG CHC team is unable to deliver its recovery plan to enable the backlog of reviews to be cleared and new cases to be processed in a timely way, with robust case management processes in place that demonstrate value for money whilst not compromising quality of care , there is a risk of adverse financial consequences for the CCG and inappropriate or out of date care packages being provided for patients which potentially would not be meeting their health needs. This could also have	4	4	<b>16</b>	<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 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</p>	<p>Chief Nurse</p> <p>Finance &amp; Performance Committee</p> <p>And</p> <p>Quality &amp; Patient Safety Committee</p>	SMT discussion	4	4	<b>16</b>	02/21	<p><b>February 2021</b></p> <p>Vacant posts – all post filled awaiting start dates.</p> <p>Agency nurses – 2 outstanding COVID backlog cases then the focus will be on the outstanding Fast track reviews which there is a trajectory in place to monitor productivity</p> <p>Training plan – competency framework in place and all nurses completed on line CHC training. The operational Lead and Team leader are reviewing a 12 months training plan for the team</p>	03/21

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		implications on meeting the KPI's as set by NHSE.				consistency to staff and patients in relation to the cost of care packages and rationale for the level of care provided.							CPA panel – this commenced in November 2020 with senior clinicians and finance manager to ensure quality and assurance and Governance in place of care packages in excess of £1000 per week.  <b>January 2021</b> Following a discussion at GBDS on 28.1.21 it was agreed to score this risk at 4x4=16 since given the range of pressures and challenges on the CHC team it was felt that a likelihood score of 4 was appropriate at this stage.	
14/15	1, 5, 6	There are two main risks: 1.	4	4	16	Ongoing discharge medication risks escalated to BCCG Chief Officer and	Head of Medicines Optimisation	Risk Assessment & audit of	3	5	15	02/21	<b>Feb 2021</b> Risk increase from 3x5=15 to	03/21

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		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 confident about the reasons for the change.				<p>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 &amp; Patient Safety Committee.</p> <p>A working Group (with reps from Practice managers Group &amp; BHNFT) looking at D1 Discharge Summary Letters.</p>	(Quality & Patient Safety Committee)	discharge letters					4x5=20. TO BE APPROVED AT Q&PSC IN APRIL 2021. The national Community Pharmacy Discharge Service was launched on 15th February 2021. Community Pharmacies will be receiving D1 letters and will ( in addition to GP practices) be undertaking medicines reconciliation against their PMR systems ( medicines supply pre admission). This service will be significantly affected (clinical risk and efficiency) by the quality of the discharge meds information.	

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		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.											hospital systems and audit work remains on hold due to impact of COVID-19.  <b>Oct 20</b> The volume of hospital discharges has significantly reduced since beginning of March 20 ( due to COVID 19) The D1 Audit Report (November 2018 audit data) was received by the CCG Quality and Patient Safety Committee on 2 <sup>nd</sup> July 2020. This showed an improvement; 61.4% of D1 forms had all medicines accurately accounted for at discharge. It was noted that the D1	

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													e-form had been withdrawn at the beginning of the COVID pandemic and the Medway system introduced in July 20. BHNFT have advised they are re-establishing the pre-COVID D1 Task and Finish Group and are also undertaking a mapping of hospital pathways and primary care medicines management are being involved.	

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CCG 19/05 added Dec 2019	6  5  3	<p><b>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:</b></p> <p><b>a) Quality and Patient Safety Risks</b> 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.</p> <p>b) Patients at home without a care package or a care package that is not being delivered as required.</p>	5	4	20	<p>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.</p> <p>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</p>	Chief Nurse  QPSC	End of Life Team in BCCG Continuing Healthcare Team	5	3	15	02/21	<p><b>February 2021</b> February 2021 The Operational lead attends SIT rep each morning and also Bronze to discuss any risks to the CHC service eg Winter pressures EOL liaise closely with all partners involved in delivering EOL Care. EOL care packages are prioritized via the Discharge Pathway and community referrals, Reviews of all EOL care packages take place at 2 and 4 weeks to ensure care package is sufficient enough to meet needs. CHC continue to use the framework</p>	03/21

	2	<p><b>b) Financial Risks</b> 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><b>c) Performance Risks</b> Delayed discharges impact upon patient flow which could affect delivery of 4 hour A&amp;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>providers, then providers of last resort and then spot providers which are at a higher cost. <b>Dec 2020</b> As below.</p>	
CCG 13/31/ COVID 4	1,2, 3, 8	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.	3	4	12	<p>A Programme Management Office is established with monthly reports on progress against targets through revised organisational governance arrangements: QIPP Delivery Group reporting to Finance and Performance Committee and onward to the Governing Body.</p> <p>Monthly Reports on the CCG's financial position and forecast outturn to Finance and Performance Committee and</p>	<p>Chief Finance Officer</p> <p>Governing Body</p> <p>(Finance &amp; Performance Committee)</p>	Risk Assessment	3	4	12	02/21	<p><b>February 2021</b> No update from January 2021.</p> <p><b>January 2021</b> The CCG has QIPP plans for Prescribing and CHC that are being monitored, all other efficiency targets in year will be met through underspends across budgets,</p>	05/21

					<p>Governing Body as part of Integrated Performance Report (IPR)</p> <p>Robust financial management is in place for each area of budget with monthly budget meetings to identify variances from budget and mitigating actions.</p> <p>Development of further QIPP programmes and savings schemes to be overseen by Programme Management Office.</p> <p>Budget Holders receive training and support from the finance team to allow variations from plan and mitigating actions to be identified on a timely basis.</p> <p>Prime Financial Procedures and Standing Orders are in place</p> <p>Internal Audit Reports on general financial procedures and Budgetary Control Procedures (including review of shared service functions) Annual Governance Statement</p> <p>Local Counter Fraud Specialist Progress Reports to Audit Committee</p> <p>Annual Report &amp; Accounts subject to statutory external audit by KPMG, reported via Annual Governance (ISA260)</p>						<p>due to delays in planning and the impact of Covid-19. Plans need to be addressed to deliver efficiency and improve patient care pathways in line with programmes of work agreed across partners from 2021/22 and beyond. The CCG is currently on track to achieve a balanced budget position in line with guidance.</p> <p><b>December 2020</b> Plans continue to be monitored with financial risk and delivery of efficiency being flagged to the Finance and Performance Committee and Governing Body.</p>	
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						Report, and Annual Audit Letter.  Monthly monitoring reporting to NHS England  Develop a joint approach to future efficiency to ensure costs are taken out of the system to allow financial balance.								
CCG 13/3	1,3, 5,6, 8	If the system, via the Urgent and Emergency Care Delivery Board fails to deliver and sustain improvements in urgent care services which in turn improve BHNFT's performance against the target that 95% of A&E patients are treated or discharged within 4 hours there is a risk that the Trust and CCG will fail to deliver the NHS constitution standard.	4	5	20	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 developing an improvement plan following the a UEC Summit hosted in October 2019.  Analysis of A&E activity data is undertaken on an ongoing basis to understand the drivers behind attendances and changes in patterns and trends  UEC Delivery Board representatives participating in the NHSE/I Action on A&E programme – Developing and implementing plans to improve in hospital patient flow.  Daily Reporting and SitRep calls including local health and care partners  Winter & Bank Holiday Planning arrangements	Chief Operating Officer  (Finance & Performance Committee)	Risk Assessment	3	4	12	02/21	<b>February 2021</b> A&E performance continues to be impacted by COVID. UEC Delivery Board has plans in place to support improvement and recovery  <b>November 2020</b> Increased COVID related activity is impacting on A&E activity and performance.  Plans against priority areas are being refined to ensure clear focus on reducing activity in hospital and providing earlier support in the community.  <b>July 2020</b> Activity levels have reduced as	05/21

						<p>IHEART Barnsley established and operational offering out of hours GP appointments on evenings and Saturdays and OOH GP services. From May 2019 GP Home Visiting Service will also be in place available for all practices</p> <p>Strengthened GP Streaming adjacent to ED in place. BHF commenced provision of service in September 2017 in ED but with a GP providing the service and from December 2017 in new separate primary care area adjacent to ED.</p>								<p>a result of COVID 19, however this continues to be a risk and is enhanced by the reduced capacity to meet higher demand due to social distancing requirements within the hospital. Whilst activity is lower performance continues to fluctuate.</p>	
CCG 15/13		If BHNFT are unable to achieve their control total, as agreed with NHS Improvement, there is a risk that the financial sustainability of the Trust may have a detrimental impact on the future of local services for the people of Barnsley.	3	4	12	<p>The CCG's strategic objectives aim to support a safe and sustainable local hospital.</p> <p>Revised contract governance arrangements (in operation from Oct 2015) will facilitate regular engagement of Board/Governing Body colleagues with an update being provided by the Trust on the financial position</p>	<p>Chief Finance Officer</p> <p>(Finance &amp; Performance Committee)</p>	Risk assessment	3	4	12	02/21	<p><b>February 2021</b> No updates to note</p> <p><b>January 2021</b> There are currently no risks flagged with BHNFT in achieving the in year target with a surplus position.</p> <p><b>December 2020</b> The Trust to continue to report a surplus delivery position and whilst pressures continue additional costs remain contained</p>	05/21	

													with the income received.	
<b>COVI D 3</b>		<b>Flu season 2020/21</b> A possible influenza epidemic that will be additive to the challenges above. The size and severity of the influenza epidemic in winter 2020/21 will be particularly difficult to estimate. A generalised increase in respiratory infections over the winter could also rapidly overwhelm test and trace capacity.	<b>5</b>	<b>5</b>	<b>25</b>	<p>20/07/20</p> <ul style="list-style-type: none"> <li>Local flu group mobilised.</li> <li>Waiting on detail from national team on over 50's element of the programme: a bigger task than previous years.</li> <li>Silver feel the greatest risk to delivering the flu vaccination programme is the delivery of the vaccines. Additional supply has been made available from central supplies to ensure practices and other providers do not have shortfalls.</li> <li>These issues are being picked up at local, regional and national flu delivery calls.</li> </ul> <p>February 2021 Update</p> <ul style="list-style-type: none"> <li>Local flu group continues to meet.</li> <li>Vaccine uptake across all groups earlier and higher than previous years</li> <li>Additional vaccine supply made available to ensure sufficient for additional cohorts</li> <li>Funding available to support GP's with additional costs</li> <li>Strong comms in place linked to other</li> </ul>	<p>Chief Operating Officer</p> <p>CCG Gold Command</p> <p>F&amp;PC</p>	COVID-19	<b>2</b>	<b>5</b>	<b>10</b>	01/21	<p><b>Jan 2021</b> Following discussion at GB, it was agreed that the COO would review the risk score in light of low flu cases this winter.</p> <p>Recommend amending risk score based upon current low flu levels and high vaccine uptake</p> <p><b>Oct 20</b> * Barnsley Flu Group is meeting regularly and a flu plan is in place aiming to meet aspirational targets and which been discussed in Peer Review with Rotherham CCG. * There is a large early demand from "at risk" cohorts and barriers to increased time for immunisation due to social distancing are being overcome by innovative</p>	04/21

						campaigns around Covid etc							approaches. * NHSE have informed approx £52K for Barnsley flu plan delivery and an application & approval process is being developed by the CCG. * NHSE have advised sufficient vaccine stock is nationally available and published a process for obtaining additional stock. * The local care home alignment and phased flu vaccine delivery has delayed immunisation of some care home residents, however a coordinated plan is in place to "offer" to all care home residents.	
13/13	1,5,6	If improvement in Yorkshire Ambulance Service (YAS) performance against the ARP response time targets is not secured and sustained, there is a risk that the quality	4	5	20	July 2016 Regular consideration of YAS incident reporting by QPSC and GB to understand the frequency and severity of incidents associated with ambulance response.	Chief Nurse  (Quality & Patient Safety Committee)	Risk Assessment	2	5	10	11/20	<b>November 2020</b> Performance monitoring continues. YAS attend daily Bronze group and SitRep to report activity. No exceptions	02/21



													category one and category 2 targets at the end of July 2020 and there being no serious incidents reported relating to delays affecting Barnsley patients. Performance to be kept under review via regular review of performance and serious incidents via attendance at the South Yorkshire and Bassetlaw 999/IUC Clinical Quality Group.	
20/02	1/2/3	If, due to a lack of guaranteed LeDeR reviewer resource, the outstanding backlog of LeDeR reviews are not completed by December 31 <sup>st</sup> 2020 there is a risk of: <ul style="list-style-type: none"> <li>• Non-compliance with NHSEI quality and performance target, leading to scrutiny and criticism at Govt. level</li> <li>• Poorer health outcomes for the LD population of</li> </ul>	4	3	12	<p>Non-recurrent funding from NHSEI. Interim CCG B6 1WTE nurse reviewer equivalent (seconded from CHC team) to complete outstanding reviews in the backlog until end of December 2020.</p> <p>Non-recurrent funding IRO £7,000 awarded by NHSEI to fund additional reviewer resource. Additional reviewers recruited from within SWYPFT – also 1 reviewer has committed to completing occasional reviews within contracted working hours.</p>	Chief Nurse  Quality & Patient Safety Committee	Risk identified by QPSC following discussion of a paper relating to LeDeR	3	3	9	11/20	<p><b>November 2020</b></p> <p>Full time reviewer working on backlog, plus LAC has recruited 2 reviewers from SWYFT using funds secured from NHSEI. A further £4000 has been awarded. There have been problems obtaining records from GPs and this has been addressed with each practice as it has arisen.</p>	03/21

		Barnsley from delayed implementation of learning into action to improve quality of services to people with LD.				<p>Reviews of 4-17 year olds included in JD for new post of CCC Nurse</p> <p>LeDeR reviews need to be included in JDs of CHC LD Nurses</p> <p>Need to include LeDeR reviews in contracts and service specifications with NHS providers.</p>								<p><b>Oct 2020</b> Risk drafted and added to risk register following discussion at QPSC.</p>	
15/12	1, 2, 5, 6	If BHNFT does not improve its performance in respect of people waiting longer than 62 days to be treated following an urgent cancer referral, there is a risk to the reputation of the CCG and the quality of care provided to the people of Barnsley in respect of this service.	4	3	12	<p>The CCG and the providers are working as part of a South Yorkshire Cancer Alliance and continuing to improve and develop services to ensure delivery of cancer standards</p> <p>BHNFT are actively working with the CCG through the Barnsley Cancer Steering Board to improve pathways and ensure delivery of waiting times standards.</p>	<p>Chief Operating Officer</p> <p>(Finance &amp; Performance Committee)</p>	Risk assessment	3	3	9	02/21	<p><b>February 2021</b> Cancer performance continues to be impacted by COVID particularly in relation to some diagnostic tests</p> <p><b>November 2020</b> Cancer performance continues to be impacted by COVID particularly in relation to some diagnostic tests following good recovery during the summer as a result of increased COVID in hospital.</p> <p><b>July 2020</b> During the COVID19</p>	05/21	

													<p>pandemic the number of cancer referrals has reduced significantly which may result in a surge which puts further pressure on the system particularly in relation to diagnostics. As a result of capacity reductions the number of people waiting longer than 62 days has increased. Plans are in place to address long waits across the SYB cancer alliance.</p>	
CCG 13/41	1,2, 4,8	Lack of completed Declarations in respect of the Policy on the Managing Conflicts of Interest and the Acceptance of Sponsorship, Gifts and Hospitality	3	3	9	<p>Policy on the Managing Conflicts of Interest and the Acceptance of Sponsorship, Gifts and Hospitality Online training in Conflicts of Interest for relevant CCG staff.</p> <p>Regular reminders by Corporate Affairs team to Governing Body, CCG staff, and Membership Council to submit declarations</p> <p>Annual Internal Audit review of Conflicts of Interest provided significant assurance (Jan 2019)</p>	<p>Head of Governance &amp; Assurance  (Audit Committee)</p>	<p>Risk Assessment Identified by Audit Committee 30.05.13</p>	3	3	9	01/21	<p><b>January 2021</b> Internal Audit review now complete; significant assurance opinion and just 2 low risk recs.</p> <p><b>December 2020</b> No change to overall risk assessment. Annual internal audit now complete, awaiting draft report. Have sent</p>	04/21

													reminders to all staff currently non-compliant with mandatory online training to ensure 90% target achieved by January 2021.	
CCG 13/13 b	1,2	If the CCG fails effectively to engage with patients and the public in the commissioning or co-commissioning of services there is a risk that:  (a) services may not meet the needs and wishes of the people of Barnsley, and  (b) the CCG does not achieve its statutory duty to involve patients and the public.	4	4	16	CCG Engagement and Equality Committee reporting into Governing Body in place Healthwatch Barnsley member of above committee  Organisational member of The Consultation Institute (tCI) through SYB ICS S75 agreement in place with Barnsley Council for community involvement activity.  CCG member of and funder of Barnsley Reach (equalities forums in Barnsley)  Refreshed Patient and Public Engagement Strategy 19/20  Barnsley Patient Council PRGs are a requirement of the GP core contract  OPEN membership for any stakeholder, patient, public  Effective Service Change Guidance and Toolkit / Patient and Public participation in commissioning health and	Head of Communications & Engagement  (Governing Body)  (Equality and Engagement Committee)	Risk Assessment	2	4	8	02/21	<b>Feb 2021</b> Reduced risk from 12 to 8 in Dec 2020 meeting. The CCG received a 'Green Star' rating from NHSE in respect to compliance with statutory guidance on patient and public participation in the 2019/20 IAF ratings.  <b>Oct 2020</b> No further updates – reduce risk in Dec 2020 meeting.  <b>Jan 2020</b> Changes to forum names updated.	05/21

						care - Statutory Guidance training in place for CCG staff								
						Review of, and implementation of, internal 14z2 form capturing engagement requirements combined with equality impact assessments.								
<b>COVI D 5</b>	8	<b>Data Sharing</b>  If the CCg does not plan for the continuance of data sharing in the post-covid phase there is a risk that the benefits of sharing enjoyed during the pandemic will be lost and / or that data will continue to be shared without an appropriate lawful basis.	4	4	16	COPI notice allows sharing of data for covid-19 response but is time limited (currently to end March 2021)  Lawful basis for sharing probably exists for most of our purposes but will need to be reviewed and properly documented  Log of sharing during covid being maintained but will need review (with specialist IG support) and arrangements put in place prior to expiry of COPI.	Head of Governance & Assurance  SMT / Gold Command	Silver & Gold Command meetings	3	4	12	12/20	<b>December 2020</b> No change since last update. Review will need to be prioritized in Q1 of 2021.  <b>September 2020</b> COPI notice has now been extended initially to March 2021.	03/21
<b>COVI D 6</b>	4,5	<b>Keeping our employees safe</b>  If the CCG does not take appropriate steps to keep our employees safe, due to a failure properly to follow guidelines and H&S advice, there is a risk of negative impacts on the health of our staff	3	4	12	The vast majority of CCG staff have worked from home throughout the epidemic and continue to do so.  1:1s have been held with all staff and follow up risk assessments undertaken for higher risk groups (inc BAME staff). Testing is available for any CCG staff member showing symptoms.	Head of Governance & Assurance  SMT / Gold Command  H&S&BC Group	Silver & Gold Command meetings	2	4	8	12/20	<b>December 2020</b> CCG staff continue to be supported to work from home. Action plan in place in response to pulse survey to tackle key themes re workload, work life balance, goal clarity and isolation.	03/21

		(and our community), and the capacity of the CCG to deliver its functions.				<p>Staff tracker allows daily check of our staff's whereabouts and wellbeing.</p> <p>Weekly staff briefings, staff pulse survey, virtual staff rooms, activities organized by Radiators etc all in place to keep staff informed and to enable a check on staff mood / morale</p> <p>All staff have been supported and encouraged to continue to take annual leave regularly through the year</p> <p>Extensive preparations were undertaken, supported by H&amp;S and staff side, to ensure Hillder House is safe prior to staff indicated by 1:1s as having a need to work from the office being permitted to return.</p>								<p><b>September 2020</b> In light of recent indications that case numbers may be increasing the CCG is continuing to support staff to work from home wherever possible and to ensure Hillder House is covid secure for those small numbers requiring to work from there.</p>	
<b>COVI D 7</b>	2,4	<p><b>Supporting our staff to work effectively</b></p> <p>If the CCG does not support its staff to work effectively during the pandemic there is a risk that productivity will diminish and key tasks or deliverables will not be completed</p>	3	4	12	<p>Early in the pandemic conversations were held with staff to understand what parts of their jobs may slow down or stop and to consider how any spare capacity could best be deployed</p> <p>Portable IT, swivel (VPN), and MS Teams provided to staff to support effective home working</p> <p>Staff have been allowed to</p>	Head of Governance & Assurance  SMT / Gold Command	Silver & Gold Command meetings	2	4	8	12/20	<p><b>December 2020</b> Position unchanged. All but a handful of CCG staff working from home and regular structured 1:1s being held to identify and address any issues.</p> <p><b>September 2020</b> Position remains as previously</p>	03/21	

						<p>take office chairs, keyboards, mouses and monitors home to support home working</p> <p>Throughout the pandemic a small number of staff doing essential functions not capable of being done remotely have been provided with access to Hillder House</p> <p>Following completion of the 1:1s / risk assessments Hillder House has been made safe &amp; reopened for a small number of staff indicated as having a need to work from the office</p>							reported.	
CCG 15/03	If the CCG does not effectively discharge its delegated responsibility for contract performance management there is a risk that the CCG's reputation and relationship with its membership could be damaged.	3	4	12	<p>The CCG has access to existing primary care commissioning resource within the Area Team under the RASCI agreement.</p> <p>The CCG has an open channel of communication with the Membership Council regarding commissioning and contracting arrangements (e.g. equalisation).</p>	<p>Head of Primary Care</p> <p>(Primary Care Commissioning Committee)</p>	Risk Assessment	2	4	8	02/21	<p><b>Feb 2021</b> 360 Assurance audit has been completed for 2020-21 and indications are of good assurance of quality and contract management</p> <p><b>Oct/Nov 2020</b> The PC action from the 360 audit has been completed. The CCG continues to manage its delegated responsibilities.</p>	05/21	



						values based recruitment techniques and 'radiators' group.  Regular staff surveys with resulting action plans.								
CCG 13/16	1, 8	Failing to meet the requirements of the Regulatory Reform (fire safety) Order to effectively, manage our fire safety arrangements	3	4	12	<p>Fire Brigade inspections (Held by H &amp; S department)</p> <p>HSE inspections Reviewed</p> <p>Fire and Health and Safety Training within CCG Mandatory training reports</p> <p>Local shared Fire &amp; H&amp;S service provides oversight health and safety and fire advice through corporate services team</p> <p>Landlord (NHSPS) provides routine maintenance of emergency lights, fire extinguishers etc</p> <p>Annual Organisational Risk Assessments with action plans overseen by H&amp;S Group</p> <p>Oversight of Fire Safety Arrangements by H&amp;S Group reporting to Audit Committee</p>	Head of Governance & Assurance  (Audit Committee)	Risk Assessment	2	4	8	02/21	<p><b>Feb 2021</b> Position largely unchanged. V few staff in HH therefore fire risks minimal. H&amp;S Lead briefed HH users on fire arrangements.</p> <p><b>Nov 2020</b> Fewer staff now in HH due to recent tightening of lockdown restrictions. No guaranteed SMT cover so regular users briefed as to arrangements in case of fire.</p> <p><b>Aug 2020</b> 10-15 staff now working from HH. Fire safety arrangements have been included in handbook and training provided by Ian Plummer.</p>	05/21
CCG 13/20	1, 6	Conflicts of interest re commissioning,	3	4	12	CCG has a conflict of interest policy and declarations of	Head of Governance	Risk Assessment	2	4	8	12/20	<b>December 2020</b> Position remains	03/21

		<p>decommissioning and procurement processes. In light of national scrutiny of commissioning decisions made by Clinical Commissioning Group we need to ensure we have:</p> <ul style="list-style-type: none"> <li>• Robust processes in place for the review of services which are auditable resulting in the commissioning or decommissioning of services;</li> <li>• Clear and consistent documentation of declarations of interest</li> </ul>				<p>interest are included on every agenda.</p> <p>Audit Committee has a standing item regarding declarations of interest and provides scrutiny of its application.</p> <p>Governing Body development sessions have taken place and training provided to Governing Body Members and CCG staff on the management of conflicts of interest.</p> <p>Register of Procurement Decisions maintained and published on website detailing how any conflicts have been managed</p> <p>Procurement Policy approved Sep 2016 (updated 2019) includes detailed section on managing C of I in procurement.</p> <p>Procurement Checklist used for large procurements or procurement for primary medical services where potential for conflicts is greatest.</p> <p>Primary Care Commissioning Committee established to which procurement decisions can be delegated where conflicts of interest preclude Governing Body from taking them. This responsibility has been incorporated into the PCCC ToR (Nov 2017).</p>	<p>&amp; Assurance  (Finance &amp; Performance Committee)</p>						<p>as previously described. Some procurement activity has now resumed – any conflicts being identified and managed through <b>usual means.</b></p> <p><b>Sept 2020</b> No further update.</p> <p><b>Jun 2020</b> No change. As we move into stabilization and recovery we may need to refocus on management of conflicts in commissioning &amp; procurement.</p>	
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						<p>Governing Body has approved a decision making process for determining when procurement decisions will be delegated to PCCC (Nov 2017).</p> <p>As part of PCN development it has been decided that locality clinical directors may not be on the CCG Governing Body although they may be on the Membership Council.</p>								
17/02	12 36 78	If the CCG does not put in place appropriate and robust arrangements to mitigate cyber-attack there is a risk that the CCGs business systems could be compromised leading to reputational damage, business interruption and potential financial loss	3	4	12	<p>Sheffield CCG shared service manages and maintains CCG IT systems and servers and ensures appropriate safeguards are in place. Assurance report received.</p> <p>CCG staff aware of need for vigilance re suspicious emails etc – regular reminders via weekly comms and direct email.</p> <p>SIRO identified as organizational lead cyber security</p> <p>360 Assurance delivered briefing on cyber security to Governing Body in July 2017 and to staff in Sept 2017.</p> <p>NHS Digital Cyber Security Briefing for Governing Body (May 2019)</p> <p>Training on cyber security provided to all staff via online</p>	<p>Head of Governance &amp; Assurance</p> <p>IT Group QPSC</p>	Internal Audit Review	3	3	9	12/20	<p><b>December 2020</b> Position largely unchanged. Continue to work with IG &amp; IS colleagues on non networked backups; security of tablets &amp; mobiles; pen testing &amp; on site assessment; &amp; network security policy.</p> <p><b>Sep 2020</b> No significant change from previous update. DSP Toolkit requirements for 2020/21 have recently been updated and the CCG will work with the shared IG and IT services to ensure</p>	03/21

						<p>mandatory data security module.</p> <p>Additional NHSD provided, GCHQ accredited online training in cyber security provided for IAOs and IAAs</p> <p>CCG self-assessed as fully compliant against the requirements of the DSP Toolkit 2020 which gives greater emphasis to data security.</p>						<p>compliance.</p> <p><b>Jun 2020</b> No change to previous position. New IT service bedding in well.</p>	
17/05 added October 17	If the planned improvements to the IAPT Service do not result in delivery of the nationally mandated performance targets there is a risk that the CCG reputation will be damaged.	4	3	12	<p>IAPT procurement undertaken during 2018 for a revised model and specification which aims to deliver improved outcomes and performance.</p> <p>IAPT Intensive Support Team Review completed and final report received in December 2017. Action/improvement Plan developed by SWYPFT to address all recommendations in the IST report.</p> <p>Performance monitored and reported via the IPR.</p> <p>Regular Commissioner/Provider review meetings are held to agree actions to improve uptake and performance</p> <p>Service have developed a website and promotional</p>	<p>Chief Operating Officer</p> <p>F&amp;P</p>	Performance Monitoring	4	3	12	02/21	<p><b>February 2021</b> Access rates are improving as referrals increase, other key performance standards around recovery and waiting times are being achieved.</p> <p><b>November 2020</b> IAPT access performance continues to be impacted by COVID with referrals still not sufficient to meet the expected access rate. Other IAPT indicators around waiting times and recovery are good.</p>	05/21

						materials to raise awareness of the service and increase self referrals.								<b>July 2020</b> During the COVID19 pandemic the number of IAPT referrals reduced which may result in a surge which leads to increased waiting times. The reduced level of referral activity has impacted upon the ability to achieve the access target.	
17/06 added October 17		If the planned changes to the IAPT Service do not result in more patients being treated in accordance with waiting time targets there is a risk that the efficacy of the treatment they receive will be diminished	4	3	12	<p>IAPT Intensive Support Team Review completed - final report now received.</p> <p>Action/improvement Plan developed by SWYPFT to address all recommendations in the IST report.</p> <p>CCG issued contract performance notice to SWYPT requiring development of a final <b>action</b> plan on receipt of the IST report. The delivery of the improvement plan will be monitored via contract monitoring arrangements.</p> <p>Assurance provided to GB Nov 17 that achievement of agreed improvement</p>	<p>Head of Commissioning (MH, children, Specialised)</p> <p>QPSC PO</p>	Performance monitoring	4	3	12	03/21	<b>March 2021</b> Although referrals into the service have recovered significantly in Q's 2, 3 & 4 they are still below what is required for the access target, this is related to the ongoing pandemic, plus it is unrealistic for the service to recover the reduction of referrals in Q1 due to the pandemic. The full service offer remains available for clients	06/21	



														coming months, once a sense of normality resumes. The service is planning for this surge in demand to ensure that an appropriate offer can be sustained.	
CCG 19/03 (added June 2019)		If there is not an adequate and rapid response from White Rose Medical Practice to the areas identified by CQC in their recent inspections there is a risk that the Practice does not meet contractual and service requirements potentially leading to:  Practice remaining in 'special measures';  Poor quality or unsafe services for the people of Barnsley;  Reputational /brand damage.	2	5	10	There is an action plan in place as required by the CQC and CCG to achieve compliance no later than 6 months from date of publication of reports  Progress against the action plan is to be monitored by the CCG's Primary care team.  QPSC and PCCC are both fully sighted on the issues and the action plan. Regular update reports will be provided CQC will re inspect within 6 months of publication of report	JF (Exec Lead)  SK (Clinical Lead)  (Quality & Patient Safety Committee)	CQC inspection	2	5	10	02/21	<b>Feb 2021</b> CQC have monitored this practice during the pandemic and are assured that the practice is improving since the change in partnership and practice management team.  <b>Oct/Nov 2020</b> Rose Tree has been reviewed by the CQC as part of the C-19 support offer to practices with CQC concerns and no further follow up was necessary until the inspection programme resumes.	05/21	

CCG 20/01	5/6	If the CCG and SWYPFT do not hold timely and regular Clinical Quality Board meetings, they will not fulfil the requirements of the NHS Standard Contract (Ref GC8.1) and the ability of the CCG to gain assurance that the services it has commissioned from SWYPFT are being delivered in a high quality, safe and effective manner is impaired.	5	3	15	<p>Review of contract performance by various staff in the CCG including, Chief Nurse, Head of Commissioning (MH, Children, Specialised) Quality Manager, Head of Contracts, Commissioning Team staff.</p> <p>Regular 1:1 meetings between Chief Nurse, Barnsley CCG and Director of Nursing, SWYPFT</p> <p>Barnsley CCG review investigation reports for SWYPFT's STEIS reported serious incidents.</p>	<p>Jayne Sivakumar, Chief Nurse</p> <p>Q&amp;PSC</p>	<p>QPSC Meeting 12 December 2019</p>	2	3	6	02/21	<p><b>Feb 2021</b> No SWYPFT CQB meeting since 1/10/2020. Last 2 meetings have been cancelled due to availability of key members, and this continues to be a challenge. Subject to QPSC agreement it is proposed that the risk rating is increased to 9 (3x3).</p> <p><b>August 2020</b> Subject to QPSC agreement it is proposed that the risk rating is reduced from 9 to 6 (2X3) following discussions between SWYPFT and the Quality Team regarding alignment of availability of key Board members. Meetings to resume on 27 August 2020.</p>	08/21
CCG 13/19	1, 5, 8	<p>CCG as Level 2 Responder</p> <p>Barnsley CCG does not meet legislation and standards in</p>	4	3	12	<p>Contribute to Barnsley Health and Social Care Emergency planning group and work programme, including testing of plans and training.</p>	<p>Chief Operating Officer</p> <p>(Finance &amp; Performance)</p>	<p>Risk Assessment</p>	2	3	6	02/21	<p><b>February 2021</b> EPRR arrangements have served well throughout the COVID pandemic</p>	08/21

		relation to protecting Barnsley people from harm related to major incidents and other emergencies.				<p>Contribute to Local Health Resilience Partnership (LHRP) either directly or through Lead CCG rep.</p> <p>Nominated CCG “Accountable Emergency Officer”</p> <p>Ensure contracts with provider organisations contain relevant emergency preparedness and response elements including Business Continuity</p> <p>Emergency Preparedness Memorandum of Understanding with Public Health Public Health (including CCG) Incident Response Plan, Outbreak Plans etc.</p> <p>Reports to Governing Body on emergency resilience issues, including Business Continuity Management.</p>	Committee)						<p>– arrangements remain in place</p> <p><b>July 2020</b> EPRR arrangements have been tested throughout the COVID pandemic and have ensured that the CCG has been able to respond to the resulting challenges and support partners to continue to deliver essential services.</p>	
<b>COVI D 8</b>	8	<p><b>Governance arrangements (1)</b></p> <p>If the CCG does not set up appropriate governance arrangements to coordinate the response to the pandemic there is a risk that decision making may not be sufficiently rapid or responsive.</p>	4	3	12	<p>SMT re-established as CCG Gold Command, with delegated authority to commit CCG funds in accordance with directions received via the national &amp; regional command and control arrangements.</p> <p>Gold command held daily at start of pandemic, now reduced to weekly but with option to step back up if necessary.</p>	<p>Chief Operating Officer</p> <p>SMT / Gold Command</p>	Silver & Gold Command meetings	2	3	6	02/21	<p><b>February 2021</b> EPRR arrangements and associated Governance established in response to COVID19 have supported the CCG to continue to deliver statutory responsibilities. Arrangements are continually</p>	08/21

						<p>2 additional GB GPs added the Gold Command membership for duration of pandemic to ensure resilience.</p> <p>CCG Silver Command established, initially daily, now twice a week, to coordinate operational matters. Membership includes BHF representatives to facilitate better coordination with primary care.</p>							reviewed and refined.	
COV/D 9	8	<p><b>Governance arrangements (2)</b></p> <p>If the CCG does not maintain appropriate arrangements for 'business as usual' decision making, and clarity between what can be done under covid arrangements and what cannot, there is a risk that ultra vires decisions could be made.</p>	2	5	10	<p>GB has continued to meet virtually throughout.</p> <p>SMT has been meeting each Wednesday as usual.</p> <p>SMT Gold Command leads on GB agenda setting to ensure all matters requiring a decision are handled appropriately.</p> <p>Decisions taken by SMT Gold Command reported to GB for noting.</p> <p>Other decisions not taken under covid arrangements taken by SMT or GB as usual.</p> <p>Arrangements now in place for public participation in GB meetings by putting papers on website, inviting written</p>	<p>Head of Governance &amp; Assurance</p> <p>SMT / Gold Command</p>	<p>Silver &amp; Gold Command meetings</p>	1	5	5	12/20	<p><b>December 2020</b></p> <p>The dual arrangements continue to work well. GB and all committees now operating as normal for business as usual; silver command still meeting 2x pwe week and gold command 1x per week where decisions re the covid pandemic are taken and actioned. These are then reported to next GB for assurance.</p>	06/21

						<p>questions, and recording meetings for later broadcast through website &amp; social media.</p> <p>Committees of the Governing Body were initially suspended but now reintroduced.</p>								
CCG 15/05	1, 3, 8	If the CCG does not comply in a fully transparent way with the statutory Conflicts of Interest guidance issued in June 2016 (updated 2017) there is a risk of reputational damage to the CCG and of legal challenge to the procurement decisions taken.	3	3	9	<p>Standards of Business Conduct Policy and Procurement Policy updated to reflect statutory guidance.</p> <p>Registers of Interests incorporate relevant GP practice staff.</p> <p>Declarations of interest tabled at start of every meeting to enable updating. Minutes clearly record how any declared conflicts have been managed.</p> <p>PCCC has Lay Chair and Lay &amp; Exec majority, and GP members are non-voting.</p> <p>Delegation of decisions from GB to PCCC where necessary to manage conflicts of interest.</p> <p>Register of Procurement decisions established to record how any conflicts have been managed.</p> <p>Guidance provided to minute takers on recording decisions re managing conflicts of</p>	Head of Governance & Assurance  (Audit Committee)	Risk Assessment	2	3	6	01/21	<p><b>January 2021</b> Internal audit review now complete – significant assurance opinion received and just 2 low risk recs made.</p> <p><b>Nov 2020</b> No significant change. Reminders have been sent out to staff to complete outstanding online modules asap. Annual internal audit currently underway, feedback expected shortly.</p> <p><b>Apr 2020</b> No change. Audit report provided significant assurance. C of I online training completed to required levels in 2020, now all</p>	07/21

						<p>interest.</p> <p>Online Conflicts of Interest training provided to relevant CCG staff.</p> <p>Quarterly self-declarations of compliance to NHSE in line with IAF requirements.</p> <p>Annual internal audit review to confirm compliance with guidance.</p> <p>As part of PCN development it has been decided that locality clinical directors may not be on the CCG Governing Body although they may be on the Membership Council.</p>								relevant staff have been asked to do levels 2 and 3. Declarations updated March 2020.	
CCG 16/02	If GP Practices opt to cease provision under their Primary Medical Services Contract there is a risk that the CCG could not source appropriate provision of services in all localities in Barnsley.	2	4	8	<p>SY&amp;B have completed the procurement of a number of providers under the Emergency Framework that could support the continuing provision of Primary Medical Services. The BHF is a provider on this framework.</p> <p>APMS Contracts allow increased diversity of provision.</p>	Head of Primary Care (Primary Care Commissioning Committee)		1	4	4	01/21	<p><b>Jan 2021</b> No further updates</p> <p><b>July 2020</b> The commencement of the Dynamic Purchasing System to support a more simplified approach to procurement has increased the options available to support service provision. The Emergency Framework remains in place.</p> <p><b>October 2019</b></p>	06/21		



CCG 15/04		If the CCG is unable to secure sufficient operational & strategic capacity to fulfil the delegated functions this may impact on the ability of the CCG to deliver its existing delegated statutory duties, for instance in relation to quality, financial resources and public participation.	3	5	15	<p>CCG considered its strategic capacity &amp; capability as part of the successful application process.</p> <p>The CCG has access to existing primary care commissioning resource within the Area Team under the RASCI agreement.</p> <p>The CCG is undertaking a review of management capacity including delegated responsibilities.</p>	Head of Primary Care  (Primary Care Commissioning Committee)	Risk Assessment	1	3	3	07/20	<p><b>July 2020</b> This risk was reviewed earlier in the year and remains low risk</p> <p><b>Feb 2020</b> Risk reviewed at January PCCC meeting where it was agreed to reduce the likelihood score to 1 and therefore the overall score to 3 (low risk).</p> <p><b>August 2019</b> The CCG is recruiting 3 posts to support the work towards integration via a revised community service specification and with the PCN.</p>	07/21
CCG 13/38	1, 3, 8	If the CCG does not have sufficient processes and controls in place to prevent fraud there is a risk of loss of resources and damage to the CCG's reputation.	2	3	6	<p>Completion of Self Review Toolkit (SRT) in relation to 2015/16 Commissioner Standards – along with production of an action plan for development/rectification.</p> <p>Annual Budgets and review of these on a periodic basis</p> <p>Budgetary control system Regular Financial Reporting Cash flow Projections</p>	Chief Finance Officer  (Audit Committee)	Risk Assessment	1	3	3	02/21	<p><b>February 2021</b> SRT submission in May 2020 scored as 'Green' overall maintaining the 2019 position.</p> <p><b>July 2019</b> SRT submission in April 2019 scored as 'green' overall</p>	02/22



## Risk to be approved at GB Feb 2021

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			
20/XX	3,5,6	<p>If the CCG is does not implement robust arrangements to approve packages of Children's Continuing Health Care and associated NHS funding, there is a risk of:</p> <ul style="list-style-type: none"> <li>Challenge to decisions not to award funding in some cases – possible risk of litigation</li> <li>Negative impact on patient safety due to lack of quality monitoring of placements for CCC funded children;</li> <li>adverse financial consequences for the CCG</li> </ul>	5	4	20	<p>Improved record keeping systems in line with CHC Adults and the CCC Framework</p> <p>CCG attendance at funding panels to provide clinical scrutiny and challenge</p> <p>Specialist Clinical Portfolio Manager has assumed responsibility for CCC</p> <p>CCC process brought under CCG control</p> <p>Recruited a permanent Specialist CCC Assessor / case manager and a DCO.</p> <p>Developed a CCG appeals and disputes procedure</p> <p>All specialist funding referred to IFR panel with a written clinical recommendation for</p>	<p>Chief Nurse</p> <p>Finance &amp; Performance Committee</p> <p>And</p> <p>Quality &amp; Patient Safety Committee</p>	GBDS January 2021	4	4	16	02/21		03/21

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
			Likelihood	Consequence	Score				Likelihood	Consequence	Score			
						the treatment / intervention / equipment being a prerequisite								

**GOVERNING BODY – PUBLIC SESSION**  
**ASSURANCE WORK PLAN/AGENDA TIMETABLE 2021/2022 (Covid-19)**  
**March 2021 to March 2022**

<b>AGENDA ITEMS</b>	<b>Exec Lead</b>	<b>Mar 21</b>	<b>May-21</b>	<b>July-21</b>	<b>Sep-21</b>	<b>Nov-21</b>	<b>Jan- 22</b>	<b>Mar 22</b>
<b>OPENING ITEMS</b>								
Housekeeping	NB	✓	✓	✓	✓	✓	✓	✓
Apologies	NB	✓	✓	✓	✓	✓	✓	✓
Quoracy	NB	✓	✓	✓	✓	✓	✓	✓
Declarations of Interests Report	RW	✓	✓	✓	✓	✓	✓	✓
Patient Story	JS	✓	✓	✓	✓	✓	✓	✓
Patient & Public Involvement Activity Report	KW	✓	✓	✓	✓	✓	✓	✓
Questions from the Public & Answers	KW	✓	✓	✓	✓	✓	✓	✓
Minutes of previous GB/Pu meeting	NB	Jan 21	Mar 21	May 21	July 21	Sept 21	Nov 21	Jan 22
Matters Arising Report	NB	✓	✓	✓	✓	✓	✓	✓
<b>STRATEGY</b>								
Report of the Chief Officer, inc as required: <ul style="list-style-type: none"> <li>• SY&amp;B ICS Updates</li> <li>• Assurance Letters from NHSE</li> <li>• NHSE IAF outcomes</li> </ul>	CE	✓	✓	✓	✓	✓	✓	✓
Covid-19 response & Recovery Reset Update	JW & JB	✓	✓	✓	✓	✓	✓	✓
<b>UPDATE &amp; ASSURANCE PRIORITY AREAS ON GBAF</b>								
Urgent & Emergency Care Update	JW		✓			✓		
Primary Care Update	JF/N B		✓			✓		
Cancer Update	LS				✓			✓
Mental Health Update	PO		✓			✓		
Integrated Care at place	JB			✓			✓	

AGENDA ITEMS	Exec Lead	Mar 21	May-21	July-21	Sep-21	Nov-21	Jan- 22	Mar 22
Transforming Care Update	PO	✓			✓			✓
Maternity Update	PO			✓			✓	
Digital and IT Updates	JB		✓			✓		
Care Homes		✓			✓			✓
<b>QUALITY AND GOVERNANCE</b>								
Quality Highlights Report	JS	✓	✓	✓	✓	✓	✓	✓
Commissioning of Children's Services	PO	✓			✓			✓
Risk and Governance Exception Reports, to include:	RW	✓	✓	✓	✓	✓	✓	✓
<ul style="list-style-type: none"> <li>• Governing Body Assurance Framework</li> <li>• Corporate Risk Register</li> <li>• Register of Interests &amp; Register of Gifts Hospitality</li> <li>• IG / GDPR / Cyber Update</li> <li>• Policies – as required</li> <li>• Constitution changes - as required</li> <li>• EPRR &amp; Business Continuity</li> <li>• Quarterly Workforce Reports <ul style="list-style-type: none"> <li>○ 2020-21 Q3 (Oct-Dec) to January 2021 GB</li> <li>○ 2020-21 Q4 (Jan-Mar) to May 2021 GB</li> <li>○ 2021-22 Q1 (Apr-Jun) to July 2021 GB</li> <li>○ 2021-22 Q2 (Jul-Sep) to Nov 2021 GB</li> </ul> </li> </ul>	RW RW RW RW JW RW	Full Full	Ex Ex	Full Ex	Full Ex	Full Ex	Ex Ex	Full Full
Updating of Governing Body Assurance Work Plan/Agenda Timetable	RW	✓		✓		✓		✓

AGENDA ITEMS	Exec Lead	Mar 21	May-21	July-21	Sep-21	Nov-21	Jan- 22	Mar 22
Terms of Reference As required (AC, FPC, QPSC, EEC, RC, PCCC, ICOPC)	RW	✓	✓	✓	✓	✓	✓	✓
Committee Annual Assurance Reports for AC, F&P, Q&PSC, E&EC and PCCC	RW		✓					
<b>Annual Report &amp; Accounts To EO meeting ON 10 June 2021</b>	RN							
<b>FINANCE AND PERFORMANCE</b>								
Integrated Performance Report inc QIPP	RN/J W	✓	✓	✓	✓	✓	✓	✓
2021/22 Budgets	RN		✓					
Operational and Financial Plan 2021/22 –	RN/J W			✓			✓	
<b>MISCELLANEOUS</b>								
Annual Report – Childrens Safeguarding	JS				✓			
Annual Report – Adult Safeguarding	JS				✓			
<i>Add miscellaneous items as required</i>								
<b>COMMITTEE REPORTS AND MINUTES</b>								
Minutes of Audit Committee	NBe	21/01/21	18/03/21 15/04/21	20/05/21		Sept 21		Jan 22
Minutes of Finance and Performance Committee	NB	07/01/21 04/02/21	04/03/21 01/04/21	06/05/21 03/06/21	01/07/21	02/09/21 07/10/21	4/11/21 02/12/21	Jan 22 Feb 22
Minutes of Quality & Patient Safety Committee	SK	17/12/20		15/04/21	17/06/21	19/08/21	21/10/21	16/12/21
Assurance Report / Minutes of Equality and Engagement Committee	KW	19/11/20		18/02/21	20/05/21		12/08/21	
Primary Care Commissioning Committee Assurance Report / Minutes	CM	Ass Rep 30/01/21 Mins 26/11/20	Ass Rep 25/03/21 Mins 30/01/21	Ass Rep 27/05/21 Mins 25/03/21	Ass Rep 29/07/21 Mins 27/05/21	Ass Rep 30/09/21 Mins 29/07/21	Ass Rep 25/11/21 Mins 30/09/21	Ass Rep Jan 22 Mins 25/11/21
Minutes of Membership Council	NB	19/01/21	23/03/21	18/05/21	13/07/21	14/09/21	23/11/21	Jan 22

<b>AGENDA ITEMS</b>	<b>Exec Lead</b>	<b>Mar 21</b>	<b>May-21</b>	<b>July-21</b>	<b>Sep-21</b>	<b>Nov-21</b>	<b>Jan- 22</b>	<b>Mar 22</b>
Minutes of Health and Well Being Board (Refer Peter Mirfin at the BMBC)	NB	✓	✓	✓	✓	✓	✓	✓
Minutes of the PUBLIC Joint Committee of Clinical Commissioning Groups	CE	✓ As reqd	✓ As reqd	✓ As reqd	✓ As reqd	✓ As reqd	✓ As reqd	✓ As reqd
<b>CLOSING BUSINESS</b>								
Reflection on how well the meeting's business has been conducted	NB	✓	✓	✓	✓	✓	✓	✓
<b>Close meeting and move into Private Session</b>	NB	✓	✓	✓	✓	✓	✓	✓

## Governing Body

11 March 2021

### Integrated Performance Report

#### PART 1A – SUMMARY REPORT

<b>1.</b>	<b>THIS PAPER IS FOR</b>											
	<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"/>										
<b>2.</b>	<b>PURPOSE</b>											
2.1	<p>This report provides an update on the CCGs performance against key performance indicators, including constitution standards, an update on the CCGs financial position and updates on financial reimbursements outstanding to 31 January 2021.</p> <p>This report also provides details of all Covid-19 expenditure incurred and approved in line with Governing Body delegation.</p>											
<b>3.</b>	<b>REPORT OF</b>											
	<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr style="background-color: #d9e1f2;"> <th style="width: 30%;"></th> <th style="width: 40%;">Name</th> <th style="width: 30%;">Designation</th> </tr> </thead> <tbody> <tr> <td style="background-color: #d9e1f2;">Executive / Clinical Lead</td> <td>Roxanna Naylor/</td> <td>Chief Finance Officer/</td> </tr> <tr> <td style="background-color: #d9e1f2;">Author</td> <td>Jamie Wike</td> <td>Chief Operating Officer</td> </tr> </tbody> </table>				Name	Designation	Executive / Clinical Lead	Roxanna Naylor/	Chief Finance Officer/	Author	Jamie Wike	Chief Operating Officer
	Name	Designation										
Executive / Clinical Lead	Roxanna Naylor/	Chief Finance Officer/										
Author	Jamie Wike	Chief Operating Officer										
<b>4.</b>	<b>SUMMARY OF PREVIOUS GOVERNANCE</b>											
4.1	<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;"> <thead> <tr style="background-color: #d9e1f2;"> <th style="width: 40%;">Group / Committee</th> <th style="width: 20%;">Date</th> <th style="width: 40%;">Outcome</th> </tr> </thead> <tbody> <tr> <td>Finance and Performance Committee</td> <td>4 March 2021</td> <td>Considered the paper and noted the actions</td> </tr> </tbody> </table>			Group / Committee	Date	Outcome	Finance and Performance Committee	4 March 2021	Considered the paper and noted the actions			
Group / Committee	Date	Outcome										
Finance and Performance Committee	4 March 2021	Considered the paper and noted the actions										

<b>5.</b>	<b>EXECUTIVE SUMMARY</b>
5.1	<p data-bbox="252 280 790 315"><b>2020/21 - Month 10 Finance Update</b></p> <p data-bbox="252 353 1420 501">The detailed finance report, attached at Appendix 2, provides an assessment of the current financial performance of the CCG up to 31 January, together with the forecasts for the year end. The report contains the headline messages along with monthly financial monitoring.</p> <p data-bbox="252 539 1420 902">As at 31 January the CCG is forecasting to achieve all yearend financial duties and planning guidance requirements, with an in-year balanced budget position, subject to further technical adjustments relating to the Hospital Discharge Programme and Additional Roles Reimbursement schemes for primary care. The total allocation adjustments relating to these areas are approx. £854k assuming no change in forecast position; it should be noted that the forecast for the Additional Roles Reimbursement has been updated based on latest conversations with the Primary Care Network (PCN) and the required funding against the nationally held £797k is now £358k (underspend of £439k). This remains under review working with the PCN to ensure this funding is maximised.</p> <p data-bbox="252 940 1420 1160">The in-year adjustment relating to independent sector providers has also this month been updated as NHSEI allowed amendments to the baseline where reconciliations had taken place in the period Month 5-6, this has resulted in the defund expected within this area to be £926k based on latest data which is a reduction from the position reported in Month 9 of £1,520k. This movement has resulted in a favourable movement in the overall forecast position reported below.</p> <p data-bbox="252 1198 1420 1377">In-year pressures, emerging risks and under delivery of planned efficiency schemes are included within the reported position with a forecast underspend (after risk assessment in the 'most likely' scenario) of £538k. It is expected that this position will be managed by the year end to ensure financial duties are achieved.</p> <p data-bbox="252 1415 1420 1489">Further information on the CCG's financial performance targets is set out in section 2 of Appendix 2.</p> <p data-bbox="252 1527 1420 1818">The position as at 31 January is that planned efficiency schemes are forecast to deliver £2.771m against the £4.441m target. In-year non recurrent budget reductions have contributed to mitigate against the unidentified QIPP requirement and shortfall in planned schemes. It is likely given the lack of flexibility across budgets further efficiency will be identified and underspends within actual expenditure are likely to mitigate against the non delivery of efficiency plans to support the CCG to achieve the requirement to breakeven (noting the technical adjustments required).</p> <p data-bbox="252 1856 1420 1930">As risks and mitigations emerge the Governing Body will be updated through this report.</p>
5.2	<p data-bbox="252 1966 638 2002"><b>Covid-19 Finance Update</b></p> <p data-bbox="252 2040 1316 2074">Section 4 of Appendix 2 provides the details of covid-19 expenditure with a</p>

	forecast position to 31 March 2021.
5.3	<p><b>2021/22 Planning</b></p> <p>There are no further updates in national guidance on the approach to 2021/22, latest guidance confirms that block arrangements will continue into quarter 1 of 2021/22 and details of allocations are to be shared mid to late March as discussions with treasury are finalised.</p> <p>As further updates are received these will be provided to the Governing Body.</p>
5.4	<p><b>Performance Update</b></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 10 (Jan 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. The number of people waiting over 52 weeks has continued to increase, with 562 patients waiting over 52 weeks as at January 2021.</p> <p>Urgent care related measures such as A&amp;E waits also continue to be below standard and have been impacted by increased activity levels and challenges with flow due to COVID.</p> <p>Performance on some cancer pathways is also falling below the national standards. 2 week wait and diagnosis to treatment times remain good however the number of people waiting over 62 days from referral to treatment increased, linked to diagnostic waits.</p> <p>IAPT access rates also continue to be below the target level with however there has been an increase in referrals in January which has seen performance improve as higher numbers access the service.</p>
<b>6.</b>	<b>THE GOVERNING BODY IS ASKED TO:</b>
	<p>Note the contents of the report including:</p> <ul style="list-style-type: none"> <li>• Performance to date 2020/21</li> <li>• Finance update to Month 10</li> </ul>
<b>7.</b>	<b>APPENDICES / LINKS TO FURTHER INFORMATION</b>
	<p><b>Performance Section</b></p> <ul style="list-style-type: none"> <li>• Appendix 1 – IPR M10 2020/21</li> </ul> <p><b>Finance Section</b></p> <ul style="list-style-type: none"> <li>• Appendix 2 – Month 10 Finance update</li> </ul>
<b>Agenda time allocation for report:</b>	
	10 Minutes

## PART 1B – SUPPORTING INFORMATION &amp; ASSURANCE

<b>1.</b>	<b>Links to Corporate Priorities, GBAF and Risk Register</b>			
	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	
<b>2.</b>	<b>Links to statutory duties</b>			
	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)	
<b>3.</b>	<b>Governance Considerations Checklist</b>			
<b>3.1</b>	<b>Clinical Leadership</b>			
	Have GB GPs and / or other appropriate clinicians provided input and leadership?			<b>NA</b>
<b>3.2</b>	<b>Management of Conflicts of Interest (s14O)</b>			
	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?			<b>NA</b>
<b>3.3</b>	<b>Discharging functions effectively, efficiently, &amp; economically (s14Q)</b>			
	Have any financial implications been considered & discussed with the Finance Team?			<b>Y</b>
	Where relevant has authority to commit expenditure been sought from Management Team (<£100k) or Governing Body (>£100k)?			<b>NA</b>

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

Performance Indicator	Target	CCG Quarterly	CCG Latest			CCG Performance	Latest Pr Monthly	
			Monthly Position	YTD Position	Barnsley Hospital			
<b>NHS Constitution</b>								
Referral To Treatment waiting times for non-urgent consultant-led treatment	All patients wait less than 18 weeks for treatment to start	92%		Provisional 76.42%	Jan-21	Provisional 73.56%		Published Dec-20 75.23%
	No patients wait more than 52 weeks for treatment to start	0		562	Jan-21	1779		344
Diagnostic test waiting times	Patients waiting six weeks or more for a diagnostic test	1%		Provisional 50.81%	Jan-21			Published Dec-21 57.15%
Q3 20/21								
A&E Waits	Patients are admitted, transferred or discharged within 4 hours of arrival at A&E	95%	78.48%	85.35%	Jan-21	85.66%		85.22%
	No patients wait more than 12 hours from decision to admit to admission	0		0	Jan-21		0	
Q2 20/21								
Cancer Waits: From GP Referral to First Outpatient Appointment	2 week (14 day) wait from referral with suspicion of cancer	93%	97.65%	95.85%	Dec-20	96.86%		97.17%
	2 week (14 day) wait from referral with breast symptoms (cancer not initially suspected)	93%	98.17%	93.88%	Dec-20	96.02%		93.75%
Cancer Waits: From Diagnosis to Treatment	1 month (31 day) wait from diagnosis with suspicion of cancer to first treatment	96%	97.71%	98.03%	Dec-20	97.49%		100.00%
	1 month (31 day) wait for second/subsequent treatment, where treatment is anti-cancer drug regimen	98%	96.58%	100.00%	Dec-20	97.26%		100.00%
	1 month (31 day) wait for second/subsequent treatment, where treatment is radiotherapy	94%	94.70%	100.00%	Dec-20	94.25%		
	1 month (31 day) wait for second/subsequent treatment, where treatment is surgery	94%	88.14%	93.75%	Dec-20	91.03%		83.33%
Cancer Waits: From Referral to First Treatment	2 month (62 day) wait from urgent GP referral	85%	82.86%	66.67%	Dec-20	78.04%		69.23%
	2 month (62 day) wait from referral from an NHS screening service	90%	50.00%	84.62%	Dec-20	73.53%		84.62%
	2 month (62 day) wait following a consultant's decision to upgrade the priority of the patient	(85% threshold)	90.32%	80.00%	Dec-20	78.49%		44.44%
Cancer Waits: Faster diagnosis standard	Cancer 28 day waits - Told within 28 Days	75%	60.51%	70.27%	Dec-20	65.57%		
Ambulance response times	Category 1 (life threatening) calls resulting in an emergency response arriving within 7 minutes (average response time)	7 mins		8mins 0secs	Jan-21			
	Category 2 (emergency) calls resulting in an emergency response arriving within 18 minutes (average response time)	18 mins		24mins 30secs	Jan-21			
	Category 3 (urgent) calls resulting in an emergency response arriving within 120 minutes (90th percentile response time)	120 mins		2hrs 34mins 58secs	Jan-21			
	Category 4 (less urgent) calls resulting in an emergency response arriving within 180 minutes (90th percentile response time)	180 mins		4hrs 08mins 48secs	Jan-21			
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		12.83%	Dec-20	9.45%		26.31%
	Ambulance Handover - reduction in the number of delays over 1 hour in clinical handover of patients to A&E	Local Reduction		3.15%	Dec-20	1.85%		8.33%
	Crew Clear - reduction in the number of delays over 30 minutes from clinical handover of patients to A&E to vehicle being ready for next call	Local Reduction		9.09%	Dec-20	8.47%		3.81%
	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		0.42%	Dec-20	0.48%		0.33%

Performance Indicator		Target	CCG Quarterly	CCG Latest		CCG Performance	Latest Pr Monthly
				Monthly Position	YTD Position		
IAPT	Improved Access to Psychological Services-IAPT: People entering treatment against level of need	1.83%		1.77%	Jan-21	13.82%	
	Improved Access to Psychological Services-IAPT: People who complete treatment, moving to recovery	50%		51.43%	Jan-21		
	Proportion of people waiting 18 weeks or less from referral to first IAPT treatment appointment	95%		100.00%	Jan-21		
	Proportion of people waiting 6 weeks or less from referral to first IAPT treatment appointment	75%		94.75%	Jan-21		

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

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



<b>Provider Total by Position</b>
Yorkshire Ambulance Service

Provider Total by Position
Yorkshire Ambulance Service

Provider Total by Position
Yorkshire Ambulance Service

# NHS Barnsley Clinical Commissioning Group

## Finance Report 2020/21

### Month 10



# 1 Headline Messages and contents

Headline Messages	Contents	
<ul style="list-style-type: none"> <li>As at 31 January the CCG is forecasting to achieve all yearend financial duties and planning guidance requirements, with an in-year balanced budget position. However this position is predicated on the assumptions outlined within this report.</li> <li>The forecast position on CCG expenditure before mitigation and other technical adjustments show an underspend of £578k. Allocation adjustments in relation to the Hospital Discharge Programme and Independent Sector Providers remain outstanding and total (-£72k). Adjustments and guidance to CCGs on these balances is expected during Month 11 reporting. The CCG has also received the Primary Care funding expected totalling £263k, leaving the balance of technical adjustments outstanding at £439k which relates to the Additional Roles Reimbursement scheme.</li> <li>The Finance and Performance Committee considered detail on risks and mitigations with the current projections in the 'Most Likely' scenario indicating a potential net underspend of £538k. The CCG continues to work to identify further opportunities/investments to ensure that financial duties and targets can be achieved.</li> <li>All NHS providers above £500k are included under the national block contract arrangement as previously reported with the value of payments being made set by NHSEI. Some adjustments have been made to block contract for Mental Health Investments as agreed with the Governing Body in March 2020. No payments are made to providers where contract values for 2019/20 were below £500k per annum.</li> <li>Private provider arrangements and guidance has now been received with the Month 1-4 baseline in cost being used to measure in year performance and activity, however NHSEI have allowed baselines to be adjusted where reconciliations for these providers took place in Month 5/6, therefore the position for Barnsley has been updated. This will result in the CCG being defunded by approx. £926k, which is a reduction against the position reported in Month 9. The CCG Finance and Performance Committee and Governing Body were made aware of this risk during the Phase 3 planning process and a contingency was held for this defund.</li> <li>Primary Care prescribing data has been received for Month 8 and continues to show pressures with an overspend position. The forecast overspend at this stage is estimated to be approx. £498k. The Head of Medicines Optimisation is working closely with the Finance and Contracting team to ensure this position is reviewed with further risk likely to be included within the forecast as part of Month 11 reporting.</li> <li>Primary Care Co-Commissioning Budgets are forecast at present to fully commit funding in relation to Additional Roles Reimbursement, however it is likely given delays in recruitment and development of plans that there will be a significant underspend against this budget, this is currently estimated to be an underspend of £439k.</li> </ul>	1	Headline Messages and Content
	2	Financial Performance Targets
	3	Monthly Finance Monitoring Statement – Executive Summary
	3.1	Detailed Summary Resource Allocation – Detailed Summary
	4	Covid-19 expenditure

# 1 Headline Messages continued

## Headline Messages

- Continuing Healthcare continues to be a volatile area of expenditure and increases in the costs of care provided is creating budget pressures, current forecasts show an overspend of £1.1m against the budget agreed with the Chief Nurse in December, this is a movement of £479k from month 9. The main pressure experienced seems to be as a result of increasing care package costs rather than numbers of patients being eligible for continuing healthcare funding. The Chief Nurse and Continuing Healthcare team are implementing a plan of action to address outstanding recommendations from the audit undertaken in 2019/20, take forward plans where further issues have arisen in year, develop a training plan for staff, develop a financial framework to support nurses in undertaking assessments and establish a case management panel to assess costs and care package arrangements in place. Further updates will be provided as this plan progresses and any potential impact is captured in the financial position.
- The CCG's Efficiency Programme requires £4.441m to be delivered during the last 6 months of 2020/21. This is clearly a challenging position and the balance of unidentified QIPP was unlikely to be delivered given the challenging environment due to the pandemic, block contracts arrangements in place and time and capacity to deliver. The CCG Finance and Contracting team have undertaken a stringent review of all budgets and with agreement of budget holders have reduced budgets further to those submitted within the financial plan. This has resulted in being able to offset the unidentified QIPP and create a risk reserve to mitigate against further prescribing and CHC risk. Continuing Health Care QIPP plans are currently forecasting a shortfall against the targets agreed and it is unlikely this position will improve before the end of the financial year.
- Section 4 details total covid spend to date with details of a forecast position to 31 March 2021.

## 2 Financial Performance Targets

### 1) Financial Duties

NHS Act Section	Duty	2020/21 Target £'000	2020/21 Actual Performance £'000	2020/21 Actual Achievement
223H (1)	Expenditure not to exceed income	490,255	490,255	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	490,206	490,206	YES
223J(1)	Capital resource use on specified matter(s) does not exceed the amount specified in Directions	0	0	YES
223J(2)	Revenue resource use on specified matter(s) does not exceed the amount specified in Directions	0	0	YES
223J(3)	Revenue administration resource use does not exceed the amount specified in Directions	5,244	4,101	YES

### 2) Financial targets/NHS England Business Rules requirements

There are no NHSE financial targets in 2020/21 due to the Covid-19 financial regime.

#### Comments

The CCG is forecasting to achieve all financial duties/targets and NHS England (NHSE) Business Rules predicated on the delivery of the CCGs efficiency programme, national funding being provided for additional roles reimbursement and mitigations being identified against in-year pressures identified within this report.

It is important to note that whilst the in year position reflects a balanced budget the CCG has a historic surplus held by NHSE. The historic surplus balance in 2020/21 now totals £12,532k.

### 3 Monthly Finance Monitoring Statement – Executive Summary

PROGRAMME AND RUNNING COST AREAS	YTD BUDGET £'000	YTD ACTUAL £'000	YTD VARIANCE OVER / (UNDER) £	TOTAL ANNUAL BUDGET £000	FORECAST OUTTURN £'000	OUTTURN VARIANCE OVER / (UNDER) £
<b>PROGRAMME EXPENDITURE</b>						
Acute	202,036	200,889	(1,147)	244,532	243,336	(1,196)
Patient transport	2,006	1,997	(9)	2,407	2,397	(11)
Mental Health	31,294	30,668	(626)	37,834	37,395	(440)
Community Health	41,255	40,773	(482)	51,033	51,180	148
Continuing Health Care	23,186	23,747	561	27,821	28,936	1,115
Primary Care Other	52,151	52,005	(146)	62,631	62,568	(63)
Primary Medical Services (Co-Commissioning)	34,455	33,766	(688)	41,386	40,513	(873)
Other Programme Costs	3,005	2,833	(171)	3,606	3,547	(59)
<b>TOTAL COMMISSIONING SERVICES (INCLUDING PRIMARY CARE RESERVES)</b>	<b>389,387</b>	<b>386,679</b>	<b>(2,708)</b>	<b>471,250</b>	<b>469,872</b>	<b>(1,378)</b>
Corporate Costs - EMBED/DSCRO	144	147	4	173	177	4
Corporate Costs - IFR	37	37	0	44	44	0
NHS Property Services/Community Health Partnerships	670	685	15	804	816	11
Depreciation Charges	17	0	(17)	20	0	(20)
<b>TOTAL CORPORATE COSTS</b>	<b>868</b>	<b>869</b>	<b>2</b>	<b>1,041</b>	<b>1,036</b>	<b>(5)</b>
Coronavirus Costs - Acute	3,249	3,249	0	4,873	4,873	0
Coronavirus Costs - MH	272	399	128	448	444	(3)
Coronavirus Costs - PrimCare	1,380	1,442	63	1,599	1,608	9
Coronavirus Costs - PrimCare - COVID Capacity Expansion Fund Oximetry At H	10	10	0	10	10	0
Coronavirus Costs - CoComm	0	0	0	0	0	0
Coronavirus Costs - CoComm - COVID Capacity Expansion Fund	358	358	0	716	716	0
Coronavirus Costs - CHC	3,902	3,834	(68)	3,840	4,183	343
Coronavirus Costs - Community	741	910	169	741	1,115	373
Coronavirus Costs - Other Prog.	26	111	86	26	179	154
Coronavirus Costs - PrimCare - Flu Vacs	27	38	11	27	0	(27)
<b>TOTAL CORONAVIRUS COSTS</b>	<b>9,964</b>	<b>10,352</b>	<b>388</b>	<b>12,279</b>	<b>13,128</b>	<b>849</b>
<b>TOTAL PROGRAMME COSTS (INCLUDING PRIMARY CARE RESERVES)</b>	<b>400,218</b>	<b>397,900</b>	<b>(2,318)</b>	<b>484,570</b>	<b>484,036</b>	<b>(534)</b>
<b>RUNNING COSTS</b>						
Pay	2,566	2,143	(423)	3,008	2,527	(482)
Non Pay	1,357	1,155	(201)	1,628	1,549	(79)
Coronavirus Costs	20	23	3	20	25	5
<b>TOTAL RUNNING COSTS</b>	<b>3,943</b>	<b>3,321</b>	<b>(622)</b>	<b>4,656</b>	<b>4,101</b>	<b>(555)</b>
CCG Reserves	447	0	(447)	537	537	0
Private Providers defund reserve	795	0	(795)	954	954	0
Allocation Received for PrimCare	219	0	(219)	263	0	(263)
In Year (Over)/underspend	(3,255)	0	3,255	0	578	578
<b>TOTAL RESERVES/CONTINGENCY (EXCL. PRIMARY CARE RESERVES)</b>	<b>(1,794)</b>	<b>0</b>	<b>1,794</b>	<b>1,754</b>	<b>2,069</b>	<b>315</b>
<b>TOTAL EXPENDITURE</b>	<b>402,367</b>	<b>401,221</b>	<b>(1,146)</b>	<b>490,980</b>	<b>490,206</b>	<b>(774)</b>
Programme	364,600	364,600	0	445,293	445,293	0
Primary Care Co-Commissioning	32,582	32,582	0	39,383	39,383	0
Running Costs	4,439	4,439	0	5,244	5,244	0
<b>RESOURCE ALLOCATIONS</b>	<b>401,622</b>	<b>401,622</b>	<b>0</b>	<b>489,920</b>	<b>489,920</b>	<b>0</b>
<b>SURPLUS/(DEFICIT)</b>	<b>(746)</b>	<b>400</b>	<b>1,146</b>	<b>(1,060)</b>	<b>(286)</b>	<b>774</b>

<b>Summary of Surplus/Deficit</b>						
Original Planned Deficit	746	746	0	1,060	1,060	0
Allocation Received for Primary Care		-263	-263		-263	-263
ARRS		-366	-366		-439	-439
<b>Adjusted Net Deficit</b>	<b>746</b>	<b>117</b>	<b>-629</b>	<b>1,060</b>	<b>358</b>	<b>-702</b>
Hospital Discharge Programme - Month 9 - actual		215	215		215	215
Hospital Discharge Programme - Month 10 - actual		176	176		176	176
Hospital Discharge Programme - Month 11 - 12 Forecast		0	0		463	463
Defund Independent Sector		-908	-908		-926	-926
<b>Total Technical Adjustments awaiting allocations</b>	<b>746</b>	<b>-400</b>	<b>-1,146</b>	<b>1,060</b>	<b>286</b>	<b>-774</b>

### 3.1 Resource Allocation – Detailed Summary

RESOURCE ALLOCATIONS - PROGRAMME, RESERVES & SURPLUS		RECURRENT £000	NON RECURRENT £000	TOTAL £000	RESOURCE ALLOCATIONS - RUNNING COSTS		RECURRENT £000	NON RECURRENT £000	TOTAL £000
Description	Month	£	£	£	Description	Month	£	£	£
Allocations -Final allocation after place-based pace of change	M1	416,113		416,113	2020/21 Allocation	M1	4,882		4,882
Allocations - Other funding after pace of change	M1	1,532		1,532	Transfer 8 months Running Costs allocation to central reserve	M2		(3,255)	(3,255)
Delegated Allocations - Final allocation after place-based pace of change	M1	39,771		39,771	Prospective 4 months running costs Non-recurrent Adjustment	M2		(517)	(517)
Reduction for central indemnity scheme	M1	(1,142)		(1,142)	Transfer 2 months Running Costs allocation from central reserve	M5		814	814
IR PELs transfer	M1	188		188	Prospective 2 months running costs Non-recurrent Adjustment	M5		(259)	(259)
Month 12 IR changes	M1	(8)		(8)	Transfer 6 months Running Costs allocation from central reserve	M7		2,441	2,441
2018/19 FYE - IR Final Changes	M1	(8)		(8)	Covid retro transfer from programme			5	5
Transfer pf ventilators to NHS Emland	M1	(34)		(34)	Retro transfer from Programme			513	513
SCH IR/PEL	M1	53		53	Covid retro transfer from programme			16	16
CCG core services additional funding from 2020/21 to 2023/24	M1	301		301	Retro transfer from Programme			250	250
Transfer 8 months Programme Allocation to central reserve	M2		(278,758)	(278,758)	Pension (6.3% uplift ) based on Mth09 BSA data and forecast for full year	M10		354	354
Prospective 4 months Programme Non-recurrent Adjustment	M2		(3,341)	(3,341)					
Transfer 8 months delegated allocation to central reserve	M2		(25,753)	(25,753)					
Prospective 4 months delegated Non-recurrent Adjustment	M2		25	25					
Month 3 Retro COVID Adjustment agreed	M3		1,236	1,236					
Retro Top-up Allocation signed off COVID - M3	M4		987	987					
Retro Top-up Allocation signed off NON COVID	M4		3,904	3,904					
Transfer 2 months Programme allocation from central reserve	M5		69,690	69,690					
Prospective 2 months Programme Non-recurrent Adjustment	M5		(1,671)	(1,671)					
Transfer 2 months delegated allocation from central reserve	M5		6,438	6,438					
Prospective 2 months delegated Non-recurrent Adjustment	M5		13	13					
Month 4 Retro Top-up Allocation signed off COVID	M5		1,018	1,018					
Month 4 Retro Top-up Allocation signed off Non COVID	M5		1,180	1,180					
Month 5 Retro Top-up Allocation signed off Non-COVID	M6		1,454	1,454					
Month 5 Retro Top-up Allocation signed off COVID	M6		1,205	1,205					
CCG NR Adjustments to Model Breakeven	M7		(4,083)	(4,083)					
CYPMH Green Paper	M7		74	74					
Transfer 6 months delegated allocation from central reserve	M7		19,315	19,315					
Transfer 6 months Programme allocation from central reserve	M7		209,061	209,061					
STP Plan Transfer - System top up distribution to other CCGs	M7		9,391	9,391					
STP Plan Transfer - System Covid distribution to other CCGs	M7		10,723	10,723					
STP Plan Transfer - Growth funding distribution to other CCGs	M7		1,421	1,421					
Learning Disabilities Mortality Review Programme (LeDeR)	M7		4	4					

## 4 Covid-19 Expenditure

Commentary - spend type	April-September 2020	October - March 2021 Forecast	Total Expenditure - Covid-19/HDP
Intermediate Care - Move of Acorn Unit to Independent Sector to free up bed capacity at BHNFT	208,796	253,500	462,296
Mapleton Court - Additional bed capacity - during April/May/June	215,332	136,030	351,362
Discharge to Assess costs*	2,860,741	1,242,093	4,102,834
Support to stay home	846,622	220,593	1,067,215
Primary Care reimbursements - PPE/Hotsite/Bank Holiday cover/locum cover	774,055	777,981	1,552,036
Covid 19 home visiting service	325,896	325,047	650,943
Other minor costs	46,257	47,503	93,760
Contingency to cover further costs		-	-
<b>Total</b>	<b>5,277,699</b>	<b>3,002,747</b>	<b>8,280,446</b>
Breakdown of total expenditure:			
Covid	2,416,958	1,760,654	4,177,612
Hospital Discharge Programme	2,860,741	1,242,093	4,102,834

**Comments:**

The table above includes details of all expenditure claimed during the year 2020/21.

**Minutes of the Meeting of the Barnsley Clinical Commissioning Group AUDIT COMMITTEE held on Thursday 21 January 2021 at 9.30 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

**IN ATTENDANCE:**

Rashpal Khangura	KPMG Director (up to & including minute reference AC 21/01/17)
Kay Meats	Client Manager, 360 Assurance
Kay Morgan	Governance and Assurance Manager
Usman Niazi	Assistant Client Manager 360 Assurance
Roxanna Naylor	Chief Finance Officer
Richard Walker	Head of Governance and Assurance
Salma Younis	KPMG Senior Manager up to & including minute reference AC 21/01/17)

**APOLOGIES**

No Apologies

Ref	Agenda Item	Action	Dead line
AC 21/01/01	<b>HOUSEKEEPING</b> – Microsoft Teams Meeting etiquette was discussed.		
AC 21/01/02	<b>QUORACY</b> - The meeting was declared quorate		
AC 21/01/03	<b>DECLARATIONS OF INTEREST, SPONSORSHIP, GIFTS AND HOSPITALITY</b>		
	The Committee noted the Declaration of Interests Report. The KPMG Director and KPMG Senior Manager declared a direct financial interest in agenda item 12 'External Audit Extension'. The Chairman determined that item 12, will be taken as the final agenda item. The KPMG Director and KPMG Senior Manager will not partake in discussion and will leave both the meeting after agenda item 19.		

	No other new declarations of interest were received.		
<b>AC 21/01/04</b>	<b>MINUTES OF THE PREVIOUS MEETING HELD ON 15 OCTOBER 2020</b>		
	The Minutes of the meeting held on 15 October 2020 were approved as a correct record of the proceedings.		
<b>AC 21/01/05</b>	<b>MATTERS ARISING</b>		
	<p>The Committee noted that all actions on the Matters Arising Report are complete.</p> <ul style="list-style-type: none"> <li>• <b>Minute reference AC 20/10/11 - Audit Committee Work Plan Agenda Timetable - To add the Mental Health Investment review to the Work Plan when actual timescales are known.</b></li> </ul> <p>The Audit Committee was informed that guidance had been issued in respect of the Mental Health Investment Review and reports will be ready by 28 February 2021. The Director KPMG advised that there is some national noise of potential delays and he will update the Chief Finance Officer as appropriate.</p>		
<b>STANDING AGENDA ITEMS</b>			
<b>AC 21/01/06</b>	<b>ASSURANCE ON COMPLIANCE WITH STANDING ORDERS &amp; PRIME FINANCIAL POLICIES</b>		
	The Audit Committee noted the report providing assurance on compliance with standing orders & prime financial policies.		
<b>THIRD PARTY ASSURANCE</b>			
<b>AC 21/01/07</b>	<b>INTERNAL AUDIT PROGRESS REPORT</b>		
	<p>The Client Manager, 360 Assurance introduced the Internal Audit Progress Report to the Audit Committee. Members noted progress against the Internal Audit Plan and the reports issued. The terms of reference for all outstanding Audits have now been agreed. The Audit Committee noted that a draft Head of Internal Audit Opinion – Stage 2 report will be produced by the end of January 2021.</p> <p>The Client Manager, 360 Assurance informed the Committee that the follow up recommendation tracker is in an excellent position regarding follow up of actions falling due before 31 January 2021, except for five actions relating to the 2019/20 audit of Continuing Healthcare, due 31 January 2021 now</p>		

	<p>delayed with a revised completion date to until 30 April 2021. The Chief Finance Officer advised that a CHC Assurance Report and action plan will be considered at a Governing Body Development Session on 28 January 2021. The assurance report will include links to the outstanding internal audit recommendations.</p> <p>In response to a question raised by the Chairman in relation to delivery of the audit plan in particular IM&amp;T and quality, the client Manager confirmed that all outstanding audits will be completed by the end of the financial year. For the IM&amp;T audit a lot of work and evidence is year back ended to 31 March 2021. The internal audit team is working with the Information Governance Manager and Head of Governance and Assurance to gain the required evidence for the IM&amp;T audit.</p>		
	<p>The Client Manager reported that the 2021/22 Audit Plan is being developed with some uncertainty around core audits and a reserve bank of 27 days. Further risk based work will be undertaken, and a full Audit Plan submitted to the Audit Committee in March 2021. The Chief Finance Officer advised that the audit plan will be considered by the Senior Management Team on 22 January 2021 with feedback being provided to the Client Manager. The Chairman requested that the Audit Committee be kept informed regarding the potential use of the reserve 27 days.</p>		
	<p><b>The Audit Committee noted the key messages and progress made against the Internal Audit Plan since the last meeting.</b></p> <p><b><i>Agreed action</i></b></p> <p><b><i>To share the Governing Body CHC Assurance Report with the Client Manager and Assistant Client Manager</i></b></p> <p><b><i>To provide the Audit Committee Chairman with confirmation when the outstanding CHC actions are complete</i></b></p> <p><b><i>To discuss the outstanding CHC recommendation 1920/BCCG/08/R re strengthening the CCGs S117 policy and operating processes / procedures alongside new and emerging legislation and guidance with Jo Harrison Specialist Clinical Portfolio Manager.</i></b></p>	<p>RN</p> <p>KMe</p> <p>RN</p>	<p>18.03.21</p> <p>18.03.21</p> <p>18.03.21</p>
AC 21/01/08	RE 360 ASSURANCE – COVID SECOND WAVE, 2020 PFA AWARDS AND MANAGEMENT BOARD SURVEY RESULTS		

	<p>The Audit Committee noted the letter to 360 Assurance Management Board Members regarding Covid second wave / pressures of clients to assist with the delivery of audits, and the success of 3060 Assurance in winning a 2020 Public Finance Award for 'Excellence in Public Sector Audit',</p> <p>It was noted that during the Covid pandemic, there is a focus to deliver core audits to give clients required assurance at year end. In Barnsley Children's Continuing Care is the only non core audit.</p>		
<b>AC 21/01/09</b>	<b>UPDATE FROM EXTERNAL AUDITORS</b>		
	<p>The KPMG Director presented the Audit Plan 2020/2021 and Health Technical Update to the Audit Committee.</p> <p>The Audit Committee considered the Audit Plan 2020/2021 noting the risks identified as a focus for the audit, audit approach, audit cycle timetable and agreed audit fee.</p> <p>The KPMG Director highlighted that the updated Audit Code of Practice provides revisions to External Audit responsibilities in providing a value for money conclusion with enhanced risk assessment.</p> <p>In response to a question raised by the Committee Chair it was clarified that the Annual Audit Letter would be shared with the committee prior to being posted on the CCG website.</p>		
	<p><b>The Audit Committee noted the Audit Plan 2020/2021 and Health Technical Update</b></p> <p><b><i>Agreed action</i></b> <b><i>To provide the Audit Committee with early sight of the draft Annual Audit Letter.</i></b></p>	<b>RK</b>	
<b>ITEMS FOR APPROVAL</b>			
<b>AC 21/01/10</b>	<b>NAO CHECKLIST ON FINANCIAL REPORTING &amp; MANAGEMENT DURING COVID-19</b>		
	<p>The Head of Governance and Assurance provided the Audit Committee with assurance in respect of the CCG's financial reporting and management during covid-19. The assurance was determined following self assessment against the financial governance control elements checklist from the NAO Guide for Audit &amp; Risk Committees on financial reporting and management during covid-19.</p>		

	The Client Manager and KPMG Director concurred with the assessment.		
	<b>The Audit Committee noted the report.</b>		
<b>AC 21/01/11</b>	<b>CCG GOVERNANCE YEAR END ACCOUNTING POLICIES AND TIMETABLE 2020/21</b>		
	<p>The Head of Governance and Assurance presented the year-end timetable, accounting policies and assurance requirements for the 2020/21 accounts to the Audit Committee. Members were informed that work had commenced on the CCG's Annual Report 2020/21, with no major change to content of the report to that of the previous years report. The Committee noted the following key dates for the annual report and final accounts.</p> <ul style="list-style-type: none"> <li>• 27 April 2021 - Unaudited Accounts 2020/21 to be submitted to NHS England and the external auditor (KPMG)</li> <li>• 22 April 2021 - Audit Committee - (page turner) 'page by page' review of draft Annual Report, Governance Statement, and Accounts 2020/21</li> <li>• 10 June 2021 - Audit Committee Receive, review, and recommend for GB approval the audited Annual Report, Governance Statement, and Accounts. Governing Body adopt the final, audited Annual Report, Governance Statement, and Accounts 2020/21</li> <li>• 16 June 2021 – Deadline for the final, audited adopted and signed Annual Report, Governance Statement, 2020/21 and Final Audited Accounts 2020/21 to be submitted to NHS England</li> </ul>		
	<p>The Chief Finance Officer advised in terms of notes for the accounts, NHSE&amp;I guidance re 'going concern' in light of the impact of the expected White Paper remained outstanding. It was also noted that the current financial framework was to continue to at least into Quarter 1 of 2020/21.</p> <p>In terms of additional assurance on Primary Care Co commissioning and Rotherham Shared services, the same approach as in previous years would be followed with controls within the CCG managing risk around Primary Care Co-commissioning and work undertaken by 360 assurance and KPMG would provide assurances on the Rotherham Shared Service.</p>		
	<b>The Audit Committee:</b>		

	<ul style="list-style-type: none"> <li>• <b>Approved the accounting policies for the 2020/21 Annual Accounts (Appendix 1)</b></li> <li>• <b>Approved the draft 2020/21 Governance Year End Timetable (Appendix 2)</b></li> <li>• <b>Noted that the accounts will be prepared on a Going concern principle</b></li> <li>• <b>Noted the audit assurance requirements for Primary Care Co-Commissioning</b></li> <li>• <b>Approved the principle of using the audit assurance requirements for the Shared Financial Services with RCCG based on the principle adopted from 2017/18.</b></li> </ul>		
<b>AC 21/01/12</b>	<b>AUDIT COMMITTEE ANNUAL ASSURANCE REPORT 2020/21</b>		
	The Head of Governance and Assurance presented a first draft of the Audit Committee Annual Assurance Report 2020-21. It was noted that all other CCG committee annual assurance report will be submitted to the Audit Committee on 22 April 2021.		
	<p>The Committee received and noted the draft Audit Committee Annual Assurance Report 2020/21</p> <p><b><i>Agreed action</i></b>  <b><i>To include in the Audit Committee Annual Report, reference to the Audit Committee escalating issues relating to the CHC and delays in implementing Internal Audit recommendations.</i></b></p>	<b>RW</b>	
<b>AC 21/01/13</b>	<b>HEALTH and SAFETY &amp; FIRE &amp; BUSINESS CONTINUITY UPDATE</b>		
	The Head of Governance and Assurance introduced the Health and Safety & Fire & Business Continuity Update to the Audit Committee. It was highlighted that during the Covid Pandemic the H&S Manager has visited Hilder House on a monthly basis to ensure the CCG complies with all required H&S/Fire safety legislation. Staff are working from home and additional guidance and support including a home working booklet has been provided for staff whilst they are working from home due to the Covid 19 pandemic. In response to a question raised it was clarified that the home working booklet was consulted upon and approved.		
	<b>The Audit Committee noted the Health/ Safety &amp; Fire &amp; Business Continuity Update and the assurance it provided.</b>		
<b>GOVERNANCE</b>			

<b>AC 21/01/14</b>	<b>ASSURANCE FRAMEWORK AND RISK REGISTER</b>		
	The Head of Governance and Assurance introduced the Governance Governing Body Assurance Framework (GBAF) and Risk Register Report to the Audit Committee. The Committee noted that a risk around delivery of the CHC recovery plan with a score of 12 (amber) had been added to the Risk Register		
	<b>The Audit Committee</b> <ul style="list-style-type: none"> <li>• Reviewed the Assurance Framework and Risk Register</li> <li>• Determined that all risks are being appropriately Managed</li> <li>• Did not identify any potential new risks or risks for removal</li> <li>• Noted the exception report</li> </ul>		
<b>AC 21/01/15</b>	<b>REGISTER OF INTERESTS, REGISTER OF GIFTS, HOSPITALITY &amp; SPONSORSHIP REGISTER OF PROCUREMENT DECISIONS</b>		
	The Audit Committee considered and noted the Register of Interests, Register of Gifts, Hospitality & Sponsorship Register of Procurement Decisions Report.		
<b>ITEMS FOR DISCUSSION</b>			
<b>AC 21/01/16</b>	<b>AUDIT COMMITTEE TRAINING REQUIREMENTS</b>		
	No training requirements were identified.		
<b>AC 21/01/17</b>	<b>ESCALATION OF ITEMS TO GOVERNING BODY</b>		
	<p>The following items were agreed for escalation to the Governing Body:</p> <ul style="list-style-type: none"> <li>• External Audit KPMG Audit Plan 2020/21</li> <li>• CCG Self Assessment Against the NAO Checklist on Financial Reporting &amp; Management During Covid-19</li> <li>• Approved CCG Governance Year End Accounting Policies and Timetable 2020/21</li> <li>• External Audit contract extension</li> <li>• Mental Health Investment Standard – Governing Body sign off</li> </ul>		

	<b>At this point the Director KPMG and the KPMG Senior Manager left the meeting</b>		
<b>AC 21/01/18</b>	<b>EXTERNAL AUDIT EXTENSION</b>		
	<p>The Chief Finance Officer introduced a paper requesting Audit Committee approval of a further twelve month extension to the current external audit contract. The Audit Committee noted the increased fee and a potential further fee for additional 'value for money' work.</p> <p>The Committee was informed that other SY&amp;B CCGs had agreed the extension to the external audit contract prior to transition into the new SY&amp;B commissioning organisational structures. The SY&amp;B Chief Finance Officers will establish a procurement group, but it will be difficult to progress procurement without clarity on the evolving future SY&amp;B and place based commissioning structures.</p>		
	<p><b>The Audit Committee</b></p> <ul style="list-style-type: none"> <li>• <b>Supported the approval of the extension of the current KPMG contract as approved already by Governing body.</b></li> <li>• <b>Supported subsequent work in exploring a re-procurement of the external audit service options, including collaborative approaches with other SYB CCG's.</b></li> </ul>		
<b>ITEMS FOR INFORMATION</b>			
<b>AC 21/01/19</b>	<b>REFLECTION ON HOW WELL THE MEETING'S BUSINESS HAS BEEN CONDUCTED:</b>		
	No areas of additional assurance required.		
<b>AC 21/01/20</b>	<b>DATE AND TIME OF NEXT MEETING</b>		
	The next meeting of the Audit Committee will be held on Thursday 18 March 2021 at 09.30 am, via Microsoft Teams..		

**Minutes of the Meeting of the NHS Barnsley Clinical Commissioning Group  
FINANCE & PERFORMANCE COMMITTEE held on Thursday 7 January at 10.30am  
via Microsoft Teams.**

**PRESENT:**

Dr John Harban	- Elected Member Governing Body - Contracting
Chris Edwards	- Accountable Officer
Roxanna Naylor	- Chief Finance Officer
Jamie Wike	- Chief Operating Officer
Nigel Bell	- Lay Member Governance

**IN ATTENDANCE:**

Leanne Whitehead	- Executive Personal Assistant
Adrian Bailey	- Head of Finance Statutory Accounts and Financial Reporting

**APOLOGIES:**

Patrick Otway	- Head of Commissioning (MH, Children, Specialised)
Dr Nick Balac (Chair)	- Chair
Dr Adebowale Adekunle	- Elected Member Governing Body
Dr Andrew Mills	- Membership Council Member
Dr Jamie MacInnes	- Elected Member Governing Body

Agenda Item		Action & Deadline
<b>FPC21/01</b>	<b>QUORACY</b>	
	The meeting was declared quorate.	
<b>FPC21/02</b>	<b>DECLARATIONS OF INTEREST, SPONSORSHIP, HOSPITALITY AND GIFTS RELEVANT TO THE AGENDA</b>	
	The Committee noted the declarations of interest report. There were no declarations of interest raised relevant to the agenda.	
<b>FPC21/03</b>	<b>MINUTES OF THE PREVIOUS MEETING HELD ON 3 DECEMBER 2020 – Approved.</b>	
<b>FPC21/04</b>	<b>MATTERS ARISING REPORT</b>	
	<b>20/141 – Items for Escalation to GB</b>	
	The Item regarding CHC is on the private agenda for the January Governing Body.	

FPC21/05	<b>UPDATE ON RECENT PUBLISHED AND EXPECTED GUIDANCE</b> – No update to report.	
FPC21/06	<b>UPDATE ON CONTRACTING CYCLE</b>	
	<p>The Chief Finance Officer presented the report to the Committee. An update was given on the diabetes service, it was reported that the Trust had responded to the CCG's letter regarding a light touch managed change process on 4 December 2020, agreeing to extend the current contract for 9 months from 31 December 2020, however the Trust response also agreed to terminate the contract after 9 months and to the procurement of a new service the CCG responded on 11 December 2020 requesting to arrange a meeting to discuss the process week commencing 4 January 2021. The response also included the following action points for discussion:</p> <ul style="list-style-type: none"> <li>• Align the Diabetes service to a community single point of access (SPA) and clock speeds previously agreed.</li> <li>• Work as part of a wider community MDT to prioritise care for individuals</li> <li>• Increased integration with primary care/ PCN and Neighbourhood Teams</li> <li>• Working within the shared Neighbourhood teams leadership model.</li> </ul> <p>The CCG published the intention to the market via a VEAT notice on the 14 December 2020 and hoped to schedule a meeting in with the Trust soon.</p> <p>It was reported that the First4Care had requested additional funding to fund the additional journeys that were happening it was noted that cost for the additional crews would be funded by the CCG using the CCGs Covid-19 allocation for Month 7-12 and totals £46,479 to the end of January and was likely this may continue for a while longer.</p> <p>The Chief Finance Officer reported that BHNFT hoped to share their budget plan with the CCG soon. Discussion was had around PBR (payment by results) type contracts and the impact on Trusts should this payment mechanism be reintroduced, it was noted that given current levels of activity it was unlikely national tariffs would be reintroduced due to the impact of covid-19. Latest guidance suggested block type arrangements would continue into 2021/22. Discussion was had around covid funds and the Chief Finance Officer reported that funds received would cover costs being incurred by the CCG. It was also noted that allocations had been received for Primary Care Resilience, Covid assessment service and pulse oximetry and that these funds will be deployed as soon as possible once the service models are agreed.</p> <p><b>The Committee were asked to note the report including:</b></p> <ul style="list-style-type: none"> <li>• <b>an update to the Barnsley Integrated Diabetes Service</b></li> </ul>	

	<ul style="list-style-type: none"> <li>• an update to the additional transport provision until 31 January 2021</li> <li>• an update to the Independent Sector Framework</li> <li>• an update to the Contract consultations for 2021/22</li> </ul>	
<b>FPC21/07</b>	<b>APPROVAL AND OR UPDATE ON PROCUREMENTS</b>	
	<p>The Procurement Update paper was presented to the committee. The current status of each tender was set out as follows:</p> <p>Barnsley REspiratory Assessment and THERapy (BREATHE) in the Community Service. Following a request from a potential bidder the deadline for submitting bids was extended to the 5 February 2021.</p> <p>Mental Health Support Teams Service. The tender closed on the 30 November 2020. The preferred bidder is Compass. The standstill is due to end on the 29 December 2020 at midnight.</p> <p>Health provision for Children and Young People in Barnsley Special Schools with Special Educational Needs and Disability Service. The tender closed on the 5 November 2020. No bids were submitted and the service continues to be provided by BHNFT until alternative arrangements are made. The Head of Commissioning (MH, Children, Specialised) is currently working on an alternative model to ensure a smooth transition of provision by 1 April 2021.</p> <p>Barnsley Integrated Diabetes Service. A transparency notice was issued to inform the market that the current contract is to be extended to the 30 September 2021.</p> <p>It was agreed by members that more information was needed within the report in future.</p> <ul style="list-style-type: none"> <li>• <b>Agreed Actions:</b>  <b>Chief Operating Officer to discuss future reports and contents with Head of Commissioning (MH, Children, Specialised).</b></li> </ul> <p><b>The Committee received and noted the report.</b></p>	<b>JW</b>
<b>FPC21/08</b>	<b>INTEGRATED PERFORMANCE REPORT</b>	
	<p><u>Performance</u></p> <p>The Chief Operating Officer updated members on the performance section of the report noting 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 however to November there have been reductions in the number of patients waiting longer than the standards. Urgent care related measures such as A&amp;E waits and ambulance response times</p>	

continue to be below standard and have been impacted by increased activity levels.

Overall performance on cancer pathways including 2 week wait and referral to treatment remains strong with the majority of key performance targets being achieved. Performance at Barnsley Hospital in relation to waiting times remains strong.

IAPT performance has also continued to improve although the access rate remains slightly below the target level. It was noted that there was some work to do around IAPT.

It was reported that the hospital and community were still very busy with covid activity. Data for December/January was awaited and were expecting to see a change within this.

### Finance

The Chief Finance Officer presented the finance section of the report to Committee highlighting that as at 30 November the CCG is forecasting to achieve all yearend financial duties and planning guidance requirements, with an in-year balanced budget position, subject to further technical adjustments relating to the Hospital Discharge Programme and Additional Roles Reimbursement schemes for primary care.

In-year pressures, emerging risks and under delivery of planned efficiency schemes are included within the reported position with a forecast overspend (after risk assessment in the 'most likely' scenario) of £50k. This position assumes full reimbursement for costs relating to the Hospital Discharge Programme for Month 7 and 8 of £648k and any costs incurred relating to the Primary Care Additional Roles Reimbursement Scheme (maximum reimbursement £797k).

The position as at 30 November is that planned schemes are forecast to deliver £4.0m against the £4.441m target. In-year non recurrent budget reductions has contributed to mitigate against the £962k unidentified QIPP requirement. It is likely given the lack of flexibility across budgets further efficiency will be identified and underspends within actual expenditure are likely to mitigate against the non delivery of efficiency plans to support the CCG to achieve the requirement to breakeven (noting the technical adjustments required).

As previously reported the total allocation is £1,768,000 for the period October 2020 to March 2021 for Covid-19 related expenditure.

Expenditure to date is being contained within this financial envelope and no further commitments against this funding have been made.

	<p>The Committee is asked to note the contents of the report including:</p> <ul style="list-style-type: none"> <li>• Performance to date 2020/21</li> <li>• Finance update to Month 8</li> </ul>	
<b>FPC21/09</b>	<b>ASSURANCE FRAMEWORK</b>	
	<p>The Chief Operating Officer presented the Assurance Framework to the Committee. There were 2 red risks and 4 amber risks shared with the Quality and Patient Safety Committee. Discussion was had around priority area 6 Financial Balance and Efficiency Plans and it was agreed given the current position to change the score a 12 this would then move from red to amber. Discussion was had around priority are 3 cancer and the need to review the score around this, it was agreed to raise this at Governing Body then review the score again.</p> <p><b>Agreed Actions:</b></p> <ul style="list-style-type: none"> <li>• Change priority area 6 Financial Balance and Efficiency Plans to a score of 12 and amber rating.</li> <li>• Review priority area 3 Cancer following Governing Body discussions.</li> </ul> <p>The Committee received and noted the report.</p>	<p>RN</p> <p>ALL</p>
<b>FPC21/10</b>	<b>RISK REGISTER</b>	
	<p>The Chief Operating Officer presented the Risk Register to the Committee. There were 5 red risks for the Committee and a number of these were related to covid. An additional risk around CHC had been added and the committee were asked to agree this risk and its score. The Committee agreed to review this following the CHC item planned for the January Governing Body therefore agreed to accept the risk but review the score next time. The Lay Member for Governance noted that mental health was not included in any of the covid risks given the increase GP's were seeing in peoples mental health due to covid, this would be considered.</p> <p><b>Agreed Actions</b></p> <ul style="list-style-type: none"> <li>• Review CHC risk score following January Governing Body.</li> <li>• Covid 4 Risk 13/31 change score to 3/4.</li> <li>• Consider adding wording around Mental Health to one of the covid risks.</li> </ul> <p>The Committee received and noted the report.</p>	<p>ALL</p> <p>RN</p> <p>?</p>
<b>FPC21/11</b>	<b>MINUTES OF THE BHNFT CONTRACT EXECUTIVE BOARD –</b> No minutes available.	

FPC21/12	<b>MINUTES OF THE SWYPFT CONTRACT EXECUTIVE BOARD –</b> No minutes available.	
FPC21/13	<b>MINUTES OF THE CHILDRENS EXECUTIVE COMMISSIONING GROUP – 29 September 2020</b>	
	<p>The notes of the meeting held on the 29 September 2020 were presented to the group for information. The Chief Finance Officer had picked up various points within in the minutes that she was going to clarify with the Head of Commissioning (MH, Children, Specialised).</p> <p><b>Agreed Actions:</b></p> <ul style="list-style-type: none"> <li>• <b>Chief Finance Officer to raise with Head of Commissioning (MH, Children, Specialised).</b></li> <li>• <b>Chief Operating Officer to pick up single point of access.</b></li> <li>• <b>Personal Assistant to pick up with minute taker name spellings within minutes for accuracy.</b></li> </ul>	<p>RN</p> <p>JW</p> <p>LW</p>
FPC21/14	<b>MINUTES OF THE ADULTS JOINT COMMISSIONING GROUP</b> – No minutes available.	
FPC21/15	<b>MANAGEMENT TEAM DECISIONS WITH FINANCIAL IMPLICATIONS</b>	
	<p>The Chief Operating Officer presented the report the Committee. The Finance &amp; Performance Committee is asked to note the following decisions to commit expenditure taken by Management Team during December 2020:</p> <ul style="list-style-type: none"> <li>• SMT agreed to fund the cost of Fridges, Coolers, Carriers and data loggers to support the set-up of the Primary Care Vaccination Hubs up to £21,000 recognising that this may not be reimbursable from the national funding.</li> </ul> <p>It was noted that SWYPFT had really stepped up and helped out during the pandemic and are working in partnership to deliver care and the vaccination programme. Discussions also remain open and transparent around the financial position too..</p> <p><b>Agreed Actions:</b></p> <ul style="list-style-type: none"> <li>• <b>Accountable Officer to feed this back to SWYPFT and BHF partners for all support and give thanks.</b></li> </ul>	<p>CE</p>
FPC21/16	<b>ANY OTHER BUSINESS</b>	
	No items were raised under this heading.	
FPC21/17	<b>ITEMS FOR ESCALATION TO GOVERNING BODY</b>	
	<ul style="list-style-type: none"> <li>• Level 5 of pandemic, planning level 4, governance etc</li> <li>• Risk score for cancer on Assurance Framework Governing Body to review.</li> </ul>	

**GB/Pu 21/03/19.2a**

	<ul style="list-style-type: none"><li>• CHC risk score review in February following GB discussion.</li></ul>	
<b>FPC21/18</b>	<b>REFLECTION ON HOW THE MEETINGS BUSINESS WAS CONDUCTED</b>	
	The meeting went well and business was conducted.	
<b>FPC21/19</b>	<b>DATE AND TIME OF NEXT MEETING</b>	
	Thursday 4 February 2021 at 10.30am via Mircosoft Teams.	

Adopted

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

**PRESENT:**

Dr Nick Balac (Chair)	- Chair
Dr John Harban	- Elected Member Governing Body - Contracting
Chris Edwards	- Accountable Officer
Roxanna Naylor	- Chief Finance Officer
Dr Adebowale Adekunle	- Elected Member Governing Body
Jamie Wike	- Chief Operating Officer
Dr Andrew Mills	- Membership Council Member
Dr Jamie MacInnes	- Elected Member Governing Body

**IN ATTENDANCE:**

Leanne Whitehead	- Executive Personal Assistant
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**APOLOGIES:**

Nigel Bell	- Lay Member Governance
Jeremy Budd	- Director of Strategic Commissioning and Partnerships
Patrick Otway	- Head of Commissioning (MH, Children, Specialised)

Agenda Item		Action & Deadline
<b>FPC21/20</b>	<b>QUORACY</b>	
	The meeting was declared quorate.	
<b>FPC21/21</b>	<b>DECLARATIONS OF INTEREST, SPONSORSHIP, HOSPITALITY AND GIFTS RELEVANT TO THE AGENDA</b>	
	The Committee noted the declarations of interest report. There were no declarations of interest raised relevant to the agenda.	
<b>FPC21/22</b>	<b>MINUTES OF THE PREVIOUS MEETING HELD ON 7 JANUARY 2021 – Approved.</b>	
<b>FPC21/23</b>	<b>MATTERS ARISING REPORT</b>	
	<b>FPC21/10 Risk Register</b>	
	It was reported that review was being undertaken of all the covid risks.	
	<b>FPC21/13 Minutes of the Children’s Executive Commissioning Group</b>	

	<p>The Chief Operating Officer had spoken with the Head of Commissioning (MH, Childrens &amp; Specialised) in relation to single point of access.</p> <p><b>Agreed Actions:</b></p> <ul style="list-style-type: none"> <li>• <b>It was agreed to pick this up as part of the Mental Health plans and to provide an update at the next Private Governing Body.</b></li> </ul>	PO
FPC21/24	<b>INTEGRATED PERFORMANCE REPORT</b>	
	<p>The Chief Finance Officer presented the finance section of the report to the Committee. It was reported that CFOs have been informed through a national call with Julien Kelly that planning for 2021/22 will be deferred to at least quarter 1 of 2021/22 and that the current financial regime will be rolled forward. No details have yet been shared on the basis for this arrangement as discussions with Treasury will remain ongoing until early March. It is expected that allocations and detail of the quarter 1 regime will be shared mid-March with planning guidance expected at the end of March/early April with plans to be completed by the end of June. This remains subject to change nationally as they assess the progress of the vaccination programme and impact of covid-19 on services. Further updates will be provided to the Finance and Performance Committee as details emerge in the coming weeks.</p> <p>It was reported as at 31 December 2020 the CCG is forecasting to achieve all yearend financial duties and planning guidance requirements, with an in-year balanced budget position, subject to further technical adjustments relating to the Hospital Discharge Programme and Additional Roles Reimbursement schemes for primary care. The total allocation adjustments relating to these areas are approx. £1.490m assuming no change in forecast position; however the Additional Roles Reimbursement may be subject to a revised forecast position which will be reported in Month 10.</p> <p>In-year pressures, emerging risks and under delivery of planned efficiency schemes are included within the reported position with a forecast overspend (after risk assessment in the 'most likely' scenario) of £139k. It is expected that this position will be managed by the year end to ensure financial duties are achieved.</p> <p>It was noted that the CCG had approached Barnsley Hospital NHS Foundation Trust to contribute to the Acorn Unit given the unding for this service is included within the block contract and are waiting to hear back on this. Discussion was had around the additional roles reimbursement and ongoing discussions with Primary Care and PCN's around this to ensure we maximise funding available as any uncommitted funding would be lost.. The Chair reported that a new group of the Primary Care Strategic Group was starting to</p>	

	<p>meet and would hope that this group would work with finance colleagues and others to look at the integration of Primary and community care and new models of care to ensure future funding is maximised.. It was also noted that staff turnover within the PCN's needs to be considered as part of the retention plan, with clarity around roles and responsibilities during the recruitment process..</p> <p>It was reported that work was ongoing with the Head of Medicines Optimisation around efficiencies and the expected prescribing position with month 10 expecting to show some significant pressures. CHC is also showing further increases with regards to care packages etc and the CFO is working with the Chief Nurse to look at external support to review care packages in place.</p> <p>The Chief Finance Officer reported that ICS funds and other national funding were still being received with little to no notification..</p> <p>The Chief Operating Officer presented the performance section of the report. The information included in the performance report continued to show the adverse impact of COVID19 upon delivery of some constitutional standards including referral to treatment times and waiting times for diagnostic waits. The number of people waiting 18 weeks or more for treatment has reduced overall however the number waiting over 52 weeks has continued to increase.</p> <p>Urgent care related measures such as A&amp;E waits also continue to be below standard and have been impacted by increased activity levels and challenges with flow due to COVID.</p> <p>Overall performance on cancer pathways including 2 week wait and referral to treatment remains strong however there has been an increase in the number of patients waiting 62 days for treatment taking performance below the 85% standard.</p> <p>IAPT access rates also continue to be below the target level with a deterioration in this month following a period of improvement.</p> <p><b>Agreed Actions:</b></p> <ul style="list-style-type: none"> <li>• <b>It was agreed that an update on IAPT included in the Mental Health Report to the next Governing Body.</b></li> <li>• <b>24 hour helpline that was set up for IAPT – Chief Operating Officer to include some figures on usage of this.</b></li> </ul>	<p>PO</p> <p>JW</p>
<p>FPC21/25</p>	<p>MANAGEMENT TEAM DECISIONS WITH FINANCIAL</p>	

	<b>IMPLICATIONS</b>	
	<p>The Chief Operating Officer presented the report the Committee. The Finance &amp; Performance Committee are asked to note the following decisions to commit expenditure taken by Management Team during January 2021:</p> <ul style="list-style-type: none"> <li>SMT agreed to a proposal to fund an increase in the fee payable to KPMG for the CCG's external audit of £10,000 in 2020/21 and £5,000 in 2021/22, related to a change in the statutory requirements with respect to the value for money (VFM) element of their work</li> </ul> <p><b>The Committee received and noted the report.</b></p>	
<b>FPC21/26</b>	<b>ANY OTHER BUSINESS</b>	
	<p><b><u>Breathe</u></b></p> <p>Dr J Harban asked whether there had been any requests to extend the procurement timetable for the breathe service. It was reported that no requests/challenges had been received and the deadline was the 5 February 2021.</p>	
<b>FPC21/27</b>	<b>ITEMS FOR ESCALATION TO GOVERNING BODY</b>	
	<ul style="list-style-type: none"> <li>Finance Position</li> <li>CHC Feedback from Governing Body Development Session presentation from Chief Nurse.</li> <li>Risk Register Scores for CHC to be reviewed/discussed</li> </ul>	
<b>FPC21/28</b>	<b>REFLECTION ON HOW THE MEETINGS BUSINESS WAS CONDUCTED</b>	
	The meeting went well and all business was conducted.	
<b>FPC21/29</b>	<b>DATE AND TIME OF NEXT MEETING</b>	
	Thursday 4 March 2021 at 10.30 am via Microsoft Teams.	

## GOVERNING BODY

11 March 2021

### PRIMARY CARE COMMISSIONING COMMITTEE HIGHLIGHTS REPORT

#### PART 1A – SUMMARY REPORT

<b>1.</b>	<b>THIS PAPER IS FOR</b>											
	<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"/>										
<b>2.</b>	<b>PURPOSE</b>											
	The purpose of this report is to provide Governing Body with the agreed highlights from the public Primary Care Commissioning Committee held on 28 January 2021.											
<b>3.</b>	<b>REPORT OF</b>											
	<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr style="background-color: #e0e0e0;"> <th style="width: 35%;"></th> <th style="width: 35%;">Name</th> <th style="width: 30%;">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										
<b>4.</b>	<b>SUMMARY OF PREVIOUS GOVERNANCE</b>											
	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: #e0e0e0;"> <th style="width: 45%;">Group / Committee</th> <th style="width: 20%;">Date</th> <th style="width: 35%;">Outcome</th> </tr> </thead> <tbody> <tr> <td>PCCC</td> <td>28.01.2021</td> <td>Highlights agreed</td> </tr> <tr> <td> </td> <td> </td> <td> </td> </tr> </tbody> </table>			Group / Committee	Date	Outcome	PCCC	28.01.2021	Highlights agreed			
Group / Committee	Date	Outcome										
PCCC	28.01.2021	Highlights agreed										
<b>5.</b>	<b>EXECUTIVE SUMMARY</b>											
	<p>This report provides the March 2021 Governing Body with the agreed highlights from the public Primary Care Commissioning Committee held on 28 January 2021.</p> <p>It was agreed at the meeting that the following would be highlighted:</p> <ol style="list-style-type: none"> <li>1. The Primary Care Network (PCN) has not achieved full recruitment to the 60% allocation to the Additional Roles currently available as part of the Primary Care Network DES. The underspend has resulted in the CCG being unable to draw down the additional 40% funding from NHS England to further the recruitment.</li> <li>2. The current risk regarding Primary Care Workforce was discussed and it was agreed that the underspend in Additional Role recruitment and retention</li> </ol>											

	of staff in the Additional Roles has resulted in the risk remaining as previously assessed.
<b>6.</b>	<b>THE GOVERNING BODY / COMMITTEE IS ASKED TO:</b>
	<ul style="list-style-type: none"> <li>Note the above which is provided for information and assurance.</li> </ul>
<b>7.</b>	<b>APPENDICES / LINKS TO FURTHER INFORMATION</b>
	<ul style="list-style-type: none"> <li>Adopted Minutes of the Primary Care Commissioning Committee 26 November 2020</li> </ul>

<b>Agenda time allocation for report:</b>	<i>5 mins.</i>
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**PART 1B – SUPPORTING INFORMATION & ASSURANCE**

<b>1.</b>	<b>Links to Corporate Priorities, GBAF and Risk Register</b>		
	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		
	The report also provides assurance against the following red or amber risks on the Corporate Risk Register:		<i>Provide ref(s) or state N/A</i>
<b>2.</b>	<b>Links to statutory duties</b>		
	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)	<b>See 3.1</b>	Duties as to reducing inequalities (s14T) <b>See 3.4</b>
	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)	<b>See 3.2</b>	Duty as to patient choice (s14V)
	Duty as to improvement in quality of services (s14R)	<b>See 3.3</b>	Duty as to promoting integration (s14Z1)
	Duty in relation to quality of primary medical services (s14S)	<b>See 3.3</b>	Public involvement and consultation (s14Z2) <b>See 3.5</b>
<b>3.</b>	<b>Governance Considerations Checklist</b> ( <i>these will be especially relevant where a proposal or policy is brought for decision or approval</i> )		
<b>3.1</b>	<b>Clinical Leadership</b>		
	Have GB GPs and / or other appropriate clinicians provided input and leadership?		<b>NA</b>
	<i>If relevant provide brief details here OR cross refer to detailed report if used</i>		
<b>3.2</b>	<b>Management of Conflicts of Interest (s14O)</b>		
	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?		<b>Y</b>
	<i>If relevant provide brief details here OR cross refer to detailed report if used</i>		
<b>3.3</b>	<b>Discharging functions effectively, efficiently, &amp; economically (s14Q)</b>		
	Have any financial implications been considered & discussed with the Finance Team?		<b>Y</b>
	Where relevant has authority to commit expenditure been sought from Management Team (<£100k) or Governing Body (>£100k)?		<b>NA</b>
	<i>If relevant provide brief details here OR cross refer to detailed report if used</i>		

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

**Minutes of the PUBLIC Primary Care Commissioning Committee meeting  
held on Thursday, 26 November 2020 at 2.30pm via MS Teams**

**PRESENT: (VOTING MEMBERS)**

Chris Millington ( <i>Chair</i> )	Lay Member for Patient & Public Engagement and Primary Care Commissioning
Nigel Bell	Lay Member for Governance
Mike Simms	Secondary Care Clinician
Richard Walker	Head of Governance & Assurance
Chris Edwards	Chief Officer

**GP CLINICAL ADVISORS: (NON-VOTING)**

Dr Madhavi Guntamukkala	Governing Body Member
Dr Mark Smith	Governing Body Member

**IN ATTENDANCE:**

Julie Frampton	Head of Primary Care
Angela Musgrave	Executive Personal Assistant
Nick Germain	Primary Care Manager, NHSEI
Carrie Abbott	Public Health, BMBC
Roxanna Naylor	Chief Finance Officer
Ruth Simms	Assistant Finance Manager

**APOLOGIES:**

Dr Nick Balac	CCG Chairman
Julia Burrows	Director of Public Health, BMBC
Sue Womack	Manager, Healthwatch Barnsley

**MEMBERS OF THE PUBLIC:**

There were no members of the public present at the meeting.

Agenda Item	Note	Action	Deadline
<b>PCCC 20/11/01</b>	<b>WELCOME AND APOLOGIES</b>		
	The Chair welcomed members to the meeting and apologies were noted as above.  Members welcomed Nick Germain, Primary Care Manager, to the meeting. It was noted that going forward Nick would be attending the meeting on behalf of NHSEI.		
<b>PCCC 20/11/02</b>	<b>QUORACY</b>		

	The meeting was declared quorate.		
<b>PCCC 20/11/03</b>	<b>DECLARATIONS OF INTEREST RELEVANT TO THE AGENDA</b>		
	<p>The Chair reported that Nick Germain had submitted a nil declarations of interest return which would be added to the register.</p> <p>The Chair also reported that as part of the Contractual Issues report two items were requesting Committee approval one of which was to consider and approve a 12 month contract extension to the APMS contract for Barnsley Healthcare Federation (BHF) Brierley Medical Centre.</p> <p>It was acknowledged that the General Practitioners on the Committee had already declared a non-financial professional interest in BHF.</p> <p>The Chair agreed to allow the GP members to remain present for this item to allow them to hear the clinical aspects of the proposal and, if required by the voting members, to ask for their clinical advice. However the Chair noted that, as non voting members of the Committee, they would not participate in the decision making with respect to this item.</p>		
<b>PCCC 20/11/04</b>	<b>MINUTES OF THE LAST MEETING</b>		
	<p>The minutes of the meeting held on the 24 September 2020 were verified as a true and correct record of proceedings. The Lay Member for Governance made the following comments that were noted and agreed.</p> <ul style="list-style-type: none"> <li>Minute item 20/09/10 – include on the Matters Arising report an action for an update to the primary care staffing risk on the corporate risk register to be brought to the PCCC meeting in January 2021, reflecting a future update from James Barker in relation to the recruitment process for the PCN additional roles.</li> </ul>	<b>JF/RW /AM</b>	
<b>PCCC 20/11/05</b>	<b>MATTERS ARISING REPORT</b> <u>PCCC 20/09/06 - Primary Care Network Update</u> The Chair reported that the PCN update had been presented at a recent Patient Council meeting. Members of the Patient Council had expressed their appreciation for the update.		

	<p><u>PCCC 20/07/07 – GP Patient Survey 2020</u> The Lay Member for Governance recommended the action be amended to reflect that the GP Patient Survey analysis had been reported at the November meeting; however a full analysis would be presented at a future meeting once the Primary Care Team had an opportunity to engage with practices in more detail post Covid.</p> <p><b>Action: Matters Arising Report to be amended to reflect the above.</b></p>	AM	Complete
<b>STRATEGY, PLANNING, NEEDS ASSESSMENT AND CO-ORDINATION OF PRIMARY CARE</b>			
<b>PCCC 20/11/06</b>	There was nothing to report relating to the strategy, planning, needs assessment and co-ordination of Primary Care.		
<b>QUALITY AND FINANCE</b>			
<b>PCCC 20/11/07</b>	<b>FINANCE UPDATE</b>		
	<p>The Assistant Finance Manager presented an update to members in relation to Finance.</p> <p><u>2020/21 Budget Update</u> It was reported that although the 2020/21 national allocation for Barnsley CCG's Primary Care Co-Commissioning annual budget was £38,629,000, the final annual budget requirement was £41,691.363, creating a deficit of £3,062,363 which would be funded from CCG programme costs, and that this had been approved at the Governing Body meeting in November 2020.</p> <p><u>Primary Care Network – Direct Enhanced Services (DES)</u> Additional core PCN funding of £1.50 per registered patient totalling £395,478 had been allocated to the PCN DES which would also be funded from CCG programme allocations.</p> <p><u>General Practice Forward View Funding (GPFV)</u> It was reported that discussions were taking place relating to the 2020/21 GPFV allocations for SYB CCGs.</p> <p><u>Supporting General Practice</u> It was reported that NHS England had established a new General Practice Covid capacity expansion fund. Funding of £150m would be allocated through the ICS system to SYB CCGs to support the expanding GP capacity, pulse oximetry and post Covid assessment clinic etc. until the end of March 2021.</p>		

	<p>Discussions were currently ongoing with the SYB ICS on the GPFV and Supporting General Practice funding. Further information would be provided to the Committee once this was available.</p> <p><b>The Committee:</b></p> <ul style="list-style-type: none"> <li>• <b>Noted the update on the financial framework for 2020/21.</b></li> </ul>		
<b>CONTRACT MANAGEMENT</b>			
<b>PCCC 20/11/08</b>	<b>CONTRACTUAL ISSUES REPORT</b>		
	<p>The Head of Primary Care presented the Contractual Issues Report that provided members with an update on the current contractual issues in relation to primary care contracts.</p> <p><b>In Year Contract Variation</b> <u>BHF Brierley Medical Centre</u></p> <p>It was reported that the APMS contract for BHF Brierley Medical Centre was due to expire on 30 November 2020 however; the contract included a clause to provide for an extension of the contract for further 12 months.</p> <p>In response to a question from the Head of Governance &amp; Assurance the Committee was informed that the CCG were pleased with the delivery of services being provided by the Practice and were happy to initiate an extension to the contract.</p> <p>It was noted that given the current climate due to the C-19 pandemic and the impact this would have on the procurement process and any interested parties at this time, members were asked to consider and approve the option to extend the APMS contract until 30 November 2021.</p> <p><u>Huddersfield Road Surgery</u></p> <p>Following the recruitment of a new GP Partner at Huddersfield Road Surgery the CCG had received an application to vary the PMS contract to add Dr Chilukuri as a new partner from 1 August 2020. Appropriate checks to the request had been reviewed by the CCG and NHSE.</p> <p>The Committee noted that as this was a PMS Practice the Contract Variation required an amendment to the PMS Contract which required Committee approval.</p>		

	<p><u>Royston Group Practice</u>                  Following the recruitment of a new GP Partner at Royston Group Practice the CCG had received an application to vary the GMS contract to add Dr Krugar as a new partner from 1 September 2020.</p> <p>The Committee noted that as this was a GMS Practice the Contract did not require amending and the item was for information only.</p> <p><u>Rent Reimbursement for GP Practices</u>                  The Committee noted that following a rent reimbursement review at Huddersfield Road Surgery, Cawthorne Road, the CCG had approved and actioned the rent reimbursement in line with the National Health Services (GMS Premises Costs Directions) 2013.</p> <p><u>GP Practice Service Delivery</u>                  In order to obtain assurance regarding services delivered and that robust action plans were in place, Practices had been requested to complete a short survey in June and October 2020 following the third phase of the national guidance.</p> <p>Although 27 out of the 32 Practices had responded to the survey, providing confirmation that practices were delivering many of the services required, some services were not currently being delivered by all practices due to the Covid pandemic.</p> <p>Members noted that due to Covid pressures and current restrictions, liaison with individual GP practices to discuss in more detail had been temporarily suspended.</p> <p>The Primary Care Team would continue to monitor and support all GP Practices in the delivery of services and performance.</p> <p><u>GP Service Analysis</u>                  The Committee was informed that the GP Patient Survey published in August 2019 was currently being analysed. Responses had been received from 3619 of the 11032 invited patients.</p> <p>An average of 77% of Barnsley CCG patients rated the overall experience of their GP practice as good, compared to 82% nationally.</p>		
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	<p>Following a brief discussion the Committee agreed that overall 77% was pleasing, however it was important for the CCG to understand how they could support practices to improve their rating.</p> <p>The Committee was informed that the CCG was developing an action plan to work with and support practices going forward and that the Primary Care Team continued to monitor and support all GP practices in the delivery of services and performance.</p> <p><u>E-Declaration Update (eDEC)</u> All 33 practices in Barnsley had completed their electronic Annual Practice Declaration (eDEC) in December 2019 which was part of the NHS England Policy and Guidance Manual for Primary Medical Services.</p> <p>The information submitted covered 8 categories including practice details, practice staff, premises and equipment, opening hours, practice services, practice procedures, governance, compliance with CQC and GP IT.</p> <p>The eDEC update provided additional information concerning each of the 8 categories giving further details and assurance in relation to the content of the 2019 eDEC.</p> <p>An analysis of responses had been carried out however follow up on queries for clarification and development of action plans had not taken place with individual practices due to the onset of Covid-19. The Primary Care Team was planning to complete a correlation between the 2019 eDEC and review responses for the eDEC due to be completed by practices in December 2020.</p> <p><u>2020/21 Practice Development Agreement</u> Due to the significant pressure Covid-19 had had on GP Practices the CCG had received a request from NHSE that practices should not be financially impacted due to their inability to deliver major PDA schemes.</p> <p>The CCG had therefore agreed to support practices through payment of the PDA for quarters 1 and 2 without an extensive ask to deliver specific schemes.</p> <p>It was reported that discussions were ongoing regarding the PDA for the rest of 2020 and development of the PDA for 2021.</p>		
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	<p><b><u>Caxton House Surgery Closure</u></b></p> <p>The Committee noted that Caxton House Surgery closed as planned on 31 August 2020. The Primary Care Team had ensured all patients were self-registered or allocated a new practice and the CCG was working through the financial due diligence process which would be completed by 30 November 2020.</p> <p>The Chair thanked the Head of Primary Care and the Primary Care Team for all the hard work, time and effort it had taken to manage the closure of Caxton House Surgery and for ensuring the safeguarding of patients and GPs.</p> <p>The Primary Care Manager, NHSEI also thanked the Primary Care Team for providing assurance that the closure had been done reflectively and that all due diligence had been completed.</p> <p>Following a brief discussion regarding the Contractual Issues report, the Lay Member for Governance requested that, given the number of areas still being worked on, it would be helpful to receive an update report before the end of March 2021.</p> <p><b>Action: The Contractual Issues update report to include an update on areas still being worked on before the end of March 2021.</b></p> <p><b>The Committee approved the:-</b></p> <ul style="list-style-type: none"> <li>• APMS contract variation for BHF Brierley Medical Centre</li> <li>• Addition of Dr Chilukuri as a new partner at Huddersfield Road Surgery from 1 August 2020</li> </ul> <p><b>The Committee noted the:</b></p> <ul style="list-style-type: none"> <li>• Addition of Dr Krugr as a new partner at Royston Group Practice on 1 September 2020.</li> <li>• Rent Reimbursement for Huddersfield Road Surgery, Cawthorne Road</li> <li>• Work completed in respect of GP Practice Service Delivery</li> <li>• GP Survey Analysis results</li> <li>• Process completed in respect of the General Practice e-Declaration for assurance</li> <li>• Update regarding the 2020-21 PDA</li> <li>• Closure of Caxton House Surgery</li> </ul>	JF	
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<b>GOVERNANCE, RISK AND ASSURANCE</b>			
<b>PCCC 20/11/09</b>	<p>The Head of Governance &amp; Assurance presented the risk and Governance report that provided the Committee with assurance regarding the delivery of the CCG's annual strategic objectives and that current risks to the organisation were being effectively managed and monitored appropriately.</p> <p><u>Governing Body Assurance Framework (GBAF)</u> The Committee was reminded that a planned update of the GBAF in March 2020 had been suspended due to the need to respond to the Covid-19 emergency.</p> <p>Following a stabilisation and recovery phase in August and September and the receipt of planning guidance for the remainder of 2020/21, work had progressed and the revised GBAF was signed off by the Governing Body in November 2020.</p> <p>The Committee noted that sections of the Assurance Framework relating to Primary Care and Digital IT would be regularly received by the PCCC.</p> <p><u>Risk Register</u> There were currently five risks on the corporate risk register allocated to the PCCC. Of the five risks there was one red (extreme), one amber (high) one yellow (moderate) and two green (low).</p> <p>The Committee was informed that no changes or additions had been made to the risk register since the last meeting held in September 2020.</p> <p><b>The Committee:</b></p> <ul style="list-style-type: none"> <li>• <b>Reviewed and agreed that the risks were being appropriately managed and scored.</b></li> </ul> <p><u>Terms of Reference</u></p> <p>Each of the CCGs Committees reviewed their terms of reference on an annual basis. The Committee noted that as changes had already been made to the PCCC Terms of Reference earlier in 2020, these continued to be fit for purpose.</p> <p>The Head of Primary Care commented however, that it could be necessary to review membership of some sub groups of the PCCC due to recent changes and that the terms of reference should also include the remit of some</p>		

	<p>members of the Primary Care Patient Representative Group and the Primary Care Forum which had replaced the Primary Care Delivery Work stream.</p> <p><b>Action: RW to work with JF to review the ToR in light of the above comments and bring back to the January meeting if there were any amendments.</b></p> <p><u>PCCC Work Plan 2021/22</u> The Committee noted the information provided in the Work Plan for 2021/22.</p>	RW/JF	
<b>OTHER</b>			
<b>PCCC 20/11/10</b>	<b>REFLECTION OF CONDUCT OF THE MEETING</b> The Committee agreed that the meeting had been conducted appropriately.		
<b>PCCC 20/11/11</b>	<b>QUESTIONS FROM MEMBERS OF THE PUBLIC RELEVANT TO THE AGENDA</b>		
	There were no questions received from the members of the public.		
<b>PCCC 20/11/12</b>	<b>ITEMS FOR ESCALATING TO THE GOVERNING BODY</b> It was agreed to escalate the following items to the Governing Body for information:- <ul style="list-style-type: none"> <li>The approval of the request to extend the BHF contract to deliver primary medical services at Brierley Medical Practice for a period of 12 months.</li> </ul>		
<b>PCCC 20/11/13</b>	<b>DATE &amp; TIME OF NEXT MEETING</b> Thursday, 28 January 2021 at 2:30 – 3:30pm via MS Teams.		

**Minutes of the NHS Barnsley Clinical Commissioning Group  
QUALITY & PATIENT SAFETY COMMITTEE  
Thursday 17 December 2020, 13:00pm-15:00pm  
Via Microsoft Teams**

**MEMBERS:**

Jayne Sivakumar	- Chief Nurse (Chair)
Dr Madhavi Guntamukkala	- Medical Director
Mike Simms	- Secondary Care Clinician
Dr Mark Smith	- Practice Member Representative Contracting Lead from the Governing Body
Chris Millington	- Lay Member for Public and Patient Engagement and Primary Care Commissioning
Chris Lawson	- Head of Medicines Optimisation
Dr Shahriar Sepehri	- Membership Council Representative
Dr Adebowale Adekunle	- GP Governing Body Member

**IN ATTENDANCE:**

Richard Walker	- Head of Governance and Assurance
Jo Harrison	- Specialist Clinical Portfolio Manager
Terry Hague	- Primary Care and Transformation Manager
Hilary Fitzgerald	- Quality Manager
Jill Auty	- Quality Administrator (minutes)
Angela Fawcett	- Designated Nurse Safeguarding Children
Siobhan Lenzionowski	- Lead Commissioning and Transformation Manager Long Term Conditions; Cancer and End of Life/Palliative Care

Agenda Item	Note	Action	Deadline
<b>Q&amp;PSC 20/12/01</b>	<b>HOUSEKEEPING</b>		
	As the meeting was being conducted via MS Teams, the Chair advised that everyone is responsible for their own safety within their environment during the meeting.		
<b>Q&amp;PSC 20/12/02</b>	<b>APOLOGIES &amp; QUORACY</b>		
	There were no apologies to note. The meeting was declared quorate. The Chair welcomed Dr Madhavi Guntamukkala to the meeting and informed members that Dr Madhavi Guntamukkala will take over the position of chair from February 2021.		
<b>Q&amp;PSC 20/12/03</b>	<b>DECLARATIONS OF INTEREST RELEVANT TO THE AGENDA</b>		

	The committee considered the declarations of interest report, and no new declarations of interest were declared.		
<b>Q&amp;PSC 20/12/04</b>	<b>MINUTES OF THE MEETING HELD ON 22 OCTOBER 2020</b>		
	<p>Committee members were asked to approve the minutes of the previous meeting held on 22 October 2020. The Primary Care and Transformation Manager asked for an amendment to the wording in the item Q&amp;PSC 20/10/06 Quality and Patient Safety Report:</p> <p>Page 5 - remove <b>and out of hours</b> from the following statement. <i>The Primary Care and Transformation Manager updated members regarding primary care and out of hours</i></p> <p>Page 6 -add <b>Extended Access</b> to the subtitle <i>Out of Hours</i></p> <p>The committee agreed the changes to reflect accuracy.</p> <p>The Lay Member for Public and Patient Engagement and Primary Care Commissioning asked if Barnsley Hospital NHS Foundation Trust (BHNFT) had provided committee members with assurance in relation to maternity serious incidents. The Chair informed members that the Quality Manager would provide an update later in the meeting under item 6 of the agenda.</p>		
	<p><b>Actions agreed:</b> Quality Administrator to make changes to Pages 5 and 6 of the October 2020 minutes.</p>	<b>JA</b>	<b>January 2021</b>
<b>Q&amp;PSC 20/12/05</b>	<b>MATTERS ARISING REPORT</b>		
	<p>The Chair confirmed that all items were complete apart from the following:</p> <ul style="list-style-type: none"> <li>• <b>Minute reference Q&amp;PSC 20/10/06 – Quality and Patient Safety Report</b> – The Chair informed members that the communication will be sent out today (17 December 2020) detailing the change to the service offer from South West Yorkshire Partnership NHS Foundation Trust (SWYPFT) to Sheffield Teaching Hospitals NHS Foundation Trust.</li> <li>• <b>Minute reference Q&amp;PSC 20/10/06 – Quality and Patient Safety Report</b> – The Primary Care Transformation Manager and Quality Manager to discuss what is in the Barnsley Healthcare Federation contract around reporting of serious</li> </ul>	<b>Complete</b>	

	<p>incidents. The Quality Manager informed members a meeting was held on 18 November 2020. A review has taken place of the existing process for reporting serious incidents and comments have been fed back to Barnsley Healthcare Federation which will be picked up by the Primary Care Transformation Manager at the next Contract meeting. A discussion took place around the clarity of the action and it was agreed to keep the action ongoing for assurance.</p> <ul style="list-style-type: none"> <li>• <b>Minute reference Q&amp;PSC 20/10/09 – Annual LeDeR Report</b> – The Specialist Clinical Portfolio Manager to discuss with the Primary Care and Transformation Manager the issues regarding access to GP records for LeDeR work. The Specialist Clinical Portfolio Manager informed members that this has been resolved locally by contacting practice managers on a case by case basis. It was noted that practices are now the best returners of information by making this change to the process.</li> <li>• <b>Minute reference Q&amp;PSC 20/10/14 - Minutes of 26 August 2020 Primary Care Quality &amp; Cost Effective Prescribing Group Meeting</b> - The Chair requested a further meeting with the Head of Medicines Optimisation to discuss the Community Pharmacy Emergency Hormonal Contraception Service. The Head of Medicines Optimisation advised that although work has progressed with providers and a service is now in place, there are still gaps in the service provision of long acting contraception. It was agreed the Quality Administrator would organise a further meeting and invite the Medical Director to ensure any gaps from a primary care aspect are covered.</li> <li>• <b>Minute reference Q&amp;PSC 20/08/13 Individual Funding Requests</b> – The Specialist Clinical Portfolio Manager informed members that contact has been made with the Individual Funding Team and minor tweaks have been made to the Policy.</li> </ul>	<p>Ongoing</p> <p>Complete</p> <p>Ongoing</p> <p>Complete</p>	
	<p><b>Agreed actions:</b> Quality Administrator to organise a meeting between Chief Nurse, Medical Director and Head of Medicines Optimisation to discuss the gaps in the Community Pharmacy Emergency Hormonal Contraception Service.</p>	<p>JA</p>	<p>January 2021</p>
<p><b>QUALITY AND GOVERNANCE</b></p>			

<b>Q&amp;PSC 20/12/06</b>	<b>QUALITY AND PATIENT SAFETY REPORT</b>		
	<p>The Quality Manager presented the Quality and Patient Safety report for assurance highlighting the following:</p> <p><u>Barnsley Hospital NHS Foundation Trust (BHNFT)</u></p> <p>The Trust has recently experienced a particularly challenging few weeks and its Operational Pressures Escalation (OPEL) moved to Level 4. The Trust was moved to OPEL 3 at the beginning of December 2020. Members were advised that the CCG had formally thanked the Trust at the December 2020 Clinical Quality Board meeting for management of the situation and the ongoing resolution of such a challenging position.</p> <p>There has been no increase in serious incidents as a result of the pressures the Trust has been facing. However, members were advised that due to the increased pressure on clinical staff the Trust had changed its format for investigation reports. The new style of reporting is being kept under review by the CCG.</p> <p>The CCG has undertaken a review of Maternity Incidents which has highlighted a theme of patients whose first language is not English. BHNFT's Chief Nurse has reassured the CCG that actions are being taken forward to tackle this issue. Members were advised no incidents have been reported since July 2020. For further assurance the Chief Nurse informed members that minutes from the monthly Maternal and Neonatal Safety Champion Meetings are being shared and will be discussed at each 1:1 meeting with the Trust. The Quality Manager also highlighted that some categories of maternity incidents are now routinely reported to the Healthcare Safety Investigation Branch which provides further assurance.</p> <p>The Trust was issued with a Regulation 28 notice from the Coroner's Office in November 2020 relating to a patient who had frequent falls while in the hospital in 2018. The Coroner has issued recommendations and the Trust is confident it will deliver a satisfactory action plan by 7 January 2021.</p> <p>Members were advised that the CCG is still waiting for an action plan in relation to the Trust's Ophthalmology Failsafe system. Members were assured the Head of Contracting is liaising with the Trust on this matter.</p> <p>In relation to a previous highlighted quality concern</p>		

	<p>about the urology pathway, the Trust has appointed two consultants and a further two vacancies are being covered by long term locums.</p> <p><u>South West Yorkshire Partnership Foundation Trust (SWYPFT)</u> The Trust reported that the majority of quality reporting has been maintained during the pandemic although registered nurse staff shortages have resulted in skill mix dilution in some areas.</p> <p>Face to face contact is increasing and offered where clinically required.</p> <p>The Trust has provided assurance that backlogs in Memory service diagnostic and Early Intervention in Psychosis will be addressed by the end of December 2020.</p> <p>Members were advised work is progressing to investigate the current pathway for out of area locked rehabilitation beds. The Specialist Clinical Portfolio Manager added that the CCG is exploring gaps in services for complex young adults and an action plan is in place around Improving Quality and Reducing Financial Spend.</p> <p><u>Yorkshire Ambulance Service (YAS)</u> At the November 2020 SYB YAS 999/IUC Quality Group meeting concerns were raised regarding hospital handovers. The Head of Contracting has recently circulated an Urgent Care consultation which features hospital handovers.</p> <p>The Lay Member for Public and Patient Engagement and Primary Care Commissioning advised that concerns were raised at a recent Healthwatch Barnsley Board meeting around access to appointments at GP practices. The Primary Care and Transformation Manager provided reported figures for face to face appointments for September and October 2020 which clearly show that practices are open and seeing patients where clinically safe. Members agreed to further explore the reporting of wider contact data and felt this would fit under the Primary Care update section.</p> <p>Healthwatch had also asked who is responsible for the decontamination of ambulances following transport of COVID patients to hospital, and what are the reasons for ambulance handover delays? The Lead Commissioning and Transformation Manager Long Term Conditions; Cancer and End of</p>	<p><b>TH</b></p> <p><b>JS/HF</b></p>	
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	<p>Life/Palliative Care informed members for assurance that the End of Life Steering Group has been working with YAS to implement a standard operating procedure for patient call outs that do not require hospital admission but require ongoing care via other routes example GP.</p> <p><u>Primary Care Update</u> The Primary Care and Transformation Manager updated members regarding primary care. It was highlighted that the Care Quality Commission(CQC) has adopted a different regulatory approach due to the current situation. The CQC has held calls with The Rose Tree Practice, Dodworth Medical Practice, and The Grove Medical Practice. There was no need for any regulatory action following these calls.</p> <p>However, concerns were raised with some practices in the Goldthorpe/Dearne region around access. Following the initial calls, it was identified that the issue may relate to the number of telephone lines a practice has rather than service delivery. The CQC will not be investigating further as this issue is around systems and not practice delivery. The practices concerned are considering other processes to ensure patients are able to access services.</p> <p><u>Out of Hours/Extended Access</u> No complaints or serious incidents have been reported. Compliments have been received for the Out of Hours service providing members with positive assurance of the service patients are receiving.</p> <p>The Chair asked if the feedback on the satisfaction report had dropped. The Primary Care and Transformation Manager informed members that the satisfaction is generally static but would look back at previous month's performance and report back. The Chair advised an email providing assurance would be sufficient.</p> <p><b>The Head of Governance and Assurance left the meeting at 13.59pm</b></p> <p><u>Care Homes</u> The Specialist Clinical Portfolio Manager provided an update regarding care homes. Digital ability is the main priority as this impacts on the ability to deliver remote patient monitoring, MDTs and other important functions relevant to quality and safety of resident care. Sheffield IT Service in conjunction with NHS Digital First is conducting a pilot study in three CCGs. Ten care homes in each CCG will have detailed</p>	<p style="text-align: center;">TH</p>	
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	<p>assessments of current capability and equipment. The next priority has been identified as roll out of MDTs across all homes. This work is being progressed at pace and an initial report is due at the end of January 2021.</p> <p><b>The Head of Governance and Assurance re-joined the meeting at 14.05pm.</b></p> <p><u>LeDeR update</u> The Specialist Clinical Portfolio Manager reported that there had been significant progress in the completion of reviews and by the 31 December 2020 there will no longer be a backlog, but there may be some remedial work to complete. The Chair thanked the team involved for getting to the current position and for the additional amount of work undertaken to review cases and mitigate the risk on the risk register. The Specialist Clinical Portfolio Manager advised members that a full thematic review will take place in 2021 to establish requirements going forward.</p>		
	<p><b>Actions agreed:</b> Information to be obtained for Healthwatch Barnsley Board:</p> <ul style="list-style-type: none"> <li>• Report on the number of wider general practice contact data</li> <li>• Who is responsible for the decontamination of ambulances following transport of COVID patients to hospital?</li> <li>• What are the reasons for ambulance handover delays?</li> </ul> <p>The Primary Care and Transformation Manager to provide an update to the Chair with regards to the performance feedback on the Out of Hours and Extended Access satisfaction report and to report month of month going forward.</p>	<p><b>TH</b></p> <p><b>JS/HF</b></p> <p><b>TH</b></p>	
<b>Q&amp;PSC 20/12/07</b>	<b>MINIMISING THE IMPACT OF COVID ON PATIENT CARE AND THE RISK TO PHASE 3 RESTORATION</b>		
	<p>The Lead Commissioning and Transformation Manager Long Term Conditions; Cancer and End of Life/Palliative Care presented the report for assurance and approval. There followed a detailed discussion about safety netting patients in Primary Care.</p> <p>The Lay Member for Public and Patient Engagement and Primary Care Commissioning enquired about the Behavioural Science approach. Members were advised Cancer Alliance is the first to</p>		

	<p>adopt this approach in South Yorkshire and Bassetlaw and offered to discuss this further outside of the meeting with any members.</p> <p>The GP Governing Body Member raised a concern that following referrals to hospital the patient's outcome is not updated on the patient's clinical record. The Lead Commissioning and Transformation Manager asked for examples and to discuss further outside of the meeting.</p> <p>The Chair asked committee members to approve the adoption of the SYB ICS Cancer Alliance Harm Minimisation Principles. Committee members approved the adoption of the principles.</p>		
	<p><b>Actions agreed:</b> The Lead Commissioning and Transformation Manager Long Term Conditions; Cancer and End of Life/Palliative Care to discuss Behavioural Science approach outside of the meeting – open to all members.</p> <p>The Lead Commissioning and Transformation Manager Long Term Conditions; Cancer and End of Life/Palliative Care to meet with GP Governing Body Member to discuss further the issue of updating patient record outcomes following referral to hospital.</p>	SL	
<b>Q&amp;PSC 20/12/08</b>	<b>CONTINUING HEALTHCARE</b>		
	<p>The Chair presented the current position of the Continuing Health Care Team highlighting the issues, risks and mitigations. The position will be presented to Governing Body at the January 2021 meeting.</p> <p>Members were advised the senior management team made the decision to place the CHC on the CCG Corporate Risk Register.</p>		
<b>Q&amp;PSC 20/12/09</b>	<b>HASU/ ASU/ REHAB UPDATE</b>		
	<p>The Quality Manager verbally provided committee members with some positive assurance about the HASU service. The Stroke Regional Network's patient experience survey for Barnsley and Rotherham patients shows overwhelming positive results for the hyper acute element of care.</p> <p>Also, the National Stroke audit data for Barnsley is showing a significant improvement for accessing a stroke consultant, CT scans within the one hour timeframe and a significant improvement to admission to stroke unit. This is an early indication that patients are getting the right treatment at the right time in the</p>		

	right place. Members were informed that the CCG has requested mortality data from the service.		
<b>Q&amp;PSC 20/12/10</b>	<b>CHILDREN'S TESTICULAR TORSION PATHWAY CHANGE</b>		
	The Quality Manager updated committee members regarding the concerns raised by YAS about the changes to the pathway that occurred at short notice in November 2020. Secondary Care Clinician commented that although the CCG have not been involved in the discussions this is a positive pathway change for patients.		
<b>Q&amp;PSC 20/12/11</b>	<b>BCCG SAFEGUARDING PEOPLE POLICY</b>		
	The Designated Nurse Safeguarding Children presented the updated policy for approval. The main updates are due to changes to various acts resulting in terminology changes. The Chair thanked the safeguarding team for the work on updating the policy guidelines. Committee members approved the updated policy.		
<b>Q&amp;PSC 20/12/12</b>	<b>RISK REGISTER (STANDING ITEM)</b>		
	The Head of Governance and Assurance presented the Risk Register.  A risk will be added to the register around the staffing and financial concerns raised in relation to the CHC team. Committee members were asked to approve the risk and residual risk score. Committee members approved the addition of the risk to the register.		
<b>Q&amp;PSC 20/12/13</b>	<b>INFORMATION GOVERNANCE UPDATE</b>		
	The Head of Governance and Assurance presented for approval the updated BCCG Information Security Policy highlighting; <ul style="list-style-type: none"> <li>• Data security and protection toolkit deadline has been extended to June 2021.</li> <li>• Information Security Policy has been reviewed and updated to include an addition to temporary staff access to systems/networks.</li> </ul> <p>Following the last audit a number of standard paragraphs were found to have been omitted from the policy template. As these are standard paragraphs, members were asked to approve the policy on the proviso the paragraphs will be added before sign-off.</p>		

	<p>Committee members approved the changes to the policy.</p> <p>The Lay Member for Public and Patient Engagement and Primary Care Commissioning asked who would be responsible for Penetration Testing. BCCG has been informed that NHS Digital are unable to offer this service however IT Service will be commissioning a third party to carry out the testing.</p> <p>The Head of Medicines Optimisation pointed out the signature and dates on the Equality Impact Assessment are incorrect. The Head of Governance and Assurance agreed to review and amend before final sign-off.</p>				RW
	<p><b>Actions agreed:</b></p> <p>The Head of Governance to update the signature and dates on the Equality Impact Assessment.</p>				RW
<b>COMMITTEE REPORTS AND MINUTES</b>					
<b>Q&amp;PSC 20/12/14</b>	<b>MINUTES OF THE 14 OCTOBER 2020 AREA PRESCRIBING COMMITTEE</b>				
	<p>The Head of Medicines Optimisation presented the minutes for information.</p> <p>It was highlighted that the notice to withdraw Priadel® used to treat Bipolar disorder from the UK Market has been removed for six months mitigating the risk for patients.</p> <p>It was also highlighted that the BHNFT's definition of medically stable has resulted in patients who are acutely unwell being discharged from hospital putting community and primary care under additional pressure. The Chair asked who is picking up the acutely ill patients being discharged, and that this issue has been raised at the Gold command meeting. The Chair agreed to follow this up.</p>				JS
	<p><b>Agreed action:</b></p> <p>The Chair to follow up the concern relating to acutely ill patients being discharged from hospital to community.</p>				JS
<b>Q&amp;PSC 20/12/15</b>	<b>MINUTES OF 30 SEPTEMBER 2020 AND “* OCTOBER 2020 PRIMARY CARE QUALITY &amp; COST EFFECTIVE PRESCRIBING GROUP MEETING</b>				
	<p>The Head of Medicines Optimisation presented the minutes for information and assurance. No queries were raised.</p>				

<b>Q&amp;PSC 20/12/16</b>	<b>CLINICAL QUALITY BOARDS</b> <ul style="list-style-type: none"> <li>• <b>BHNFT – MINUTES 17 SEPTEMBER 2020</b></li> <li>• <b>SWYPFT – VERBAL UPDATE</b></li> </ul>		
	The Chair stated that these are adopted sets of minutes and were presented for information and assurance. No queries were raised. The Chair informed members that the December 2020 SWYPFT meeting has been rescheduled to 21 January 2021 due to CCG availability.		
<b>GENERAL</b>			
<b>Q&amp;PSC 20/12/17</b>	<b>ANY OTHER BUSINESS</b>		
	The Lay Member for Public and Patient Engagement and Primary Care Commissioning asked if the committee would agree to Tom Davidson BHNFT attending QPSC to demonstrate the data capability of the new patient record system (Medway). Members agreed this would add value to the meeting and a request would be made.  The Head of Medicines Optimisation informed members that unfortunately the quality of D1s has not improved with the introduction of Medway at BHNFT.  <b>The Lead Commissioning and Transformation Manager and the Medical Director left the meeting at 15:00pm</b>	<b>JS</b>	
	<b>Agreed action:</b> Tom Davidson (BHNFT) to be invited to a future meeting to present Medway data capability	<b>JS</b>	
<b>Q&amp;PSC 20/12/18</b>	<b>AREAS FOR ESCALATION TO THE GOVERNING BODY AND ITEMS TO BE COVERED IN HIGHLIGHT REPORT</b>		
	Items for escalation are <ul style="list-style-type: none"> <li>• Green – BHNFT Management of OPEL 4 position</li> <li>• Green – Minimising Harm due to Covid</li> <li>• Green – LeDeR Programme</li> <li>• Green – Safeguarding People Policy/ Information Security Policy</li> <li>• Red – Locked Rehabilitation Provision</li> </ul>		
<b>Q&amp;PSC 20/12/19</b>	<b>REFLECTION ON HOW WELL THE MEETING'S BUSINESS HAS BEEN CONDUCTED:</b> <ul style="list-style-type: none"> <li>• <b>CONDUCT OF MEETING</b></li> <li>• <b>ANY AREAS FOR ADDITIONAL ASSURANCE</b></li> <li>• <b>ANY TRAINING NEEDS IDENTIFIED</b></li> </ul>		

	The Chair thanked everyone for the support during 2020 and handed the role of Chair over to Dr Madhavi Guntamukkala.		
<b>Q&amp;PSC 20/12/20</b>	<b>DATE AND TIME OF NEXT MEETING</b> 18 February 2021, 1pm via MS Teams		

Adopted

## GOVERNING BODY

11 March 2021

## EQUALITY &amp; ENGAGEMENT COMMITTEE SUMMARY REPORT

## PART 1A – SUMMARY REPORT

<b>1.</b>	<b>THIS PAPER IS FOR</b>		
	<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"/>
<b>2.</b>	<b>PURPOSE</b>		
	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.		
<b>3.</b>	<b>REPORT OF</b>		
		<b>Name</b>	<b>Designation</b>
	Executive / Clinical Lead	Chris Millington	Lay Member
	Author	Carol Williams	Project Coordinator
<b>4.</b>	<b>SUMMARY OF PREVIOUS GOVERNANCE</b>		
	The matters raised in this paper have been subject to prior consideration in the following forums:		
	<b>Group / Committee</b>	<b>Date</b>	<b>Outcome</b>
	NA		
<b>5.</b>	<b>EXECUTIVE SUMMARY</b>		
	<p>Committee members agreed to highlight the following from the 25 February 2021 equality &amp; engagement committee meeting:</p> <ul style="list-style-type: none"> <li>Two surveys in relation to the impact of Covid-19 on local communities were presented to the committee and discussed at length. These are highlighted in the Engagement Report being presented to the Governing Body.</li> <li>The committee reviewed the People and Organisational Development Strategy 2021 to 2022. The plan has been written in response to the NHS People's Plan, aims to pull together all HR and OD activity and provides a framework that will further develop our organisation and its people as we continue to develop and deliver our ambitions. This will now be discussed by the CCG senior management team.</li> </ul>		
<b>6.</b>	<b>THE GOVERNING BODY / COMMITTEE IS ASKED TO:</b>		
	<ul style="list-style-type: none"> <li>Note the contents of this report for information and assurance.</li> </ul>		
<b>7.</b>	<b>APPENDICES / LINKS TO FURTHER INFORMATION</b>		

	<ul style="list-style-type: none"><li>• Appendix A – Adopted Equality &amp; Engagement Minutes 3 December 2020 (seen by the committee January 2021)</li><li>• Appendix B – Unadopted Equality &amp; Engagement Minutes 25 February 2021</li></ul>
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<b>Agenda time allocation for report:</b>	5 minutes
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**PART 1B – SUPPORTING INFORMATION & ASSURANCE**

<b>1.</b>	<b>Links to Corporate Priorities, GBAF and Risk Register</b>		
	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		
	The report also provides assurance against the following red or amber risks on the Corporate Risk Register:		N/A
<b>2.</b>	<b>Links to statutory duties</b>		
	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)
<b>3.</b>	<b>Governance Considerations Checklist</b> ( <i>these will be especially relevant where a proposal or policy is brought for decision or approval</i> )		
<b>3.1</b>	<b>Clinical Leadership</b>		
	Have GB GPs and / or other appropriate clinicians provided input and leadership?		<b>Y</b>
	As members of this committee		
<b>3.2</b>	<b>Management of Conflicts of Interest (s14O)</b>		
	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?		<b>Y</b>
	None declared		
<b>3.3</b>	<b>Discharging functions effectively, efficiently, &amp; economically (s14Q)</b>		
	Have any financial implications been considered & discussed with the Finance Team?		<b>NA</b>
	Where relevant has authority to commit expenditure been sought from Management Team (<£100k) or Governing Body (>£100k)?		<b>NA</b>

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

**ADOPTED Minutes of the Meeting of the EQUALITY AND ENGAGEMENT COMMITTEE held on Thursday 3 December 2020 at 3pm via Microsoft Teams**

**PRESENT:**

Chris Millington (Chair)	Lay Member for Patient & Public Engagement, CCG
Kirsty Waknell	Head of Communications & Engagement, CCG
Richard Walker	Head of Governance & Assurance, CCG
Colin Brotherston-Barnett	Equality, Diversity & Inclusion Lead, CCG
Dr Adebowale Adekunle	Elected Governing Body Member, CCG
Susan Womack	Manager, Healthwatch Barnsley

**IN ATTENDANCE:**

Emma Bradshaw	Engagement Manager, CCG
Carol Williams	Project Coordinator/Committee Secretary, CCG

**APOLOGIES:**

Jayne Sivakumar	Chief Nurse, CCG
Julie Frampton	Senior Primary Care Commissioning Manager, CCG
Esther Short	HR Manager, CCG

Agenda Item	Note	Action	Deadline
<b>EEC 20/12/01</b>	<b>HOUSEKEEPING / APOLOGIES</b>		
	The Chairman informed everyone present of the etiquette for Microsoft Teams meetings.  Apologies were received as above.		
<b>EEC 20/12/02</b>	<b>QUORACY</b>		
	The chair of the committee declared that the meeting was quorate.  There is a vacancy for a membership council member. Membership council have been asked for expressions of interest and to date we have not had a suitable application. This will be raised again at the next membership council meeting.		

Agenda Item	Note	Action	Deadline
EEC 20/12/03	<b>DECLARATIONS OF INTEREST RELEVANT TO THE AGENDA</b>		
	<p>The committee considered the declarations of interest report; a new declaration of interest was noted as follows and has been added to the report.</p> <ul style="list-style-type: none"> <li>The daughter of the head of governance and assurance employed by Health Education England.</li> </ul>		
	<p><b>Agreed Action:</b></p> <ul style="list-style-type: none"> <li><b>The head of governance and assurance to ensure that Dr Saxena is removed from the DOI report.</b></li> </ul>	<b>RW</b>	<b>Completed</b>
EEC 20/12/04	<b>MINUTES OF THE PREVIOUS MEETING HELD ON 13 AUGUST 2020</b>		
	The minutes of the meeting held on 13 August 2020 were adopted and verified as a correct record of the proceedings by members present.		
EEC 20/12/05	<b>MATTERS ARISING REPORT</b>		
	<p>The committee noted the actions from the 13 August 2020 meeting, one action remained open:</p> <p><b>EEC 19/11/07 Barnsley Service Users Forum</b> The head of communications and engagement to discuss the role of an independent chair of the forums with BMBC colleagues. <b>Update 13.08.2020:</b> The last meeting was held as we went into lockdown and this committee was paused during this time. <b>Update 03.12.2020:</b> Groups have started to meet again ad hoc.</p>		
	<p><b>Agreed Action:</b></p> <ul style="list-style-type: none"> <li>The head of communications and engagement will check to see if this item can be closed.</li> </ul>	<b>KW</b>	<b>Completed</b>
<b>PATIENT AND PUBLIC ENGAGEMENT</b>			
EEC 20/12/06	<b>ENGAGEMENT REPORT</b>		
	<p>The engagement report was presented to committee members for assurance.</p> <p>The Healthwatch manager stated that there is a lot of useful information in the summary from a broad spectrum of different organisations. There is a range of</p>		

Agenda Item	Note	Action	Deadline
	<p>issues highlighted and the summary recognised the hard work of front line staff providing care. Query raised on how we are learning about what people are telling us at a local level and how are these findings translating to actions?</p> <p>The engagement manager stated we continue to provide summaries of a range of local, regional and national patient and public experience, including long covid and health inequalities. This information is fed into the weekly surveillance reporting compiled by colleagues leading on the work of the Barnsley Intelligence Cell which is circulated to partner organisations at a senior and operational level for them to use as part of transformation work. A survey will be undertaken to evaluate how this information is being used in shaping decision making and to check how useful this information is.</p> <p>The head of communications and engagement noted the increase in information available and the need to check if this is needed to inform our work immediately or for interest. We need to now stock check to ensure we keep momentum and this work is of value to organisations. This report was seen by Patient Council this week and members noted that the information shared resonated with what they had been hearing across a range of themes, different community settings and experiences.</p> <p>Noted the new Healthwatch survey will be shared with partner organisations.</p> <p>The elected Governing Body member joined the meeting.</p>		
	<p><b>Agreed Actions:</b></p> <ul style="list-style-type: none"> <li>The engagement manager to provide an update at the February 2021 meeting on the evaluation survey in relation to information being gathered and shared with partner organisations.</li> </ul>	EB	On the February agenda - Completed
EEC 20/12/07	<b>SURVEILLANCE REPORTING</b>		
	The engagement manager gave a verbal update on surveillance reporting. This is covered in the previous agenda item.		

Agenda Item	Note	Action	Deadline
EEC 20/12/08	<p><b>NHS OVERSIGHT FRAMEWORK PATIENT &amp; COMMUNITY ENDGAGEMENT INDICATOR</b></p>		
	<p>In relation to our compliance with statutory guidance on patient and public participation in commissioning health and care: the NHS Oversight Framework Patient and Community Engagement Indicator, we have been informed by NHS England &amp; Improvement that for 2019/20 we have maintained our excellent score of 14/15 from the previous year and again been rated Green Star which is the highest rating possible.</p> <p>Healthwatch congratulated the CCG for attaining this status.</p>		
EEC 20/12/09	<p><b>MINUTES OF THE PATIENT COUNCIL MEETINGS HELD ON 30 SEPTEMBER 2020 &amp; 28 OCTOBER 2020</b></p>		
	<p>Patient Council minutes shared for information highlighting the following:</p> <p><b>30 September 2020 - Care homes and primary care realignment.</b> The primary care network (PCN) requires that all care homes are aligned to a single PCN, Barnsley has a single PCN and care homes are now aligned with a general practice. A pilot with a care home found that by residents being involved with the planning of their care they felt empowered and had control over their lives, medicine waste was decreased by 93%, hospital admissions were reduced and end of life wishes have, in the main, been fulfilled. Next steps will be to talk to other families and carers about the offer and take into consideration patient choice.</p> <p>The Healthwatch manager stated it was good to see the pilot had shown positive results and noted ongoing engagement in relation to individual circumstances re patient choice which was important. An update will be provided to Healthwatch as this project progresses.</p> <p><b>28 October 2020 - Intermediate Care</b> The four key elements of the intermediate care offer – reablement, crisis response, home based care and care home care - were explained to members. The service is tailored to specific patient needs by utilising an MDT of therapists, physiotherapists, speech &amp; language, care home support and care in the community. Members were asked how we can work differently and gave feedback that care needs to be delivered closer to home.</p>		

Agenda Item	Note	Action	Deadline
	<p>As a result of this session three patient council members will be part of a brainstorming session and some of the ideas discussed have already been incorporated into the potential new specification. The IMC services are coming to the end of their contracts and when there is a change of circumstances the overview and scrutiny committee are consulted, they have reported back to us that they were happy with the engagement approach. All information shared will be collated and shared with Healthwatch and we will wait for feedback from the Healthwatch Strategic Board in the next week or so and will provide an update at the next meeting.</p>		
<b>QUALITY GOVERNANCE</b>			
<b>EEC 20/12/10</b>	<b>CCG RISK REGISTER AND ASSURANCE FRAMEWORK</b>		
	<p>The head of governance &amp; assurance provided an overview of the risk register and assurance framework and the associated processes for information and to provide assurance for committee members.</p> <p><b>Governing Body Assurance Framework (GBAF).</b> Work previously suspended due to the pandemic is now complete and the revised GBAF was signed off by senior management team on 23rd October 2020 and Governing Body on 12th November 2020. Whilst the specific deliverables, controls &amp; assurances in the GBAF have changed slightly the key priority areas remain unchanged from 2019/20, with the exception that a new priority area relating to Care Homes has been added.</p> <p><b>Risk Register</b> There are currently 2 risks rated amber on the corporate risk register for which the equality and engagement committee are responsible for managing :</p> <ul style="list-style-type: none"> <li>• Risk Reference 13/13b (rated 12, amber high) – Potential failure of the CCG to engage with patients and the public in the commissioning of services.</li> <li>• Risk Reference CCG 14/16 (rated 8, amber high) – If a culture supportive of equality and diversity is not embedded across the CCG there is a risk that the CCG will fail to discharge its statutory duties as an employer and will not adequately consider issues of equality within the services we commission.</li> </ul>		

Agenda Item	Note	Action	Deadline
	<p>In relation to risk 13/13b the committee were asked to reduce the likelihood rating from 4 to 3 as we have had Green Star rating for engagement for two consecutive years . The committee agreed that this risk should be reduced as proposed which would bring this overall score to 8.</p>		
<p><b>EEC</b> <b>20/12/11</b></p>	<p><b>HR POLICIES</b></p>		
	<p>The following policies have been reviewed in line with the usual processes and are consistent with changes being made within SYB CCG's:</p> <ul style="list-style-type: none"> <li>• Employment Break Policy</li> <li>• Managing Concerns with Performance Policy</li> <li>• Recruitment and Selection Policy</li> </ul> <p><b>Summary of Proposed Changes</b> Changes to the Employment Break Policy are minimal and have been made in conjunction with Trade Union representatives and our Counter Fraud Specialist:</p> <ul style="list-style-type: none"> <li>• Clarification added to section 2.5 with regards to agreeing the method and frequency of communication between the employee and line manager during the career break.</li> <li>• Addition to section 2.8.8 as a reminder to employees of the need to confirm resignation in writing during an employment break.</li> <li>• Section 1.7 amended to clarify the policies / processes that will apply should an employee express a want to return to work from their career break earlier than originally agreed.</li> </ul> <p>The Managing Concerns with Performance Policy has been amended following recent manager feedback and updated CIPD best practice guidance. The policy now explicitly includes:</p> <ul style="list-style-type: none"> <li>• How to identifying poor or diminishing performance, as well as possible reasons for diminishing performance.</li> <li>• Clarification around the purpose and the running order of a formal performance review meeting</li> <li>• Section 8 added to policy following manager feedback in order to address how concerns can be managed when they are reported via other colleagues.</li> </ul>		

Agenda Item	Note	Action	Deadline
	<ul style="list-style-type: none"> <li>• Table added to section 9 to include potential reasons for the performance issues and the possible courses of action to signpost staff / managers to other policies that can be utilised in conjunction with the Managing Concerns with Performance Policy.</li> <li>• Text explaining the purpose and suggested running order of the formal review meeting added to Section 10.1.</li> </ul> <p>The Recruitment and Selection policy has been updated to reflect best practice with regards to internal recruitment. Information relating to declarations of interest has also been included at the request of the Counter Fraud Specialist:</p> <ul style="list-style-type: none"> <li>• Section 8 condensed and moved to section 10 to reflect best practice and accurately reflect process, as described in the Organisational Change Policy.</li> <li>• Section 11 deleted and incorporated in section 10 of the policy.</li> <li>• Additional text in Section 13 clarifies the process / options for line managers should an applicant request different T&amp;C's to those which we advertised e.g. reduced hours.</li> <li>• Statement with regards to 'Declarations of Interest' included in section 14.</li> <li>• Update to Appendix 1 following changes to the process for applicants with regards to work permits.</li> <li>• Update to Appendix 3 to reflect the process now followed with regards to Criminal Convictions self-declaration forms / DBS checks.</li> </ul> <p><b>Next Steps</b> Once the changes are approved by the Committee the policies will be updated, placed on the CCG's external website and the changes notified to staff via the weekly communication update.</p> <p>Committee members present approved these policies.</p> <p>The senior management team has agreed to development of Home Working Policy. We already have this as part of our Flexible Working Policy however beyond the pandemic some staff may want to continue working from home so a more robust policy is being put in place and this is going through the usual engagement process with staff, staff side and counter fraud and will be presented to the governing body in January 2021 for sign off.</p>		

Agenda Item	Note	Action	Deadline
<b>EQUALITY</b>			
<b>EEC 20/12/12</b>	<b>EQUALITY OBJECTIVES AND ACTION PLAN 2019-2021</b>		
	A review of the equality objectives and action plan for 2019-2021 had been paused though work is still ongoing and this work will be picked back up. If there is anything in the action plan that we need to escalate or amend then members are asked to contact the head of communications and engagement.		
<b>EEC 20/12/13</b>	<b>WORKFORCE RACE EQUALITY STANDARDS ACTION PLAN</b>		
	<p>The committee signed off the Workforce Race Equality Standard (WRES) report at the 13 August 2020 Equality &amp; Engagement Committee. The purpose of revisiting this report is to consider the detail of the WRES Action Plan to ensure we are doing enough to mitigate the inequalities.</p> <p>The Healthwatch Manager has looked at the report and believes the action plan is sufficient to mitigate inequalities. The head of communications and engagement stated that under normal circumstances we would have done more to co-produce this action plan with staff and for them to come up with solutions. For our next steps we would want to do this.</p> <p>The equality, diversity and inclusion lead is now officially a WRES Expert and has access to a huge number of reports and other experts which we could call upon if required. The CCG receives Barnsley provider organisation WRES reports. Members agreed that this committee would like to see these reports.</p> <p>Noted that a cultural blue print survey was undertaken and we received results in March 2020. We have undertaken pulse surveys throughout the pandemic and have not participated in the national NHS staff survey as we have collected enough information from our staff.</p> <p>A concern raised was that the WRES data is compared year on year and an action was agreed to check if the WRES action plan is fit for purpose and to ask staff for solutions to the actions.</p> <p>Conversations have taken place during Black History month and at staff briefings re racial inequalities and have been</p>		

Agenda Item	Note	Action	Deadline
	really useful for challenging perceptions and sharing experiences. Staff will be concerned about health inequalities, for the BAME community in particular, and it was suggested that a pulse survey should be undertaken to ensure any concerns raised can be addressed.		
	<p><b>Action Agreed</b></p> <ul style="list-style-type: none"> <li>Action to check if the WRES action plan is fit for purpose and to ask staff for solutions to the actions.</li> <li>Discuss at senior management team if we should undertake a pulse survey in relation to inequalities, in particular for the BAME community.</li> </ul>	<p><b>KW/ CBB</b></p> <p><b>RW</b></p>	<p><b>31.12.2020</b></p> <p><b>31.12.2020</b></p>
<b>EEC 20/12/14</b>	<b>NHS PEOPLE PLAN ACTIONS</b>		
	<p>The NHS People Plan Actions sets out actions for employers, national bodies and systems in a number of areas. This document needs to be considered within Barnsley CCG and a number of teams and groups will need to input to this to check we are compliant in each area and measure outcomes.</p> <p>The committee is asked to note the content of the NHS People Plan Actions for information and agree how to progress work to check we are compliant in all sections and measure outcomes.</p> <p>During the pandemic an interim plan was drawn up so that some actions could be progressed. This interim plan is heavily focussed on health and wellbeing and equality, diversity and inclusion. It was agreed that the interim plan is reported back to the February 2021 committee.</p> <p>The plan has actions for the CCG as an employer, a commissioner and also for our providers and we need to work through this. The HR manager has developed an outline strategy and actions for the CCG are already in the HR plan. Some of our actions from the pulse surveys and WRES action plan need to be brought together in one place and reported to the CCG senior management team and twice yearly to the governing body so they are assured in relation to the overall HR strategy. A first step towards this is for the HR manager and the equality; diversity &amp; inclusion lead to ensure actions are brought together.</p>		
	<b>Agreed Actions:</b>		

Agenda Item	Note	Action	Deadline
	<ul style="list-style-type: none"> <li>The interim NHS People Plan to be brought back to the February 2021 committee.</li> <li>The HR manager and the equality, diversity and inclusion lead to work together to ensure actions are being taken forward in relation to WRES, DES, EDS2 and health &amp; wellbeing are brought together in the HR Plan.</li> </ul>	<p>CBB</p> <p>ES/ CBB</p>	<p>On the February agenda - Completed</p>
<p><b>EEC</b> <b>20/12/15</b></p>	<p><b>HEALTH INEQUALITIES OF COVID-19 IN BARNSELY</b></p>		
	<p>COVID-19 has put a spot light on health inequalities of people and those in poor health have experienced the virus at a much worse level. To provide the committee with assurance it was noted that a number of measures to reduce health inequalities are being put in place, led by the CCG. For example from 1 December 2020 Pulse Oximetry @Home was rolled out which will help residents self-monitor blood oxygen levels to ensure they do not have hidden hypoxia. Also Post Covid Assessment Clinics have been established with an MDT approach to Long Covid which has now been recognised as a new long term condition.</p>		
<p><b>GENERAL</b></p>			
<p><b>EEC</b> <b>20/12/16</b></p>	<p><b>REVIEW OF EQUALITY &amp; ENGAGEMENT COMMITTEE TERMS OF REFERENCE</b></p>		
	<p>The head of governance &amp; assurance has reviewed the terms of reference and corrected a few minor typos and the membership changed slightly. It is proposed that these are updated to name the chief nurse as vice chair of the committee as the CCG now has a substantive post holder in this role. In addition it is proposed that the deputy chief nurse is an additional member as they have a particular interest in patient experience.</p> <p>We have recently appointed a medical director and, to meet recent NHSE requirements, one of their responsibilities is to be the named individual with interest in health inequalities. We may need to consider as a committee how we involve the medical director in the business of this committee. Noted that the medical director will chair the quality and patient safety committee.</p> <p>It was noted that all NHS boards have this requirement so we need to look at similarities/differences for health partners in Barnsley and reflect this in the terms of</p>		

Agenda Item	Note	Action	Deadline
	<p>reference. BHNFT are looking at non-executive board members that have a particular interest in this role. One option would be to consider the thoughts of leadership and staff in the WRES action plan.</p> <p>The committee approved the proposed changes to the committee terms of reference.</p>		
<b>EEC 20/12/17</b>	<b>ANY OTHER BUSINESS</b>		
	<p>During the pandemic the equality, diversity and inclusion lead joined the occupational health team to set up the psychological support to staff and will now officially lead on health and wellbeing for staff alongside equality, diversity and inclusion duties. The trust executive management team has agreed to a supporting role for equality, diversity and inclusion to pick up operational work.</p>		
	<p>NHSE and NHSI have published their proposals for the future of integrated care and commissioning and this document is now out to engagement with responses to be fed back by the first week of January 2021. The report will be shared on the CCG website and the communications team will be collating feedback to go back to the national team leading on this.</p> <p><a href="https://www.england.nhs.uk/wp-content/uploads/2020/11/261120-item-5-integrating-care-next-steps-for-integrated-care-systems.pdf">https://www.england.nhs.uk/wp-content/uploads/2020/11/261120-item-5-integrating-care-next-steps-for-integrated-care-systems.pdf</a></p>		
<b>EEC 20/12/18</b>	<b>ITEMS TO HIGHLIGHT IN THE GOVERNING BODY ASSURANCE REPORT</b>		
	<p>Committee members agreed to highlight the following areas:</p> <ul style="list-style-type: none"> <li>• NHS Oversight Framework Patient and Community Engagement Indicator Green Star rating.</li> <li>• Actions for the NHS People Plan being taken forward.</li> </ul>		
<b>EEC 20/12/19</b>	<b>REFLECTION ON HOW WELL THE MEETING'S BUSINESS HAD BEEN CONDUCTED</b>		
	<p>The Chair thanked members for their input, good quality and content of papers and a good meeting. Committee members feel assured by the ongoing activities in relation to equality and engagement and no training needs were identified.</p>		

Agenda Item	Note	Action	Deadline
<b>EEC 20/12/20</b>	<b>DATE AND TIME OF THE NEXT MEETING</b>		
	The next meeting of the equality and engagement committee will be held on Thursday 25 February 2021 at 1pm via Microsoft Teams.		

**UNADOPTED Minutes of the Meeting of the EQUALITY AND ENGAGEMENT COMMITTEE held on Thursday 25 February 2021 at 1pm via Microsoft Teams**

**PRESENT:**

Chris Millington (Chair)	Lay Member for Patient & Public Engagement, CCG
Kirsty Waknell	Head of Communications & Engagement, CCG
Richard Walker	Head of Governance & Assurance, CCG
Colin Brotherston-Barnett	Equality, Diversity & Inclusion Lead, CCG
Jayne Sivakumar	Chief Nurse, CCG
Dr Adebowale Adekunle	Elected Governing Body Member, CCG
Susan Womack	Manager, Healthwatch Barnsley

**IN ATTENDANCE:**

Esther Short	HR & OD Business Partner, CCG
Ellie Roach	Senior HR & OD Advisor, CCG
Louise Hallworth	Campaign Consultant, Magpie
Emma Bradshaw	Engagement Manager, CCG
Carol Williams	Project Coordinator/Committee Secretary, CCG

**APOLOGIES:**

Julie Frampton	Senior Primary Care Commissioning Manager, CCG
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Agenda Item	Note	Action	Deadline
<b>EEC 21/02/01</b>	<b>HOUSEKEEPING / APOLOGIES</b>		
	The Chairman informed everyone present of the etiquette for Microsoft Teams meetings. Apologies were received as above.		
<b>EEC 21/02/02</b>	<b>QUORACY</b>		
	The chair of the committee declared that the meeting was quorate.		
<b>EEC 21/02/03</b>	<b>DECLARATIONS OF INTEREST RELEVANT TO THE AGENDA</b>		

Agenda Item	Note	Action	Deadline
	The committee considered the declarations of interest report; no new declarations of interest were noted.		
<b>EEC 21/02/04</b>	<b>MINUTES OF THE PREVIOUS MEETING HELD ON 3 DECEMBER 2020</b>		
	The minutes of the meeting held on 3 December 2020 were adopted and verified as an accurate record of the proceedings by members present.		
<b>EEC 21/02/05</b>	<b>MATTERS ARISING REPORT</b>		
	<p>The committee noted the actions from the 3 December 2020 meeting. A number of items were to be discussed on the agenda and had been closed, one action had remained open:</p> <p><b>EEC 20/12/13 Workforce Race Equality Standards Action Plan</b> Check if the WRES action plan is fit for purpose and to ask staff for solutions to the actions.</p> <p><b>Update 25.02.2021</b> CCG staff have discussed the opportunities of having a Barnsley CCG BAME staff network and work is taking place to develop this with staff.</p> <p>RW was going to discuss at senior management team if we should undertake a pulse survey in relation to inequalities, in particular for the BAME staff. As this fits in with a wider piece of work a decision was made for KW &amp; CBB to pick this up with RW outside of the meeting.</p> <p><b>Action closed and further updates will be brought to the committee as they arise.</b></p>		
<b>PATIENT AND PUBLIC ENGAGEMENT</b>			
<b>EEC 21/02/06</b>	<b>PATIENT AND PUBLIC INVOLVEMENT STRATEGY</b>		
	<p>The patient and public involvement strategy for the CCG is due to be refreshed during 2021. The content of the strategy is largely up-to-date therefore the committee agreed that this could be a light touch refreshed version taking into consideration anything in relation to Covid-19 and health inequalities.</p> <p>Dr Adekunle joined the meeting.</p>		

Agenda Item	Note	Action	Deadline
	<p><b>Agreed Actions:</b></p> <ul style="list-style-type: none"> <li>• Circulate the current patient and public involvement strategy to committee members for consideration within the areas of work they lead on. The refreshed version will be brought back to the May 2021 committee meeting for approval.</li> </ul>	KW	20.05.21
EEC 21/02/07	<p><b>THE IMPACT OF COVID-19 ON LOCAL COMMUNITIES</b></p>		
	<p><b>Behaviour insight survey from Barnsley Council</b>          Louise Hallworth, from creative communications agency Magpie, has been working with partners across the borough and provided an update on some of the work being undertaken to understand people's experience, behaviours and activities of Covid-19. The most recent behaviour insight survey covered a range of things including people's attitudes and understanding of the need to self-isolate, if they needed to be tested and the Covid-19 vaccine. Members were asked to consider how we build the information being shared into our core business for staff and as commissioners. A presentation was shared with members.</p> <p><b>Comments from committee members</b></p> <ul style="list-style-type: none"> <li>• This is an excellent piece of engagement with 836 people and a number of surveys and workshops have provided valuable insights.</li> <li>• It is good to know 87% of respondents would have the Covid-19 vaccine.</li> <li>• Confirmation from members the thoughts that supermarkets are not good places to go.</li> <li>• 93% of people surveyed believe they are following guidelines yet there was a high number of people saying these guidelines are confusing, unclear and hard to follow. With a high number of admissions to BHNFT we may have people who are not fully following guidelines. It was also noted that some people will struggle to follow the guidelines because of their job or their living arrangements. Magpie deliberately phrased the question to ask if people 'believed' they were following guidelines because a hard hitting critical campaign would likely result in people not engaging with it. The message 'we are doing well but need to just do a little bit more and what can we do to make this better and easier?' is the message being pushed, along with finding a better way to make it easier to follow the guidelines.</li> <li>• Noted that behaviour changes are important. We</li> </ul>		

Agenda Item	Note	Action	Deadline
	<p>need to understand where people are at and influence and ‘nudge’ their behaviour rather than tell them what and what not to do.</p> <ul style="list-style-type: none"> <li>• The content shared is relevant to all partners, for the CCG we will particularly want to focus on the attitudes and beliefs around the vaccine. We are already starting to see push back on the attitude towards the vaccine as we move down the age groups. Changing perceptions and attitudes is key and we have to consider different shared beliefs and behaviours of groups of people in various age groups and segments of the population so that we could tie messages to these. The data is useful to be able to target these groups.</li> <li>• Some of the national and local messages in relation to Covid-19 are shock tactics and can switch people off. The campaign which is being developed with Barnsley Council will be using more muted colours that are more associated with wellbeing and not ‘danger’.</li> <li>• What next? – the engagement manager and the Healthwatch manager attend the intelligence sharing group and we can tie this into the data sources shared in that group to make the most of this. As the surveys were anonymous the raw data can be shared with any partners to look at in their own way.</li> <li>• We need to check if there is an intention to keep reinforcing to employers that they still have responsibility to provide safe working environments for their staff as there is lots of data that suggests people with manual jobs are more likely to contract Covid-19 which accounts for some of the infections in the borough. There is soft intelligence to suggest that some people flout the rules so we need to consider how to improve on this to decrease the rate of transmission as Barnsley’s rate is higher than other areas in South Yorkshire and Bassetlaw.</li> <li>• Healthwatch England is looking at vaccinations and has a questionnaire which could be utilised at a local level.</li> </ul> <p>The chair thanked Louise Hallworth on behalf of the committee for her informative presentation.</p>		
	<p><b>Survey results from Healthwatch Barnsley</b> The Healthwatch Manager presented the results of their survey which was focussed on what people told us about their experiences during the Covid-19 pandemic.</p>		

Agenda Item	Note	Action	Deadline
	<p>Louise Hallworth from Magpie left meeting.</p> <p><b>Comments from committee members</b></p> <ul style="list-style-type: none"> <li>• It will be helpful to combine this data with other surveys and day to day intelligence to form our priorities going forward.</li> <li>• Noted a good number of people had received the flu jab.</li> <li>• Prior to the pandemic lots of people were suffering with loneliness and isolation and all of us have experienced this for ourselves and wonder if we will be more empathetic to neighbours when we get back to normal lives.</li> <li>• The comparison of January results to the summer results was useful. This information has been shared with the intelligence group and also with Katy Davidson from the ICS and she will be in touch directly to thank Healthwatch for this work and to congratulate the work that we are doing in Barnsley as a partnership.</li> <li>• Noted that many respondents live in the central area so reaching residents in other areas is a challenge and we need to ensure we are communicating with all Barnsley residents.</li> <li>• The main points covered are really useful and we are trying to do the best we can across all areas however we can make a decision to focus on some areas really well and do things differently using the survey for context and to help shape our work.</li> <li>• Noted that people still want face to face support which was noted in the earlier survey. For some people the perception of being able to get this support was enough for them. However it was clear that not everyone have accessed the support they needed as they did not want to trouble already stressed services and some respondents stated they did not where to go to get support.</li> <li>• All the data going to the intelligence group is very rich across a range of areas. We now have to say 'so what?' and challenge ourselves to make use of this information and how this can best guide us.</li> <li>• We will want to refine the vaccination survey and focus on some areas recommended by Healthwatch.</li> <li>• The chief nurse added that this is a fantastic report with valuable information. There are issues that were there prior to the pandemic and have been exacerbated by this and we have seen widening of</li> </ul>		

Agenda Item	Note	Action	Deadline
	<p>inequalities across our populations. This report shows definitively that this is what the public has experienced throughout Covid-19 and we do need to ask 'so what?' and to use this information to put into practice services that make a difference to support the people of Barnsley.</p> <ul style="list-style-type: none"> <li>• What next? The CCG will share this information with relevant colleagues in our organisation and wider colleagues to ensure the information within the report is used. Public Health should also see this report and this sits alongside the work that Magpie is doing for Barnsley Council. The intelligence cell has a large dashboard of rich data and we need to ensure the right people are looking at this and it is interpreted in a way that helps inform our work.</li> <li>• The engagement experience leads meet today (25 February 2021) and this feeds into the intelligence meeting and community resilience forum so these strands of information will need to be pulled together and filtered through to the right people across all organisations for them to work together on this as one team.</li> </ul> <p>The chair thanked the Healthwatch manager on behalf of the committee for their invaluable report.</p>		
	<p><b>Agreed Actions:</b></p> <ul style="list-style-type: none"> <li>• <b>The head of communications and engagement to check if this data is telling us enough, do we need to look at the information again in a different way, and how do we share this with colleagues?</b></li> </ul>	KW	20.05.21
<p><b>EEC</b> <b>21/02/08</b></p>	<p><b>MINUTES OF THE PATIENT COUNCIL MEETINGS HELD ON 2 DECEMBER 2020 &amp; 27 JANUARY 2021</b></p>		
	<p>The Patient Council minutes were shared for information and the Chair highlighted the following:</p> <p><b>2 December 2020 - 'What people are telling us'</b> The focus of the meeting was to ask how the public voice was being captured in relation to Covid-19 and members contributed their own experiences of life during lockdown.</p> <p><b>27 January 2021 – GP Services in Barnsley during the pandemic</b> Dr Balac, Barnsley GP and Barnsley CCG Chair provided an overview of GP services in Barnsley during the pandemic. Dr Balac stated that we will continue with</p>		

Agenda Item	Note	Action	Deadline
	the new ways of working.		
<b>QUALITY GOVERNANCE</b>			
<b>EEC 21/02/09</b>	<b>EQUALITY &amp; ENGAGEMENT COMMITTEE ANNUAL ASSURANCE REPORT</b>		
	The Equality & Engagement Committee Annual Assurance report was submitted to the committee for approval. The report is to provide assurance that we are discharging the terms of reference of the committee and managing any risks. The audit committee and governing body receive this assurance report as part of year end processes. Committee members approved the report.		
<b>EEC 21/02/10</b>	<b>CCG RISK REGISTER AND ASSURANCE FRAMEWORK</b>		
	<p>The full GBAF and Risk Register are submitted to the Equality and Engagement Committee on a bi-annual basis (February and November). At all other times an exception report including red and amber risks is provided. In line with reporting timescales a full report is therefore provided to the February 2021 meeting of the Equality and Engagement Committee.</p> <p><b>Governing Body Assurance Framework (GBAF).</b> The Governing Body Assurance Framework (GBAF) facilitates the Governing Body in assuring the delivery of the CCG's annual strategic objectives. There are no risks on the Assurance Framework where the Equality and Engagement committee provides assurance.</p> <p><b>Risk Register</b> There are currently no 'red' risks and 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"> <li>• 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.</li> <li>• Risk Reference CCG 14/16 (rated 8, amber high) – If a culture supportive of equality and diversity is not embedded across the CCG there is a risk that the CCG will fail to discharge its statutory duties as an employer and will not adequately consider issues of equality within the services we commission.</li> </ul>		

Agenda Item	Note	Action	Deadline
	The committee reviewed and agreed that the risks are being appropriately managed and scored and they are assured.		
<b>EEC 21/02/11</b>	<b>PEOPLE AND ORGANISATIONAL DEVELOPMENT (OD) STRATEGY 2021 TO 2022</b>		
	<p>The People and OD Strategy had been written in response to the NHS People's Plan. This template document address themes set out in the People's Plan and highlights what we are currently doing and what we may like to do. All South Yorkshire &amp; Bassetlaw CCG's have used the same template as this was an opportunity to work together with the aim of pulling together all HR and OD activity, focus and direction of travel for CCG's and only covers 1 year, as from April 2022 we will be a new organisation.</p> <p>Doncaster and Bassetlaw have adopted this as a strategy and Sheffield and Rotherham have adopted this as an approach.</p> <p>The draft People and OD report was presented to the committee for information and comment noting that overall responsibility sits the CCG chief officer and as such final approval of the strategy will come from the senior management team.</p> <p><b>Comments</b></p> <ul style="list-style-type: none"> <li>• The Chair highlighted how good it was that this was adopted across all South Yorkshire and Bassetlaw CCG's.</li> <li>• We are keen to see more ownership and influence across the senior management team and for Barnsley CCG to make the decision if we adopt this as a strategy or an approach.</li> <li>• We will be moving to a period of organisational change and there will be an HR framework in April 2021 to guide us and will see things from that to bind into this strategy/approach which may supersede some of the content – this is covered in the document.</li> <li>• All HR plans, approaches and strategies are covered by this document and HR, L&amp;D and OD are now working as one team.</li> </ul>		
	<p><b>Agreed Action:</b></p> <ul style="list-style-type: none"> <li>• <b>The head of governance and assurance to take the People and OD Strategy to the senior</b></li> </ul>	<b>RW</b>	<b>20.05.21</b>

Agenda Item	Note	Action	Deadline
	<p><b>management team for consideration of how to embed this across the organisation.</b></p>		
<p><b>EEC 21/02/12</b></p>	<p><b>HR POLICIES</b></p>		
	<p>The following policies have been reviewed in line with the usual processes and are consistent with changes being made within SYB CCG's. The majority of amendments in the policies listed below are dates and slight updates to equality impact assessments:</p> <ul style="list-style-type: none"> <li>• Dress Code and Appearance Policy</li> <li>• Expenses Policy</li> <li>• Flexible Working Policy</li> <li>• Secondment Policy</li> </ul> <p><b>Summary of Proposed Changes</b></p> <p><b>Dress Code and Appearance Policy</b></p> <ul style="list-style-type: none"> <li>• Amendments to review dates and author in line with organisational process.</li> </ul> <p><b>Expenses Policy</b></p> <ul style="list-style-type: none"> <li>• Amendments to review dates and author in line with organisational process.</li> <li>• Statement added to section 1.9 as follows at the request of Counter Fraud Specialist: <i>“Any suspicion in relation to a possible false expense claims should be reported immediately to the CCG’s Counter Fraud Specialist”</i>.</li> </ul> <p><b>Flexible Working Policy</b></p> <ul style="list-style-type: none"> <li>• Sections 1.1 and 1.2 updated to reflect current legislation and best practice with regards to eligibility to apply for flexible working.</li> <li>• Section 7.6 amended to reflect the new Home Working Policy and to signpost staff to read this in conjunction with the Flexible Working Policy.</li> <li>• Section 8 was added following recent manager feedback and to reflect the recently updated Recruitment and Selection Policy.</li> </ul> <p><b>Secondment Policy</b></p> <ul style="list-style-type: none"> <li>• Amendments to review dates and author in line with organisational process.</li> </ul> <p><b>Next Steps</b></p> <p>Once the changes are approved by the Committee the policies will be updated, placed on the CCG’s external website and the changes notified to staff via the weekly</p>		

Agenda Item	Note	Action	Deadline
	<p>communication update.</p> <p>Committee members approved the policies listed above.</p>		
<b>EQUALITY</b>			
<b>EEC 21/02/13</b>	<b>EQUALITY OBJECTIVES AND ACTION PLAN 2019-2021</b>		
	<p>A review of the equality objectives and action plan for 2019-2021 has now been undertaken and was presented to the committee for information. The plan has been updated to reflect the inequalities raised during the pandemic.</p>		
<b>GENERAL</b>			
<b>EEC 21/02/14</b>	<b>REVIEW OF EQUALITY AND ENGAGEMENT COMMITTEE WORK PLAN</b>		
	<p>The committee workplan was shared for information.</p>		
	<p><b>Agreed Action:</b></p> <ul style="list-style-type: none"> <li>• <b>The refreshed version of the engagement strategy will be presented to the committee in May 2021, the workplan to be amended to reflect this.</b></li> </ul>	<b>CW</b>	<b>20.05.21</b>
<b>EEC 21/02/15</b>	<b>ANY OTHER BUSINESS</b>		
	<p>The chief nurse stated that her workload during the pandemic had been extremely heavy and she had not been able to attend the equality and engagement committee meetings. Portfolios of work have now moved and she can now prioritise this work and is looking forward to being part of the team.</p>		
	<p>Two members of the commissioning and transformation team have been invited to speak at the NHSE leadership academy inclusion and allyship conference being held on 10th March 2021. The conference is free to attend and the link below can be shared with others. To book please visit:  <a href="https://www.nelacademy.nhs.uk/event/inclusion-conference-allyship">https://www.nelacademy.nhs.uk/event/inclusion-conference-allyship</a></p>		
<b>EEC 21/02/16</b>	<b>ITEMS TO HIGHLIGHT IN THE GOVERNING BODY ASSURANCE REPORT</b>		

Agenda Item	Note	Action	Deadline
	<p>Committee members agreed to highlight the following areas:</p> <ul style="list-style-type: none"> <li>• The two surveys presented by Magpie and Healthwatch - these to be included in engagement report.</li> <li>• To note the committee has received and commented on the People and OD strategy and this will now be discussed by the CCG senior management team.</li> </ul>		
<b>EEC 20/02/17</b>	<b>REFLECTION ON HOW WELL THE MEETING'S BUSINESS HAD BEEN CONDUCTED</b>		
	<p>The Chair thanked members for their input, good quality and content of papers and a good meeting. Committee members feel assured by the ongoing activities in relation to equality and engagement and no training needs were identified.</p> <p>There is genuine interest in taking information from the surveys presented to the committee to make a difference within the CCG. We are living through unusual times and everyone has had a lot to do however it is clear that everyone in partner organisation are coming together to create clarity in our work. It is impressive that we never stop in our efforts to make a difference within Barnsley and understanding and hearing from our communities is very important.</p>		
<b>EEC 21/02/18</b>	<b>DATE AND TIME OF THE NEXT MEETING</b>		
	<p>The next meeting of the Equality and Engagement Committee will be held on Thursday 20 May 2021 at 9am via Microsoft Teams.</p>		

<b>MEETING:</b>	Health and Wellbeing Board
<b>DATE:</b>	Thursday, 4 February 2021
<b>TIME:</b>	2.00 pm
<b>VENUE:</b>	Held Virtually

## MINUTES

### Present

Councillor Jim Andrews BEM, Deputy Leader  
Councillor Margaret Bruff, Cabinet Spokesperson - Childrens  
Councillor Jenny Platts, Cabinet Spokesperson - Adults and Communities  
Dr Nick Balac, Chair, NHS Barnsley Clinical Commissioning Group  
Wendy Lowder, Executive Director - Adults and Communities  
Julia Burrows, Director of Public Health  
Mel John-Ross, Executive Director – Children’s Services  
Sue Barton, South and West Yorkshire Partnership NHS Foundation Trust  
Adrian England, Healthwatch Barnsley  
Chris Edwards, NHS Barnsley Clinical Commissioning Group  
Jeremy Budd, NHS Barnsley Clinical Commissioning Group  
Bob Kirton, Barnsley Hospital NHS Foundation Trust  
Amanda Garrard, Berneslai Homes  
Andrew Denniff, Barnsley and Rotherham Chamber of Commerce

### 1 **Declarations of Pecuniary and Non-Pecuniary Interests**

There were no declarations of pecuniary or non-pecuniary interest.

### 2 **Minutes of the Board Meeting held on 8th October, 2020 (HWB.04.02.2021/2)**

The meeting considered the minutes of the previous meeting held on 8<sup>th</sup> October, 2020.

**RESOLVED** that the minutes be approved as a true and correct record.

### 3 **Key points from the Children and Young People's Trust Executive Group held on 17th September and 17th December (Draft), 2020 (HWB.04.02.2021/3)**

The meeting considered the minutes from the Children and Young People’s Trust Executive Group held on 17<sup>th</sup> September and 17<sup>th</sup> December, 2020.

At the 17<sup>th</sup> December meeting, the Trust welcomed Jeremy Budd to give an overview of the Integrated Care System. Feedback had also been provided on the Emotional Health and Wellbeing Group, their priorities and their workstreams.

**RESOLVED** that the minutes be received.

**4 Key points from the Safer Barnsley Partnership held on 30th November, 2020 (HWB.04.02.2021/4)**

The meeting considered the minutes from the Safer Barnsley Partnership held on 30<sup>th</sup> November, 2020. The meeting had been well attended and had considered a case study regarding a problem area in Barnsley. This which brought to life the approach taken in working with local people to deliver sustainable change.

The meeting had also discussed the performance of the Youth Justice Team, with excellent work taking place to ensure first time entrants to the justice system were diverted from court.

**RESOLVED** that the minutes be received.

**5 Public Questions (HWB.04.02.2021/5)**

The meeting noted that no public questions had been received for consideration at the meeting.

**6 Covid Intelligence Update - Presentation by Andy Snell/ Joe Minton (HWB.04.02.2021/6)**

Dr. Andy Snell, Consultant in Public and Global Health was welcomed to the meeting to provide an overview on Covid-19.

Members heard how variations had been seen throughout the globe, with the US having experienced turbulence, and France previously seeing a significantly high peak. However, the UK rates and deaths per 1 million residents were currently high globally. This was attributed to winter and less tight controls, alongside the UK variant, which had resulted in rises in cases, deaths, and significant pressures on care.

However, it was suggested that the UK was seeing cases drop and was now over the peak. Members also heard that the rates of vaccines per million people was significantly high.

It was noted that in December/January that Barnsley had low case rates compared to other areas nationally. This could be attributed to areas with fewer restrictions and the more transmissible variant leading to high case rates in those areas. However, lockdown had contributed to reducing variations throughout the country.

Members heard that the 7-day case rate for Barnsley was 226/100,000, which was relatively low nationally, but significantly above rates in the summer and September. Though it was expected that the vaccine would have an impact, but Barnsley still had high rates of death, with it ranking 4<sup>th</sup> in the country. Pressure was also still being felt in Primary Care. The reasons behind high death rates, which included a high density of care homes, an older than average population and high rates of social and economic deprivation were discussed. It was suggested that Covid had starkly highlighted health inequalities, with an opportunity to address these in recovery and renewal, building back fairer.

With regards to vaccination, it was noted that the vast majority of over 75s has been vaccinated, with increasing numbers of those aged over 70. In addition, the majority of social care, primary care and related workforces had also been vaccinated.

Members noted the emergence of new variants, but there was evidence that the vaccination did help to reduce the spread of the virus. Also noted was the additional social and economy impacts of the pandemic and the need to work together to address these.

**RESOLVED:-** that thanks be given for the presentation, and that the update be received.

## **7 Report from the Health and Wellbeing Board Development Session (10th December, 2020) and Updated Terms of Reference - Presentation by Diane Lee and Ben Brannan (HWB.04.02.2021/7)**

Ben Brannan, Senior Public Health Officer provided a presentation which gave feedback from the development session held on 10<sup>th</sup> December, 2020.

Identified were clear strengths, which included being good at communicating key messages, having a clear vision, having committed frontline staff and a strong understanding of data. It was noted that whilst Covid had presented significant problem, partnership working to address this had improved. There was civic pride in Barnsley, with a will to improve things. This had been seen in the recent forming of the Mental Health Partnership. Members acknowledged that the forthcoming refresh of the Health and Wellbeing Strategy offered an opportunity to drive improvements and tackle inequalities in health.

Members noted a number of actions emanating from the workshop which included a 'left shift' towards prevention, and strengthening partnership working.

It was suggested that the ultimate aim was to increase healthy life expectancy and narrow gaps in life expectancy across the borough. As this was a longer-term aspiration, a number of measures were suggested in order to consider the impact in the more immediate term, including employment levels, housing conditions and school readiness.

Questions were raised about the length of term the refreshed Health and Wellbeing Strategy would cover and it was noted that this would be defined by Members. It was acknowledged that that many of the issues highlighted by the pandemic were relevant prior and would be subsequently.

The need to ensure the refreshed strategy dovetailed with the Barnsley 2030 work and vice versa was also acknowledged.

With regards to the revised terms of reference it was suggested that discussions take place in order to engage young people in the work of the Board, perhaps inviting Members of the Youth Council.

**RESOLVED:-**

- (i) That the revised Terms of Reference for the Health and Wellbeing Board be endorsed and be recommended to Full Council for approval, subject to the inclusion of further youth participation;
- (ii) That a cross-system (including the Integrated Care System) workshop is held at an appropriate time, which focusses on how we can achieve greater value for money in Barnsley;
- (iii) That Board members actively contribute to the development and delivery of the updated Joint Health and Wellbeing Strategy; that they take ownership for delivering on the strategy and advocate the work of the Board within their own organisation and at partnership meetings (as per the updated Terms of Reference);
- (iv) That the Strategy is translated into clear and measurable outcomes and the Board hold the system to account in achieving these outcomes;
- (v) That a template for the Board is updated and agreed for all reports to the Board which includes questions for the Board, recommendations and SMART actions for the Board, and identifies which outcomes of the refreshed Health and Wellbeing Strategy the reports aligns with.

## **8 Tackling Excess Winter Deaths and cold related illnesses - Jen Macphail and Julie Tolhurst (HWB.04.02.2021/8)**

Julie Tolhurst, Public Health Principal, and Jen McPhail, Senior Health Improvement Officer were welcomed to the meeting.

Work started in 2018 to plan in order to support a reduction in excess winter deaths. Over several years, work has been undertaken with partners to consider what actions can be collectively undertaken.

Members were reminded of the affect of the cold, which was linked to health inequalities and was also related to deprivation and other social economic factors. It was noted that Covid-19 was amplifying risk factors associated with the cold.

The Barnsley 2018-19 excess winter deaths rate was 17.7% which was not statistically different to England, however Barnsley is joint 6<sup>th</sup> highest when compared to neighbours. It was noted that other measures rather than excess winter deaths were being considered in light of Covid-19.

A review of the Excess Winter Deaths Plan had commenced in December 2020, aiming to review actions taken and map support available.

Members noted progress made, including establishing a single point of access for warm homes; Better Homes Barnsley improvements in private sector housing; safe and well checks; and work supported by Area Councils to promote winter warmth and falls prevention. It was also noted that seasonal flu vaccine uptake was higher than average across age groups.

Members were made aware of current support available and were asked to circulate this information through their networks.

A full review of the Excess Winter Deaths plan was planned in Summer 2021 which would also help to understand resource implications going forward.

It was noted that the plan fed into Zero Carbon work, Health and Wellbeing Strategy, and work to alleviate poverty. Questions were raised about where this work would best sit strategically.

Those present discussed the geographical variations in excess winter deaths across the borough, noting the relatively small statistics. Discussions had taken place with Area Council officers to help understand variations, but it was suggested that this was multifactorial. It was acknowledged that a greater understanding would help target resources more effectively.

Members discussed the impact of the behavioural change required in addition to increasing warm homes, especially with the use of new technologies such as air source heat pumps in social housing.

The link between digital exclusion and excess winter deaths was raised, and it was suggested that further work was needed to understand how work in each area could be mutually supportive.

**RESOLVED:-**

- (i) That the review of the 2018-21 and the work done to address excess winter deaths in Barnsley be noted;
- (ii) That Members agree to raise awareness of current guidance and support locally to address excess winter deaths this winter and beyond;
- (iii) That a review of the plan going forward in to 2021, taking account of the evidence from the Covid-19 pandemic and the zero-carbon commitment be supported;
- (iv) That further consideration be given to where Excess Winter Deaths would best strategically fit.

**9 Better Care Fund - Wendy Lowder and Jeremy Budd (HWB.04.02.2021/9)**

Wendy Lowder, Executive Director, Communities, spoke to the item and referred to the delayed publication of the Government's approach to the Better Care Fund (BCF) and it was noted that the intention was for minimal change. There was no obligation to submit the BCF plan for approval but, there were a number of requirements such as reviewing expenditure on social care and having an agreement of the plan in writing

It was noted that there were no plan targets, but this had not hampered partnership work which had helped to prevent delayed discharges despite challenges. Thanks were given to all staff involved.

Members heard that 2021 spending plans were largely a roll forward of previous years, with additional spending commitments. In addition, there were proposals for an uplift amount for 2021 and also commitments to the business cases in relation to developing an Older People Health and Wellbeing Service and Community Reablement Support.

**RESOLVED:-**

- (i) That the content of the report be noted; and
- (ii) That the 2020/1 Better Care Fund planning template including additional spending commitments, be approved.

## **10 Mental Health Partnership - Verbal update from Adrian England (HWB.04.02.2021/10)**

Adrian England, Independent Chair of the Mental Health Partnership, provided an update following the inaugural meeting of the body which was held on 27<sup>th</sup> January, 2021.

An overview was given of the topics discussed, which included the terms of reference and membership. It was noted that these would be reviewed again in a few months to ensure the partnership was fit for purpose.

Members heard that the partnership was originally to meet every quarter, but as part of its establishment would meet every two months in the immediate term.

An exercise had commenced to map all key strategic mental health meetings, which would be shared, and Public Health officers would meet all partners to discuss priorities and governance arrangements prior to the next meeting of the partnership.

A presentation had been received on data and intelligence, and further work was being undertaken to understand suppressed need as a result of the pandemic. It was noted that data and intelligence would be a standing agenda item.

The partnership had considered suicide and information from 'deep dives.' Actions resulting included the development of a multiagency approach to communication in relation to mental health, suicide and young people.

The meeting had also discussed learning disabilities and mental health needs, and this would feature on future agenda.

Members noted that the notes of the meeting would be circulated to the Health and Wellbeing Board once available.

Questions were raised around whether homelessness or substance misuse and mental health had been considered, and it was agreed that these would be discussed in the future.

Noted was the impact of the pandemic on mental health including on the workforce and on children and young people.

Questions were raised about how the Mental Health partnership may arrive at its priorities, and a suggestion was made to engage Steve Bedser through the LGA, as had happened with the board.

Members were reminded that the priorities of the Health and Wellbeing Board included Early Years and Parenting, which had links with mental health, especially when taking into account the impact of the pandemic. It was suggested it may be useful to focus a development session on the priority.

### **RESOLVED:-**

- (i) that the report be noted;

- (ii) that thanks be given for all those involved in the establishment of the partnership;
- (iii) that the notes of the Mental Health Partnership be circulated when available.
- (iv) That a future development session of the Board focuses on Early Years and Parenting.

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Chair